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WAIT…WHY DID I AGREE TO THAT?
WHY THE PATIENT CENTERED STANDARD UNDER THE DOCTRINE OF INFORMED CONSENT SHOULD BE APPLIED TO PELVIC EXAMS IN ASYMPTOMATIC WOMEN

Lily Burdick*

Abstract: In 2020, Columbia University OBGYN Robert Hadden was arrested for a second time for sexually abusing his patients. By the end of 2020, at least 245 women had accused Hadden of abuse over multiple decades. While most licensed physicians do not sexually abuse patients, the scope of the abuse is difficult to determine. This is because hospitals, clinics, and fellow doctors fail to report misconduct, medical boards handle complaints privately, and most significantly, many patients are misinformed as to when pelvic care is medically beneficial and what to expect during pelvic examinations. As a result, most such abuse is never reported. Moreover, even when pelvic care abuses are reported, patients face insurmountable legal hurdles that often preclude relief in civil suits. This paper argues that the doctrine of informed consent can fundamentally shift the dynamic between patients and doctors in pelvic care, helping to prevent gynecological abuses before they occur. Currently, some jurisdictions apply a "customary professional practice standard" to assess whether a physician has adequately informed a patient about a medical procedure—specifically, pelvic exams—based on prevailing practices among medical professionals. This paper contends that this standard is inadequate for pelvic care. Instead, it advocates for state legislatures and courts to adopt a patient-centered informed consent standard. Such a shift would better inform patients, empower them to make more autonomous decisions about their care, and help to address the power imbalances between patients and physicians that can contribute to physician misconduct.

Keywords: Health; Women; Gender; Pelvic Exams; Healthcare; Informed Consent; Medical Malpractice

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INTRODUCTION

In 2012, Evelyn Yang was pregnant and seeking gynecological care.[1] Wanting the best outcome for her baby, she chose well-respected Obstetrician-Gynecologist (OBGYN) Robert Hadden at Columbia University to provide that care.[2] At first, Hadden provided the excellent care Evelyn sought; however, as her pregnancy progressed, her pelvic examinations became longer and more frequent.[3] Yang, in her efforts to ensure a healthy pregnancy for both herself and her baby, decided she "just need[ed] to trust [Hadden]" when he informed her she needed the additional pelvic care.[4] Eventually, Hadden performed a pelvic exam on Yang ungloved.[5] This instance was not the only time Hadden used his position as Yang's gynecologist to perpetrate abuse; looking back, Yang realized she "put up with some inappropriate behavior that [she] didn't know…was straight-up sexual abuse/sexual assault until much later."[6] Yang did not initially report this crime.[7]

That same year, on a Friday in June of 2012, Hadden was arrested for the sexual assault of Laurie Kanyok, who contacted the police after Hadden "orally assault[ed]" her during a routine pelvic exam.[8] By Tuesday of the next week, Hadden was allowed back in the exam room by leadership at Columbia.[9] Despite eight initial allegations of abuse by patients in 2012, Columbia let him practice for an additional five weeks before he was removed from practice, and Hadden managed to settle the 2012 charges without jail time.[10] It was not until Evelyn Yang came forward on CNN with her allegations of abuse in 2020 and Hadden was arrested for a second time that the women Hadden assaulted saw any justice.[11] By the end of his 2020 criminal trial, at least 245 women alleged Hadden had subjected them to unnecessary pelvic exams for his own pleasure, often coercing them to travel to his office (sometimes across state lines) under the guise of providing necessary medical care.[12] Many of these women did not initially report Hadden because, like Evelyn Yang, they did not understand when a pelvic exam was

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[1] Michael Levenson, *Evelyn Yang, Wife of Andrew Yang, Says She Was Assaulted by Her Gynecologist,* NEW YORK TIMES (Jan. 16, 2020), https://www.nytimes.com/2020/01/16/us/andrew-evelyn-yang-dr-robert-hadden.html.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] Chloe Atkins et. al., *'Who's going to believe me?': Survivors of sexual assault by a New York gynecologist talk about the long road to justice,* NBC NEWS (Feb. 17, 2024), https://www.nbcnews.com/news/us-news/survivors-sexual-assault-robert-hadden-interview-rcna138556. *See also* Bianca Fortis & Laura Beil, *How Columbia Ignored Women, Undermined Prosecutors and Protected a Predator for More Than 20 Years,* PRO PUBLICA (Sept. 12, 2023), https://www.propublica.org/article/columbia-obgyn-sexually-assaulted-patients-for-20-years.
[9] Atkins, *supra* note 8.
[10] Fortis, *supra* note 8; Jan Ransom, *Gynecologist Spared Prison in '16 Sex-Crime Plea Faces New Inquiry,* NEW YORK TIMES (Feb. 20, 2012), https://www.nytimes.com/2020/02/20/nyregion/robert-hadden-investigation.html.
[11] Dana Bash, Bridget Nolan, Nelli Black, & Patricia DiCarlo, *Exclusive: Evelyn Yang reveals she was sexually assaulted by her OBGYN while pregnant,* CNN (Jan. 17, 2020), https://www.cnn.com/2020/01/16/politics/evelyn-yang-interview-assault/index.html. At the time, Evelyn Yang's husband, Andrew Yang, was running for president, giving her story an additional spotlight. *Id.*
[12] Fortis *supra* note 8.

necessary or what the standard procedure was, and they did not immediately recognize Hadden's conduct as abusive.[13] Moreover, these patients technically gave Hadden verbal consent to perform pelvic exams under the erroneous assumption that their physician abided by professional standards of care.[14]

The American College of Obstetricians and Gynecologists (ACOG), a "professional membership organization" that represents OBGYNs, medical students, and other health care professionals in the field of gynecology,[15] currently recommends women only receive pelvic exams if they have symptoms,[16] as a part of a pelvic procedure, when a woman is pregnant, or if a woman has a family history of gynecological conditions.[17] Despite this recommendation, in a survey completed for the American Journal of Obstetrics & Gynecology, almost all OBGYNs reported that they would perform a bimanual exam[18] on an asymptomatic patient at a routine visit, even if that woman had a hysterectomy (a surgical procedure which removes the reproductive organs a bimanual pelvic exam is purported to assess),[19] because they believe it is "important for adherence to standard medical practices."[20] Thus, while

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[13] *Id. See also* Bash, *supra* note 11.

[14] Fortis, *supra* note 8. *See also* Bash, *supra* note 11.

[15] The ACOG represents more than 60,000 ob-gyns, medical students, and other health care professionals. They seek to: maintain the highest standards of clinical practice for women's healthcare; strongly advocate for quality healthcare for women; provide education for its members and the public; and increase awareness of the changing issues facing women's healthcare. *About Us*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/womens-health/about-acog#:~:text=This%20website%20is%20powered%20by,dedicated%20to%20improving%20women's%20health (last visited Nov. 11, 2024).

[16] Symptoms that include abnormal bleeding, abnormal vaginal discharge, pelvic pain, or pain during sex could point to a gynecological problem. A pelvic exam can help your ob-gyn diagnose the issue. *Pelvic Exams,* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/womens-health/faqs/pelvic-exams#:~:text=The%20American%20College%20of%20Obstetricians,should%20make%20this%20decision%20together (last visited Nov. 11, 2024).

[17] *Id.* Procedures include having an IUD inserted or having an endometrial biopsy. *Id.*

[18] During the bimanual vaginal exam, a physician will insert two lubricated fingers to feel the cervix. Next, the physician will place their other hand on the patient's abdomen palpitate the uterus and, if possible, other reproductive organs such as ovaries (this is not possible in all patients due to factors such as how tense they are and their weight). W. Newton Long, *Pelvic Examination*, in CLINICAL METHODS: THE HISTORY, PHYSICAL, AND LABORATORY EXAMINATIONS, 3D EDITION (HK Walker, WD Hall, JW Hurst, eds., 1990), https://www.ncbi.nlm.nih.gov/books/NBK286/.

[19] *Hysterectomy,* JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/hysterectomy.

[20] Laura L. Norell, Miriam Kuppermann, Michelle N. Moghadassi, & George F. Sawaya, *Women's beliefs about the purpose and value of routine pelvic examinations,* 86 AM. J. OBSTETRICS & GYNECOLOGY 1, 3–5 (2017).

abuse is pervasive within the OBGYNpractice,[21] even physicians without abusive intent may perform unnecessary pelvic examinations that cause "fear, anxiety, embarrassment, pain, and discomfort" in patients.[22]

Presently, pelvic care abuses can be handled through the criminal system, the civil system, or through disciplinary action by State Medical Boards.[23] These mechanisms are overwhelmingly reactionary; they require abuse to occur before they offer relief to the patient.[24] Thus, these mechanisms only provide relief to a subset of patient-victims: those who have been abused, recognize that abuse, and report it through the proper legal channels. This ignores the larger population of women who undergo unnecessary and difficult pelvic care without knowing if there is a legitimate purpose behind the procedure in the first place.[25] Moreover, even after abuse occurs, these legal mechanisms are often insufficient to provide relief to patients injured by their physicians.[26]

In addition to further developing relief mechanisms for women injured by their practitioners, states should apply a "patient centered standard" to their informed consent doctrine as applied to pelvic exams, as this would place affirmative burdens on physicians to disclose information their patients' believe is pertinent before performing pelvic examinations, including the reasoning for the pelvic examination; the benefits and harms of the exam; alternative treatment options; and what is standard procedure during the exam. In doing so, the relationship between physicians and patients will shift as physicians relinquish some power in determining medical treatment plans without

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[21] Hadden is not the first nor the last to abuse his patient. *See, e.g., Ex-NorthShore Gynecologist Fabio Ortega Pleads Guilty To Sexually Abusing Patients,* CBS NEWS (Oct. 20, 2021), https://www.cbsnews.com/chicago/news/ex-northshore-gynecologist-fabio-ortega-pleads-guilty-to-sexually-abusing-patients/; Erin Lowrey, *Louisiana Doctor Arrested, Accused of Sexually Assaulting Patients*, WDSU NEWS (Oct. 30, 2024), https://www.wdsu.com/article/louisiana-st-tammany-doctor-keith-hickey-arrested/62766295; Jessica Schreifels, *Utah OB-GYN David Broadbent Charged with Forcible Sexual Abuse,* PRO PUBLICA (June 29, 2024), https://www.propublica.org/article/utah-ob-gyn-david-broadbent-charged-forcible-sexual-abuse; David Gonzalez, *15 Female Patients Sue Doctor for Alleged Sexual Abuse During Medical Visits at Irvine Office*, ABC EYEWITNESS NEWS (Aug. 30, 2024), https://abc7.com/post/15-female-patients-sue-doctor-alleged-sexual-abuse-during-medical-visits-irvine-office/15244710/; David Nelson, *OB/GYN Doctor Charged with Child Rape for Alleged Assaults Over Multiple Years*, KITSAP SUN (April 17, 2024), https://www.kitsapsun.com/story/news/2024/04/16/obgyn-doctor-charged-with-child-rape-for-alleged-assaults-over-multiple-years/73343984007/. Moreover, a 2009 report that assessed sexual boundary violations by physicians and concluded most self-reported sexual boundary violations were perpetrated by male physicians in the field of family medicine, psychiatry, and obstetrics/gynecology. Randy A. Sansone & Lori A. Sansone, *Crossing the Line: Sexual Boundary Violations by Physicians,* 6 THE INTERFACE: PSYCHIATRY 1, 1 (2009), https://pmc.ncbi.nlm.nih.gov/articles/PMC2720840/pdf/PE_6_06_45.pdf.

[22] Amir Qaseem, Linda L. Humphrey, Russell Harris, Melissa Starkey, & Thomas Denberg, *Screening Pelvic Examination in Adult Women: A Clinical Practice Guideline from the American College of Physicians*, 161 ANN. INTERN. MEDICINE 67, 69 (2014).

[23] *See* Nanci Hamilton, *Stopping Doctor Evil: How to Prevent the Prevalence of Health Care Providers Sexually Abusing Sedated Patients,* 45 HOFSTRA L. REV. 299, 311–17 (2016).

[24] *Id.* Criminal charges can only be brought after an assault has occurred; civil suits often must show damages from a harm that has already occurred; state board investigations require a complaint before an investigation can occur. In other words, there is "nothing in their process that aims to prevent sexual misconduct from occurring" in the first place. *Id.* at 315.

[25] *See* Norell et. al., *supra* note 20, at 3 ("Approximately one-half of the women that we interviewed did not know the purpose of the pelvic examination.").

[26] *See infra* notes 105–09.

much input from their patients and women take that power to make determinations about their own health and care plans. This would reduce the number of, and harms associated with unnecessary pelvic exams.

This paper proceeds in three parts. Part I provides background for the history of women's healthcare, starting with the development of the field of Western gynecology from the 1600s to the 1800s, culminating in the present day. Part II addresses the current pelvic examination recommendations from medical research bodies and addresses the conflict between those recommendations. Part III delves into the civil remedies available to women seeking relief for abusive or faulty pelvic care, starting with addressing the insufficiencies of medical malpractice suits. Part III will then analyze the development of the doctrine of informed consent in the state statutory scheme and the common law, discerning the best way to develop the doctrine of informed consent for pelvic care. Part IV concludes that the doctrine of informed consent has the capacity to offer protection to women seeking pelvic care, and that the "patient centered standard" is best suited to determine whether a physician has met their duty to disclose prior to obtaining the consent of their patient and is thus best suited to protect patients seeking pelvic care.

A. A Note on Language

This paper refers to patients seeking pelvic care as "women." This is because that is the identity of the patients in the case law analyzed in this paper, as well as the patients in the studies this paper contemplates. In addition, this paper briefly delves into the history of gynecological care, which was historically developed to both provide care for women and, perhaps more importantly, to subjugate women at the hands of male medical practitioners as the West solidified the patriarchy through conquest.[27] Because this paper does not address the unique issues queer, gender non-conforming, and transgender patients face while seeking pelvic care, the language used to discuss the experiences of those seeking care is gendered. This is *not* because only women seek pelvic care, and it is certainly not to erase those experiences; they are simply outside the scope of this short paper.[28]

B. The Scope of this Paper

This paper addresses the doctrine of informed consent as it relates to pelvic care for asymptomatic, adult, non-pregnant women.[29] This paper will not address legal

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[27] *See infra* note 38.

[28] For more on the issues LGBTQ+ individuals face when seeking pelvic care, *see* J. Michelle Schramm, *Seeing our invisible patients: The importance of providing inclusive sexual and reproductive healthcare to LGBTQ populations*, WOMEN'S HEALTHCARE 8 (2016); Maria J. Ruiz et. al., *Sexual and Gender Minority Patients' First Pelvic Examination Experiences: What Clinicians Need to Know*, 37 J. PEDIATRICIAN ADOLESCENT GYNECOLOGY 342 (2024).

[29] This paper includes stories of pregnant women who are injured while seeking pelvic care, such as Evelyn Yang. However, this paper does not address when pelvic exams are necessary and when pelvic exams are unnecessary during pregnant. For the ACOG recommendations for pregnant women, *see infra* note 30, at 1189.

issues of consent pertaining to age;[30] legal issues pertaining to pregnancy and abortion;[31] the specific issues that patients of color face when seeking pelvic care;[32] or the specific issues patients of varying socio-economic statuses face when seeking pelvic care.[33] These issues are important and well worth exploring; however the scope of this paper is both limited and broadened by its focus on the general population of women seeking pelvic care.

I. THE HISTORY OF WESTERN GYNECOLOGY

Current gynecological practices, and the relationship between OBGYNs and their patients, are rooted in a deep history of the displacement and dismissal of women. Before the advent of the Western medicinal field of obstetrics and gynecology, female midwives exclusively officiated births—the earliest written records of midwives are in the Bible and in ancient Greek writings.[34] In the West, female midwives monopolized providing care to pregnant and laboring women throughout the entirety of the Middle Ages.[35] In fact, the earliest record of a man attending a "normal" birth was in 1663.[36] The female model was a collaborative model among women themselves; the male model to come would render the pregnant woman a passive participant in her own labor.[37]

Beginning in the 1600s and 1700s, women were displaced from their roles as midwives and care providers for pregnant women. The 1600s and 1700s marked a period of male colonialism, conquest, and subjugation during which gynecological medical procedures were used to conquer native women.[38] This carried into the 1800s as forced gynecological procedures were used as tools to maintain the colonial structures of slavery, which were dependent on the subjugation of enslaved women and

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[30] For example, Larry Nassar prolifically abused his minor patients by informing them and their parents that pelvic floor physical therapy was a beneficial treatment for elite gymnasts. *Justice Department Pays $138 Million Over FBI Failures in Larry Nassar Case,* NPR (April 23, 2024), https://www.npr.org/2024/04/23/1246647531/doj-settles-larry-nassar-usa-gymnastics-sexual-assault-victims. This type of abuse is in-line with the type of abuse perpetrated by providers contemplated by this paper, but this specific example presents additional issues of consent and age with regards to pelvic care that are outside the scope of this paper. It is a difficult question to determine what parents should be able to consent to on behalf of their minor children with regard to pelvic care specifically. *See* Kailey Remien & Tanuj Kanchan, *Parental Consent*, in *StatPearls* (StatPearls Publishing 2024) (updated Sept. 18, 2022), available at https://www.ncbi.nlm.nih.gov/books/NBK555889/.

[31] *See, e.g.,* The American College of Obstetricians and Gynecologists, Committee Opinion Number 664, *Refusal of Medically Recommended Treatment During Pregnancy,* 127 OBSTETRICS & GYNECOLOGY 1189 (2016).

[32] *See e.g.,* Jennifer Chyu et. al., *Experiences of Black Women with Pelvic Floor Disorders—–A Qualitative Analysis Study*, UROGYNECOLOGY (June 27, 2024).

[33] *See, e.g.,* Robert E. Bristow et. al., *Disparities in Ovarian Cancer Care Quality and Survival According to Race and Socioeconomic Status,* 105 J NAT'L CANCER INSTITUTE 823 (March 28, 2013).

[34] Judy Barrett Litoff, *An Historical Overview of Midwifery in the United States*, PRE- AND PERI-NATAL PSYCHOLOGY J. 5, 5 (1990).

[35] *Id.*

[36] *Id.* at 6.

[37] *See id.*

[38] Gynecological care and sex have historically been used as a tool of Western colonialism around the world; the language used in this paper describes this history. *See, e.g.,* KAREN VIEIRA POWERS, WOMEN IN THE CRUCIBLE OF CONQUEST: THE GENDERED GENESIS OF SPANISH AMERICAN SOCIETY, 1500-1600 (2005); RICHARD C. TREXLER, SEX AND CONQUEST: GENDERED VIOLENCE, POLITICAL ORDER, AND THE EUROPEAN CONQUEST OF THE AMERICAS (1995).

control over their bodies.[39] Simultaneously, the medicalization of the field of gynecology displaced white women from their roles as midwives—for example, Peter Chamberlin invented obstetrical forceps in the early 1600s, which became popularized throughout the 1700s.[40] The development of scientific theories about pregnancy and childbirth, coupled with the invention of new 'gynecological tools', supplanted the lay midwife with male physicians who underwent specific medical 'training', which pushed women out of the profession as they were denied access to medical school and formal clinical trainings now deemed necessary qualifications for midwives.[41] Those in favor of a move from women as midwives to men in a medical practitioner role at births argued that women were "frail and emotional beings who lacked the intellectual capacity to become competent birth attendants," an attitude that persisted for centuries.[42] By the middle of the 19th century, it looked as though American midwifery would become obsolete as the field of obstetrics became recognized as a "medical specialty" that ought to be performed by a male physician.[43]

The developing field of gynecology thus had its historical origins in assault and nonconsent, performed by men who drove women out of the field completely and, in doing so, advanced a narrative that women lacked the capacity to practice medicine.[44] Forced pelvic examinations and forced gynecological procedures, which were often both unnecessary and harmful, instilled in women that they lacked the knowledge and agency they needed to maintain their own health and status in their societies, as well as control over their own bodies.[45] Furthermore, physician-directed obstetrics did not result in improved health outcomes from pregnant women; in 1917, the federal Children's Bureau reported that "childbirth caused more deaths among women fifteen to forty-four years old than any disease except tuberculosis."[46] Thus, Western gynecology developed in a context of nonconsent and poor health outcomes for the women being "treated."

These deep roots of subjugation, nonconsent, abuse, and poor health outcomes

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[39] *Id. See also* Danielle McCarthy, *Gendered Anti-Blackness, Maternal Health & Chattel Slavery: OB/GYN Knowledge as a Determinant of Death of Black Women*, 353 SOCIAL SCIENCE AND MEDICINE (2024).

[40] Litoff, *supra* note 34, at 7.

[41] *Id.* at 6–7.

[42] *Id.* at 9.

[43] *Id.* at 9–10.

[44] Stephanie Tillman, *Consent in Pelvic Care,* 65 J. MIDWIFERY & WOMEN'S HEALTH 749, 749 (2020); Jo Anne Morrow, *Women's Health Care and Informed Consent: Who Should Decide What Is Best for Women - Patients or Doctors,* 9 GOLDEN GATE U. L. REV. 553, 556–57 (1978); Litoff, *supra* note 34, at 9.

[45] Tillman, *supra* note 44, at 750. Doctors performed forced internal examinations on people "suspected of venereal infections, sterilizing people of color and people who were poor without their knowledge, unnecessarily requiring pelvic examinations for oral contraceptives, and hymen inspection for virginity testing." *Id.* at 749–50.

[46] Litoff, *supra* note 34, at 10. This is due to many factors. New gynecological tools required additional training and schooling because while forceps, for example, could save lives, if used incorrectly they could cause perineal lacerations to the woman and injuries to the fetus, and while anesthesia could improve comfort for a laboring mother, if administered incorrectly it could result in breathing problems and a prolonged (and thus more dangerous) labor. *Id.* at 11. In addition, "almost any type of intervention by the attending physician brought with it the possibility of harm due to the dangers associated with infection" as physicians themselves also spread diseases among patients. *Id.* Not surprisingly, areas reporting the lowest levels of maternal deaths were also areas with the highest rates of midwife attendants at births. *Id.*

persisted into the 1900s.[47] While physicians might not overtly have used their role as gynecologists as a tool for subjugation, the underlying belief systems regarding how women could participate in their care carried through into the 20th century. In the 1900s, the medical field, including the field of gynecology, was still dominated by white men, solidifying the physician-patient relationship as one rooted in paternalism.[48] Physicians believed "women ha[d] inferior intelligence and an inability to dispassionately evaluate what is 'best' for them."[49] Physicians took on the responsibility of determining what treatment best suited the patient, and the patient "[was] expected to cooperate in her care."[50] In other words, "the patient [was] placed in a submissive role and the doctor exercise[d] authority and control."[51] As male physicians usurped control from their female patients in the physician-patient dynamic, the complaints of female patients were often ignored. Male physicians routinely harmed women by "devaluing their complaints and by subjecting them to unnecessary surgery and to unknown risks of harmful side effects" from widely distributed and under-tested drugs designed specifically for women.[52] Indeed, in the 1930s, the national Committee on the Costs of Medical Care, an organization formed to investigate and research potential economic solutions for the organization of medical care,[53] reported that midwives took better care of patients than did physicians because a midwife "waits patiently and lets nature take its course," while physicians employed "procedures which are calculated to hasten delivery, but which sometimes result harmfully to mother and child."[54] Nevertheless, midwives were blamed for adverse health outcomes in

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[47] *See, generally* Morrow, *supra* note 44 (an analysis of the historical relationship between physicians and female patients in the early-to-mid-1900s). A 1911 survey determined that "general practitioners lose as many and possibly more women from puerperal infection than do midwives." Litoff, *supra* note 34, at 11.

[48] Klea D. Bertakis, *The Influence of Gender on the Doctor-Patient Interaction,* 76 PATIENT EDUCATION AND COUNSELING 356, 356–57 (2009) ("The percentage of women graduating from medical schools in the United States increased from 5.5% to 49.3% between 1962 and 2008."); *see also* R. Kaba & P. Sooriakumaran, *The Evolution of the Doctor-Patient Relationship*, 5 INT'L J. OF SURGERY 57 (2006); Felicity Goodyear-Smith & Stephen Buetow, *Power Issues in the Doctor-Patient Relationship*, 9 HEALTH CARE ANALYSIS 449, 450 (2001) ("deference to medical authority by patients who were assigned a sick role was necessary for the doctor-patient relationship to function effectively.").

[49] Morrow, *supra* note 44, at 555. The historical trend in Western medicine was to conflate prejudices with medical fact, resulting in a healthcare system that demeaned women and their bodies and assumed women to be incapable of making health decisions for themselves. This, coupled with the historical notion that women are so overtly emotional that they cannot perceive their own symptoms and care with an objective lens resulted in a doctor-patient relationship predicated on the idea that women cannot be trusted as reliable narrators regarding their own health. *Id.* at 559-60. For an overview of how doctors in the 1950s and 1960s determined if women had diagnosable "hysteria," *see* Robert A. Woodruff, *Hysteria: An Evaluation of Objective Diagnostic Criteria by the Study of Women with Chronic Medical Illnesses*, 114 BRIT. J. PSYCHIAT. 1115 (1967).

[50] Morrow, *supra* note 44, at 556.

[51] *Id.*

[52] *Id.* at 554–55. Drugs designed for women include DES, birth control pills, and the Dalkon Shield. *Id.*

[53] Joseph S. Ross, *The Committee on the Costs of Medical Care and the History of Health Insurance in the United States*, 19 EINSTEIN QUART. J. BIOL. MED. 129, 129 (2002). "After 5 years of work, it recommended a system where (1) medical services were provided by physician groups, (2) costs were distributed over persons and time using an insurance program, (3) funds and services dedicated to disease prevention were increased, and (4) community agencies coordinated medical care services." *Id.*

[54] Litoff, *supra* note 34, at 12.

childbirth, reinforcing the importance of obstetric specialists.[55]

As the social, cultural, and political feminist movements worked to shift societal perceptions of women and educational opportunities for women, the physician-patient relationship began to shift as well.[56] Not only have women as patients become more empowered to ask questions and advocate for the medical treatment they want,[57] there are also significantly more female providers in the medical field.[58] Thus, the physician-patient relationship is slowly shifting from a paternalistic one to one that centers the patient.[59] The patient's "story of the illness" is becoming increasingly important in the care plan devised by a physician in conjunction with the patient.[60]

While these shifts are important and beneficial to women's overall health outcomes,[61] "[a] paternalistic approach still dominates."[62] The field of gynecology has thus far been unable to fully shed its origins in nonconsent and the assumption that men better understand the needs of women when it comes to women's pelvic care. This is furthered by the development of the institutionalization of healthcare with modern technologies—for example, the development of laboratory and X-ray tests to aid in diagnosis contributed to a shift of medical care from the home to the hospital—which depersonalizes care between a physician and their patient and creates an arena for abuses at the hands of physicians.[63] To this day, women's reproductive health presents a unique arena in which physicians maintain their power over decision-making because women often do not have an understanding of the benefits, harms, or reasons for pelvic procedures; they agree to said procedures solely at the recommendation of their physician.[64] Indeed, while approximately half of women surveyed by the American Journal of Obstetrics & Gynecology lacked an understanding of the benefits of pelvic examinations, almost all OBGYNs reported that they would perform a bimanual exam on an asymptomatic patient at a routine visit, even if that woman had a hysterectomy, because it is "important for adherence to standard medical practices."[65] Similarly, women continue to have their complaints and pain categorically dismissed as impossible; the physician still knows best.[66]

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[55] *Id.*
[56] *See* Goodyear-Smith, *supra* note 48, at 450–51.
[57] *See* Alireza Nikbakht Nasrabadi et. al., *Women Empowerment through Health Information Seeking: A Qualitative Study,* 3 INT'L J. COMMUNITY BASED NURSING AND MIDWIFERY 105 (2015).
[58] Bertakis, *supra* note 48, at 357.
[59] *See* Kaba, *supra* note 48, at 61.
[60] *Id.*
[61] *See* Moira A. Stewart, *Effective Physician-Patient Communication and Health Outcomes: A Review*, 152 CAN. MED. ASSOC. 1423 (1995); S. Petrocchi et. al., *Interpersonal Trust in Doctor-Patient Relation: Evidence from Dyadic Analysis and Association with Quality of Dyadic Communication*, 235 SOCIAL SCIENCE AND MEDICINE 1 (2019).
[62] Kaba, *supra* note 48, at 63.
[63] Morrow, *supra* note 44, at 563–64. "The increased technology of modern medicine and the institutionalization of health care have also led to a depersonalization of health care. [This] has the potential for the abuse, in hospitals, of the fundamental rights of patients as individuals." *Id.* For example, "[t]he development of laboratory and X-ray tests to aid in diagnosis and the discovery of new drugs and surgical techniques provided the doctor with a new armamentarium and shifted the bulk of medical care from the home to the hospital." *Id.*
[64] *See* Norell et. al., *supra* note 20, at 3.
[65] *Id.* at 3–5.
[66] *See, e.g.,* Diane E. Hoffman and Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain,* 29 J. LAW MEDICINE AND ETHICS 13 (2021).

II. PELVIC CARE AT PRESENT

The ACOG currently recommends women should receive pelvic examinations only if they have symptoms, as a part of a pelvic procedure, when a woman is pregnant, or if a woman has a family history of gynecological conditions.[67] Standard procedure during a pelvic examination includes a careful inspection of the external genitalia, a speculum and bimanual exam to assess the internal genitalia, and sometimes a Papanicolaou test, also known as a "pap smear," in which a small wand is used to collect cells from the cervix to test for cervical cancer.[68] Pap smears are recommended every 3 years for cancer screening purposes and are not the subject of this paper; pelvic exams can and often are performed without performing a pap smear.[69] Physicians should always wear gloves while performing pelvic examinations, and they should communicate to the patient what they are doing throughout the examination without making inappropriate comments.[70] In addition, patients should be provided with privacy as they change before and after the examination and patients should be provided with coverings if their bodies are exposed.[71] To ensure these standards are met, a chaperone, often a nurse, is typically present.[72] Chaperones for "intimate exams," however, should be "impartial and have no obligation to the doctor"; in a hierarchical structure such as a hospital, a "junior nurse may feel daunted to speak up about the misconduct of a senior doctor."[73] Chaperones are thus not a guarantee of safety for patients.[74] A pelvic examination should take no more than a few minutes.[75] A breach of professional standards could constitute evidence of physician negligence or abuse.

Prior to the current recommendation, ACOG had recommended in 2012 that women aged 21 and over receive annual pelvic exams regardless of their symptoms

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[67] *Supra* notes 15–18 for more about this recommendation.

[68] *Pelvic Exam,* MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/pelvic-exam/about/pac-20385135 (last visited Nov. 11, 2024); Dr. David Mutch, *Why Annual Pap Smears are History—But Routine Ob-Gyn Visits are Not,* AM. COLL. OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/womens-health/experts-and-stories/the-latest/why-annual-pap-smears-are-history-but-routine-ob-gyn-visits-are-not#:~:text=Women%20age%2021%20to%2029,HPV%20test%20every%205%20years (last visited Nov. 11, 2024).

[69] Qaseem et. al., *supra* note 22, at 67.

[70] *See, e.g. What to expect during a routine sensitive exam: frequently asked questions*, UCLA HEALTH, https://www.uclahealth.org/sites/default/files/documents/SensitiveExamBooklet-English.pdf (last visited Nov. 11, 2024).

[71] *Id.*

[72] *See, e.g. Undergoing a Physical Examination: Your Rights*, N. CAROLINA MEDICAL BD., https://www.ncmedboard.org/images/uploads/publications_uploads/NCMB_PhysicalExamBrochure.pdf (last visited Nov. 11, 2024); *The Use of Chaperones During Sensitive Examinations and Procedures*, UNIV. OF MICH. HEALTH, https://www.uofmhealth.org/patient-visitor-guide/patients/use-chaperones-during-sensitive-examinations-and-procedures (last visited Nov. 11, 2024); *Medical Chaperones for Sensitive Examinations, Treatments and Procedures*, YALE HEALTH, https://yalehealth.yale.edu/topic/medical-chaperones-sensitive-examinations-treatments-and-procedures (last visited Nov. 11, 2024).

[73] Paul Marinaccio-Joseph, *Nurses as chaperones: legal obligations and implications,* 115 NURSING TIMES 18, 18 (2019).

[74] *Id.*

[75] MAYO CLINIC, *supra* note 65.

or medical history.[76] The benefit of the annual exam, ACOG opined, was that the "annual visit provides an excellent opportunity to counsel patients about maintaining a healthy lifestyle and minimizing risks."[77] While ACOG stated that "[n]o evidence supports or refutes the annual pelvic examination or speculum and bimanual examination for the asymptomatic, low-risk patient[s]," they also noted, "[a]n annual pelvic examination seems logical."[78] The report concluded that a patient can decide for herself whether she would like to receive a pelvic exam only if "she is asymptomatic and has undergone a total hysterectomy and bilateral salpingo-oophorectomy for benign indications and has no history of vulvar intraepithelial neoplasia, cervical intraepithelial neoplasia 2, cervical intraepithelial neoplasia 3, or cancer; is not infected with HIV; is not immunocompromised; and was not exposed to diethylstilbestrol in utero."[79] Even if all of those conditions applied, ACOG still recommended that "[a]nnual examination of the external genitalia should continue."[80]

In 2014, however, the American College of Physicians (ACP), a community of internal medicine specialists who treat the entire complex system of internal organs in the body—taking a more holistic approach than the OBGYNs in the ACOG[81]—denounced the ACOG's 2012 recommendation, finding that pelvic examinations caused more harm than good.[82] Numerous studies supported the conclusion that bimanual pelvic exams did not actually improve health outcomes for asymptomatic women at all.[83] Indeed, between 2012 and 2018, the time period when ACOG recommended annual pelvic exams, there was no evidence to support the idea that pelvic exams could detect ovarian cancer—in fact, they did nothing to improve health outcomes for those ultimately diagnosed with ovarian cancer because physicians were

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[76] Gladys M. Martinez et. al., *Receipt of Pelvic Examinations Among Women Aged 15-44 in the United States, 1988-2017,* 339 NCHS DATA BRIEF 1, 1 (2019). Committee Opinion 534 has been removed from the ACOG online archive, but I was able to locate a copy from a saved version of their 2012 website through the "Way Back Machine." The American College of Obstetricians and Gynecologists, Committee Opinion Number 534, *Well-Woman Visit,* OBSTETRICS & GYNECOLOGY (2012) (http://web.archive.org/web/20120815034841/http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Gynecologic_Practice/Well-Woman_Visit).

[77] *Id.*

[78] *Id.*

[79] *Id.* The terms in this recommendation are not defined in this paper because the technicalities are less important than the point that many women, based on this recommendation, would lack sufficient knowledge to be able to decline a pelvic exam.

[80] *Id.*

[81] The American College of Physicians is the largest medical specialty organization in the world. *Who We Are and What We Do*, AM. COLL. PHYSICIANS, https://www.acponline.org/about-acp/who-we-are-what-we-do.

[82] Qaseem, *supra* note 22, at 69–70.

[83] *See, e.g.* U.S. Preventative Services Task Force, *Screening for Gynecologic Conditions with Pelvic Examination: US Preventive Services Task Force Recommendation Statement,* 317 JAMA NETWORK 947, 947 (2017) ("Overall, the USPSTF found inadequate evidence on screening pelvic examinations for the early detection and treatment of a range of gynecologic conditions in asymptomatic, nonpregnant adult women."); Analia R. Stormo, Nikki A. Hawkins, Crystale Purvis Cooper et. al., *The Pelvic Examination as a Screening Tool*, 171 ARCH. INTERN. MEDICINE 2053, 2053 (2011) ("the conditions pelvic examinations hope to detect during these annual visits are unclear, since scientific evidence does not support their use for any specific purpose."); Carol K. Bates, Nina Carroll, & Jennifer Potter, *The Challenging Pelvic Examination*, 26 J. GENERAL INT. MEDICINE 651, 651 (2011) ("While there is a large body of evidence on the effectiveness of Pap smears for cervical cancer screening and on screening for cervical gonorrhea and Chlamydia, there is sparse evidence to support other portions of the pelvic examination and little guidance on examination logistics.").

unable to detect such cancer through the examinations alone.[84] Similarly, no studies suggested that pelvic exams were at all beneficial to the diagnosis or treatment of the other diseases—such as other types of cancer, pelvic inflammatory disease, bacterial vaginosis, and other benign conditions—that pelvic examinations were purported to address in asymptomatic women.[85] And, while there was no evidence to support any benefit of pelvic examinations in asymptomatic women, there was evidence demonstrating harms perpetuated by these unnecessary pelvic exams, including "fear, anxiety, embarrassment, pain, and discomfort."[86] The examinations also led to "false reassurance, over-diagnosis, overtreatment" and unnecessary surgeries.[87] Despite the ACP's findings in 2014, approximately 52 million pelvic exams were performed in the United States in 2015.[88]

It was not until 2018 that ACOG changed course, recommending that pelvic examinations should only be given when "indicated by medical history or symptoms."[89] Despite this shift in policy, OBGYNs often continue to perform pelvic examinations when doing so is not associated with improved health outcomes; i.e. they are unnecessary. [90] This misalignment between the actions of physicians and the effectiveness of pelvic exams as preventative care measures poses particular problems for women who consent to these procedures but do not understand their purpose.[91]

Whether (and how) a patient legally needs to verbally consent to a pelvic examination is determined by the common law created by the state courts, the statutory

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[84] Qaseem, *supra* note 22, at 68. *See also* The American College of Obstetricians and Gynecologists, Committee Opinion Number 754, *The Utility of and Indications for Routine Pelvic Examination,* 132 OBSTETRICS & GYNECOLOGY 174, 175–76 (2018).
[85] Qaseem, *supra* note 22, at 68–69.
[86] *Id.* at 69.
[87] *Id.* ("pelvic examination led to unnecessary surgery in 1.5% of women screened.").
[88] *National Ambulatory Medical Care Survey: 2015 State and National Summary Tables*, CDC, https://archive.cdc.gov/www_cdc_gov/nchs/data/ahcd/namcs_summary/2015_namcs_web_tables.pdf (last visited Nov. 11, 2024).
[89] The American College of Obstetricians and Gynecologists, Committee Opinion Number 754, *supra* note 84, at 174.
[90] Norell, *supra* note 20, at 3–5.
[91] *See id.* *See also* David M. Studdert, *Geographic Variation in Informed Consent Law: Two Standards for Disclosure of Treatment Risks*, 4 J. EMPIRICAL LEGAL STUDIES 103, 121 (2007) ("[O]ur findings hint at a substantive discrepancy between customary medical practice regarding disclosure of risk . . . and patients' expectations about risk").

scheme of the state[92] and the factual circumstances when a patient presents for care.[93] When a patient is subjected to faulty or unwanted medical procedures, the legal system offers relief through claims for medical negligence in the tort system.[94] Medical malpractice claims, however, only provide relief after an injury has occurred, and often do not provide for adequate relief after said injury.[95] Thus, when Hadden misrepresented the need for a pelvic exam to his patients by advising them that they needed additional pelvic care when they did not, the women were left with little recourse.[96] The doctrine of informed consent can be developed to prevent these occurrences—if the women had known the exams were unnecessary, they might not have continued to consent to them; this disclosure would have been imperative to their decision-making.[97]

III. MEDICAL NEGLIGENCE: CIVIL REMEDIES

Gynecology, specifically pelvic care, is a unique arena in the healthcare system that requires additional and specific legal protections for the women seeking care. Physicians perpetrate abuses across almost all medical fields, but the field of gynecology makes patients particularly vulnerable because they are expected to undress

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[92] Some states have statutes that generally articulate statutory requirements for informed consent. *See* Lori B. Andrews, *Informed Consent Statutes and the Decision-Making Process*, 5 J. L. MED. 163, 163 (1984). Some states, either in addition to or instead of a more general informed consent statute, have informed consent statutes that apply to particular medical procedures. *See, e.g.,* Ruth Colker, *Uninformed Consent,* 101 B.U. L. REV. 431 (March 2021). Specifically, regarding pelvic care, as of November 2022, twenty states in the U.S. had pelvic examination laws, (Arizona, Arkansas, California, Connecticut, Delaware, Florida, Hawaii, Illinois, Louisiana, Maine, Nevada, New Hampshire, New Jersey, New York, Oregon, Texas, Utah, Virginia, and Washington), though those laws only apply to anesthetized or unconscious patients. Thirteen states have proposed pelvic exam laws (Georgia, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Oklahoma, Pennsylvania, Rhode Island, and Wisconsin), of which eleven only pertain to anesthetized or unconscious patients. Seventeen states have no pelvic exam laws at all (Alabama, Alaska, Colorado, Idaho, Kansas, Kentucky, Mississippi, New Mexico, North Carolina, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Vermont, West Virginia, Wyoming). Prior to 2021, the Florida statute required a practitioner get informed consent before performing any pelvic examination, even if the patient were conscious. The law was changed in 2021 to only apply to unconscious patients. Mihael Plantak et. al., *Pelvic Exam Laws in the United States: A Systematic Review*, 48 AMERICAN J. OF LAW & MEDICINE 412, 413 (2022).

[93] As noted above, the statutes as they specifically pertain to pelvic exams only apply when a patient is unconscious, thus the factual circumstances are important in determining whether express consent is necessary. *Id.* In addition, in emergency situations in which physicians must act quickly or a patient cannot provide informed consent (for example, they are unconscious) and no surrogate decision-maker is available, physicians need not acquire informed consent before performing a procedure. *See* Max M. Feinstein et. al., *Informed Consent for Invasive Procedures in the Emergency Department,* 39 AMERICAN J. OF EMERGENCY MEDICINE 114, 114 (2020); Laurino v. Bd. of Professional Discipline of Idaho State Bd. of Med., 137 Idaho 596, 606 (2002) (physician appealed professional sanctions after a woman in the emergency room presenting with abnormal pelvic bleeding shortly after giving birth refused a pelvic exam and he did not give one, missing a tear from which she was bleeding out).

[94] Morrow, *supra* note 44, at 555. Medical negligence claims include medical malpractice and informed consent claims. *See* Hamilton, *supra* note 23, at 313–14.

[95] *See* Morrow, *supra* note 44. at 566–67; Stoner v. Bureau of Professional and Occupational Affairs, State Bd. of Med., 10 A.3d 364, 367 (Pa. Cmwlth. 2010).

[96] Fortis, *supra* note 8.

[97] *Id.*

and allow physicians to inspect their pelvis and genitalia.[98] Indeed, an analysis of 100,000 disciplinary documents against physicians from across the country demonstrated how "predatory physicians took advantage of a doctor's special privilege—the daily practice of asking trusting people to disrobe in a private room and permit themselves to be touched."[99] Disrobing and permitting oneself to be touched is typical of the OBGYN practice.[100]

The modern medical system has a history of devaluing the complaints of women, especially when it comes to their experience of pain during reproductive procedures.[101] Moreover, the historical development of the physician-patient relationship in gynecology is one characterized by nonconsent, paternalism, and a lack of agency and intelligence on the part of women patients.[102] Thus, women often do not report abuses by their physicians because they are uncertain an abuse has occurred, or they fear they will not be believed.[103] As a result, physicians are given leeway in this dynamic that allows them to continue their practice, both after sexual misconduct has been conclusively found and while complaints about them are actively investigated.[104]

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[98] Carrie Teegardin et.al., *License to betray: A broken system forgives sexually abusive doctors in every state, investigation finds,* ATLANTA J. CONSTITUTION, https://doctors.ajc.com/doctors_sex_abuse/?ecmp=doctorssexabuse_microsite_nav (last accessed Nov. 15, 2024). While "there just isn't concrete data," an investigation by the Atlanta Journal-Constitution obtained and analyzed more than 100,000 disciplinary documents from around the country and found that sexual abuse by physicians is pervasive across the entire country. *Id.* "While the vast majority of the nation's 900,000 doctors do not sexually abuse patients, the AJC found the phenomenon is akin to the priest scandal: It doesn't necessarily happen every day, but it happens far more often than anyone has acknowledged." *Id.* OBGYNs also experience great levels of abuse and discrimination in their profession. *See* Margit Endler et. al., *A silent pandemic of violence against providers in obstetrics and gynecology: A mixed-methods study based on a global survey***,** INT. J. GYNECOLOGY & OBSTETRICS 1 (2024) (75.2% of OBGYNs surveyed reported experiencing workplace violence); Ankita Gupta et. al., *Sexual Harassment, Abuse, and Discrimination in Obstetrics and Gynecology: A Systematic Review,* JAMA NETWORK (2024).

[99] Teegardin, *supra* note 98. Offenses ranged from lewd comments during intimate exams to molestation, masturbation by the physician in front of the patient, swapping drugs for sex and even rape. *Id.* As of 2016, the last time CEJA reported statistics on sexual misconduct by healthcare providers was 1991—even then, the report only dealt with physiatrists. *Hamilton, supra* note 23, at 304.

[100] *See supra* notes 15–18; 67–75.

[101] Morrow, *supra* note 44, at 554 ("women should be particularly concerned with the decisions that are made in their behalf, because the health care system has erred seriously in their "behalf' by devaluing their complaints."); Hoffman, *supra* note 66, at 17 (physicians gave women less pain medication than they did men of the same ages for the same procedures). *See also* Sarah Kliff, *Yale Settles with Patients Who Sued Over Painful Egg Retrievals,* NEW YORK TIMES (Sept. 9, 2024) (patients constantly complained of extreme pain during egg retrieval process and were categorically dismissed; turned out a nurse was stealing pain medication and the women received saline solution instead).

[102] *See supra* Part I for a detailed discussion on the paternalistic roots of the physician-patient relationship.

[103] *See* Teegardin, *supra* note 98 ("Some victims say nothing. Intimidated, confused or embarrassed, they fear that no one will take their word over a doctor's. Colleagues and nurses stay silent."); Atkins, *supra* note 8 ("All these things go through your mind. Who do I speak to? How do I get out of here? Who's going to believe me? It's my word against his.").

[104] *See* Teegardin*, supra* note 98 (for example, in Georgia, "two-thirds of the doctors disciplined in the state for sexual misconduct were permitted to practice again."); Fortis, *supra* note 8 (Hadden was permitted back to practice less than a week after sexual abuse allegations were reported to the police and he was arrested).

Once abuse by a gynecologist has been identified, it can be difficult for a patient to obtain relief through legal avenues.[105] Often times, these allegations are handled through criminal proceedings or through disciplinary action with the State Medical Board.[106] In criminal proceedings, a victim can participate in the prosecution of the accused, but the State is considered the 'plaintiff' in the case and is ultimately the decision-maker on if and how to prosecute, and what settlement options are available to the defendant.[107] The State Medical Board is the organization which regulates the practice of medicine, and thus has the ability to suspend or rescind licenses to practice when investigations conclude an abuse has occurred; while victims can make complaints, they ultimately are not decision-makers in how the disciplinary process functions.[108]

While criminal proceedings and State Medical Board disciplinary hearings can punish abusive physicians, these mechanisms do not always provide a path to relief for the injured patient.[109] The civil system, however, can offer relief to patients through various tort legal theories.[110] In the current system, the two main tort theories that could offer relief to injured patients operate under medical negligence theories: medical malpractice and informed consent.[111] Medical malpractice claims, however, are particularly difficult to win in the context of abusive pelvic care, and they only offer relief for patients *after* abuse has occurred.[112] The doctrine of informed consent, however, can proactively protect women by placing an affirmative burden on physicians to disclose all information a woman might want when making decisions about her pelvic health. This is ideal for two reasons: first, it has the capacity to prevent abuses *before* they occur by equipping patients with additional information about the proposed treatment plans, thus protecting women from both abuse and well-intentioned unnecessary pelvic exams; and second, by offering an additional legal mechanism to seek relief if a breach occurs. Given the unique characteristics of pelvic care, a "patient centered standard" should be applied to the doctrine of informed consent specifically

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[105] Moreover, it is impossible for a patient to seek relief when an abuse has not been found, either for lack of proof or because a patient did not make an allegation in the first place (whether that be because she feared she would not be believed or because she did not recognize an abuse occurred). *See id.*

[106] *See supra* notes 105–12 for a discussion on the types of charges that can be brought and the difficulties for patients using these mechanisms to seek relief. State Medical Board disciplinary action is sometimes hidden as cases are handled secretly—in some cases, medical boards removed "once-public orders from their websites or issue documents that cloak sexual misconduct in vague language." Teegardin, *supra* note 98.

[107] *See id.*

[108] *See id.*

[109] Criminal charges have the potential of punishing an offender, but they do not always offer relief to an injured patient; this is dependent on the laws of the state as some states have statutes that "provid[e] for the compensation of victims of crime for loss of income and unreimbursed medical expenses." Loss of income and unreimbursed medical expenses do not always capture the full picture of injury after a crime has been committed. Herbert S. Denenberg, *Compensation for the Victims of Crime: Justice for the Victim as Well as the Criminal*, 1970 INS. L. J. 628, 628 (November 1970). Civil remedies are the focus of this paper and include various theories of tort law such as the intentional torts of assault and battery and the negligence torts including medical malpractice and negligent hiring. *See* Hamilton, *supra* note 23, at 314. State Medical Boards can investigate claims of misconduct and sanction medical practitioners if the investigation finds evidence of such misconduct. *Id.* at 315. These sanctions can include revoking practitioners' licenses or suspending said licenses, which allows practitioners to continue their medical practice. *Id.* at 316.

[110] Hamilton, *supra* note 23, at 316.

[111] *Id.*

[112] *See id.*

for pelvic care to adequately provide legal protections for women.

A. Pelvic Care and the Insufficiency of Medical Malpractice Claims

When a physician acts negligently and performs care outside the standard applicable to their profession, an injured patient can assert a claim for medical malpractice.[113] Medical malpractice claims are claims for negligence—they allege that a medical professional has negligently provided substandard care to a patient, and as a result, the patient suffered an injury.[114] Generally, to succeed in pursuing a medical malpractice claim, a patient must prove four elements:

> (1) the existence of a legal duty on the part of the doctor to provide care or treatment to the patient; (2) a breach of this duty by a failure of the treating doctor to adhere to the standards of the profession; (3) a causal relationship between such breach of duty and injury to the patient; and (4) the existence of damages that flow from the injury such that the legal system can provide recourse.[115]

Medical malpractice claims present unique barriers to women seeking relief when they are injured by unnecessary pelvic examinations: (a) courts find it difficult to discern if a plaintiff can assert a negligence claim when a physician intentionally abuses them; (b) the conflicting and ever-changing recommendations as to when pelvic exams are necessary makes it difficult for prospective plaintiffs to present the expert testimony required of a malpractice claim; and (c) at times it can be difficult for an injured patient to prove a damage that the legal system can compensate for.

1. Negligence or Intentional Torts? Or Both?

Courts disagree as to whether an unnecessary pelvic exam constitutes malpractice, assault, or both as a matter of law. Where an OBGYN abuses their role as a physician and subjects their patient to unnecessary pelvic exams, courts must decide if the physician's conduct amounts to medical negligence that could be asserted on a medical malpractice theory, or if the conduct has surpassed negligence and instead constitutes intentional battery or assault.[116] If the conduct constitutes battery or assault, a medical malpractice claim cannot be asserted because there is no claim for negligence.

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[113] Provided they meet the elements thereof. *See* Joseph H. King*, The Common Knowledge Exception to the Expert Testimony Requirements for Establishing the Standard of Care in Medical Malpractice,* 59 ALA. L. REV. 51 (2007).

[114] Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPAEDICS AND RELATED RESEARCH 339, 341 (2008).

[115] *Id.* at 342.

[116] Assault is an intentional tort rather than one of negligence, which would preclude the conduct from being asserted in the medical malpractice context. *See* Jerome H. Ehrlich, *Medical Malpractice*, 18 INTRAMURAL L. REV. N.Y.U. 198, 198 (1963) ("Liability of a physician may also result, in the absence of tortious conduct, through a breach of contract or assault and battery, both of which are to be distinguished from malpractice in that the latter is unintentional."); Shirley Qual, *A Survey of Medical Malpractice Tort Reform,* 12 WM. MITCHELL L. REV. 417, 454 (1986) (Congress introduced the "Medical Offer and Recovery Act" in 1984 which precluded "claims for non-economic loss, loss of earning capacity, claims for wrongful death, and injuries intentionally inflicted by health care providers." This Act is not law, but its introduction demonstrates the distinction between intentional and negligence conduct in the malpractice context.).

Courts disagree with each other and within themselves in making this determination, and thus, it is difficult for patients to assert medical malpractice claims that implicate sexual abuse.

The South Dakota Supreme Court articulated their determination in *Martinmaas v. Engelmann.*[117] In *Martinmaas,* the plaintiff asserted claims for both negligence and intentional torts where a physician "used a piece of gauze" to obtain a sample of pelvic discharge, rather than a speculum.[118] Initially, the physician claimed he did so because "he believed the [speculum] was uncomfortable for his patients" and that using gauze would be more comfortable for them; however, he eventually "acknowledged the 'gauze procedure' was one he made up"—he "had never seen anyone perform it, it was not taught in medical school, nor had he ever read about it in any medical literature."[119] At trial, the physician contended that that "the [p]laintiff's evidence, even if believed, showed that he committed intentional acts, not negligence."[120] Thus, the defendant physician argued, his conduct could not constitute medical malpractice because medical malpractice required an act be negligent; intentional torts such as battery and rape could not constitute malpractice.[121]

The Court in *Martinmaas* determined that sexual abuse *can* constitute malpractice. First, they articulated the physician's duty to use due care and skill in their treatment of patients.[122] The Court next concluded that a physician breaches their duty to use due care and skill and thus commits malpractice when they act negligently, meaning they fail "to use 'that care and skill ordinarily exercised under similar circumstances'"[123] Because they concluded malpractice included "any professional misconduct or any unreasonable lack of skill or fidelity in the performance of professional fiduciary duties," and intentional assault demonstrated an unreasonable lack of skill in the performance of professional duties, "for tort liability purposes, sexual misconduct falls within the definition of malpractice."[124]

While the majority in *Martinmaas* concluded that sexual misconduct can constitute negligence and subsequently malpractice, one Justice wrote separately, concurring in the result only.[125] He asked whether "rape and sexual misconduct [can] constitute professional *negligence* if committed by a physician in the course of gynecological exam?"[126] He argued that because "[n]o court has ever held otherwise under these circumstances... [t]he answer is plainly no."[127] When a physician commits an intentional act rather than a negligent one, a claim for malpractice cannot be sustained. Thus, "[r]ape and sexual exploitation in the course of a pelvic exam are intentional acts utterly beyond the concept of failure to use due care and skill."[128]

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[117] 612 N.W.2d 600 (2000).
[118] *Id.* at 604.
[119] *Id.* at 604–05.
[120] *Id.* at 606.
[121] *Id*.
[122] *Id.* at 607.
[123] *Id.*
[124] *Id.* at 607–08.
[125] 612 N.W.2d 600 (Justice Kokenkamp, concurring in result).
[126] *Id.* at 613 (Kokenkamp concurring in result) (emphasis original).
[127] *Id.*
[128] *Id.* at 614 (Kokenkamp concurring in result).

The New York Supreme Court, Appellate Division also addressed this distinction in *N.X. v. Cabrini Medical Center,*[129] but came to the opposite conclusion. In *Cabrini Medical Center*, the plaintiff woke up from surgery to find a medical practitioner who was not her physician performing a pelvic exam on her without her consent and without the direction of another physician at the hospital.[130] The Court first concluded that there was no question that the physician "committed a sexual assault, not an examination."[131] Thus, the majority concluded "his acts were, as a matter of law, 'wholly personal in nature outside the scope of his employment, and not in furtherance of the defendant hospital's business,' which, of course, is to provide medical treatment."[132] Thus, because the act committed by the physician was an intentional act, the plaintiff did not have a claim against the hospital in which the assault took place.

The dissent in *Cabrini Medical Center* disagreed.[133] One Justice concluded that when a physician performs an "unnecessary pelvic examination" on a patient, that assault is still a medical procedure within the scope of business by the hospital, and thus, the plaintiff ought to have a vicarious liability claim against the hospital for their physician's actions.[134] In other words, "where the examination was conducted for a deviant purpose, an otherwise standard examination may amount to an assault; nevertheless, the deviant mental state of the physician while performing the examination does not remove the task itself from the scope of the physician's employment."[135]

Martinmaas and *Cabrini Medical Center* both articulate the disagreement amongst courts as to whether a plaintiff can assert a claim for medical malpractice when the underlying injurious conduct constitutes sexual abuse. The tension between what conduct constitutes negligence and what conduct constitutes assault or battery makes it difficult for patients injured by unnecessary pelvic exams to assert claims for medical malpractice because whether the claim can be asserted in the first place has to be litigated. This litigation is time consuming, expensive, and often re-traumatizing for the patient—and the end result could be one in which the patients' claim for malpractice is dismissed entirely, as was the case in *Cabrini Medical Center*.[136]

2. Expert Testimony and Pelvic Exams

To assert a claim for medical malpractice, a plaintiff must prove their physician breached their duty of care "by a failure of the treating doctor to adhere to the standards of the profession."[137] Thus, plaintiffs must prove what the "standards of the profession"

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[129] 280 A.D.2d 34 (2001).
[130] *Id.* at 35–36.
[131] *Id.* at 38.
[132] *Id.*
[133] *Id.* at 49 (Justice Saxe, dissenting).
[134] *Id.* at 55 (Justice Saxe, dissenting).
[135] *Id.*
[136] Victims of sexual abuse who testify in court are often re-traumatized by doing so, especially when reports result in low conviction rates. *See* Michelle Wieberneit et. al., *Silenced Survivors: A Systematic Review of the Barriers to Reporting, Investigating, Prosecuting, and Sentencing of Adult Female Rape and Sexual Assault*, 25 TRAUMA, VIOLENCE & ABUSE 1, 2 (2024) ("If a survivor decides to report the crime and the case moves to trial, the court proceedings can be re-traumatizing for the survivor."). While this study is about criminal investigations of sexual abuse, the principals can be applied to civil trials as well. *See id.*
[137] Bal, *supra* note 114, at 342.

are, and courts require expert testimony to make that determination.[138] This can present difficulties for plaintiffs seeking relief for unnecessary pelvic exams because there has been so much historical (and present) uncertainty as to when a pelvic exam is necessary and thus, there are always practitioners and experts who will testify to that effect.[139] This privileges physicians in medical malpractice claims regarding pelvic care because of the ease with which they can present conflicting expert testimony that their conduct was medically necessary—or at least, medically reasonable.

In *Stoner v. Bureau of Professional and Occupational Affairs*, the defendant physician was accused of sexual misconduct by two patients.[140] The physician in *Stoner* was a specialist in pain management, yet he agreed to see one of the plaintiff-patients for concerns such as eczema.[141] As a part of his intake with this patient, the physician performed a "complete physical examination" on the patient, which included a pelvic exam.[142] When he performed this exam, he did not have a gynecological table, and he did not have a speculum because he did not "routinely perform pelvic examinations."[143] He did the exam by moving her underwear to the side and without a visual inspection due to the lack of speculum, which is not a routine procedure.[144] The other patient accused the physician of performing an unnecessary breast examination, which the physician justified by stating while he did not typically give breast exams, he did so because "she told him she did not know how to do one and was studying nursing."[145]

At trial, to determine if the physician's actions were within the standard course of his practice as a pain management physician, another pain management physician testified that he "does not do breast or pelvic examinations as a part of his regular physical examination unless the patient has a specific complaint."[146] On redirect, however, the physician testified that

> Dr. Stoner was more qualified than he, Dr. Pagan, to perform breast examinations because of his background in breast cancer research. Dr. Pagan also acknowledged that there are certain situations where he would have performed a pelvic examination in the way Dr. Stoner did, i.e., standing at the patient's side, without having the patient's underwear removed and without a visual inspection.[147]

Throughout trial, the defendant physician maintained that the examinations he

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[138] *See* King*, supra* note 113, at 52.
[139] *See supra* Part II for an in depth discussion of the conflicting recommendations from research bodies regarding pelvic exams.
[140] 10 A.3d 364 (Pa. 2010).
[141] *Id.* at 365–66. In fact, the patient initially made the appointment with Dr. Stoner to sell him a Sam's Club Membership, but during the course of the appointment, asked if he could help her address her eczema concerns. *Id.* at Dr. Stoner conceded these conditions are typically treated by dermatologists, but insisted he could adequately treat the conditions. *Id.*
[142] *Id.* at 366.
[143] *Id.*
[144] *Id.* at 366–67. *See supra* notes 64–69 for a discussion of what is routine procedure during a pelvic exam.
[145] *Id.* at 366.
[146] *Id.* at 368.
[147] *Id.* at 368–69.

performed were medically necessary.[148] Testimony was also presented that the patients "voiced no objection" to the examinations.[149] The plaintiffs did not present any "expert testimony" that the physician's pelvic exams were not medically necessary to contradict the physician's assertion that they were.[150] Thus, the court ultimately concluded, despite all the evidence, that there was "no basis for finding that [his] pelvic examination of [the patient] fell below [the] standard [care]" required of him, and the defendant physician prevailed at trial.[151]

Stoner presents a case in which the plaintiffs did not present expert testimony at all, requiring the court to side with the testimony provided by the defendant physician and his colleagues.[152] However, the number of physicians in *Stoner* who testified that the defendant physician could reasonably perform pelvic examinations without the proper equipment and on patients without the requisite symptoms that would typically prompt a physician to perform a pelvic exam demonstrates the difficulties patients face in litigating expert testimony at trial. First, expert testimony is incredibly expensive.[153] Second, defendant physicians would easily present alternative expert testimony (such as the physicians in *Stoner*) to discount the testimony presented by the plaintiffs, reducing the likelihood that the medical malpractice claim would be successful.[154] While expert testimony presents a difficulty for all medical malpractice cases, this barrier is particularly salient in the pelvic care context because of how easy it is for physicians to obtain expert testimony in their favor due to the ACOG's previous recommendations for annual pelvic exams.[155]

3. Proving Damages

The final element a plaintiff must prove to state a claim for medical malpractice is that they have been damaged by the negligent care provided by their physician.[156] Traditionally, "a medical malpractice plaintiff could not recover damages for emotional distress, no matter how genuine and extreme the psychological harm being suffered, unless there was some physical impact from the defendant's actions on the plaintiff."[157] In other words, there had to be physical damage to the plaintiff, even is said damage

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[148] *Id.* at 370.
[149] *Id.*
[150] *Id.* at 373.
[151] *Id.* at 374.
[152] *Id.*
[153] Expert Legal Testimony, 97 HARV. L. REV. 797, 809 (1984).
[154] *See* Karen L. Posner et. al., *Variation in Expert Opinion in Medical Malpractice Review,* 85 ANESTHESIOLOGY 1049, 1052 (1996) ("Objectivity has been questioned on the basis of the advocacy relationship that may develop between an attorney and an expert witness.... The results of this study suggest the variability inherent in the implicit judgment process also plays an important role in producing divergent expert opinions."). There are additional problems inherent to the requirement for expert testimony. First, "it is not unheard of for attorneys to attempt to persuade experts to alter the content of their opinions." Steven Lubet, *Expert Testimony,* 17 AM. J. TRIAL ADVOC. 399, 440 (1993). Second, "[u]nder the Federal Rules of Evidence an expert can testify to her opinion with or without explaining the facts or data on which the opinion is based. In theory, then, an expert, once qualified, could simply state her opinion on direct examination, leaving the cross-examiner to search for its basis." *Id.* at 402.
[155] *See supra* Part II for context as to the disagreement amongst medical research bodies regarding pelvic examinations.
[156] *See* Bal, *supra* note 114, at 342.
[157] John L. Ropiequet, *Emotional Distress Claims in Medical Malpractice Cases*, 11 J. LEGAL MED. 59, 59 (1990).

was only slight.[158] This "impact rule" posed problems for patients who experienced an emotional injury at the hands of their physician—for example, if they received an unnecessary pelvic examination that traumatized them without inflicting tangible physical harm.[159]

While not in the context of a pelvic exam, *Brashaw v. Cohen*[160] illustrates this concept. In *Brashaw,* the plaintiffs were the parents of a child who died shortly after birth.[161] The plaintiffs sought damages for the emotional injuries they sustained "as a result of defendants' negligence in providing medical treatment while the mother was pregnant with the decedent."[162] During the course of the pregnancy and the delivery, neither plaintiff (mother nor father) sustained an "independent injury."[163] The New York Supreme Court, Appellate Division concluded that the lower courts properly granted summary judgment to the defendants because the plaintiffs "cannot recover damages for emotional injuries without having sustained an independent injury as a result of the alleged malpractice."[164] Thus, while the deceased infant could assert a claim for damages under a medical malpractice theory, the mother could not.[165]

Some jurisdictions do allow medical malpractices suits that allege exclusively emotional damages.[166] However, these claims often proceed under the theories presented in negligence claims for negligent infliction of emotional distress, which does not clearly apply to the circumstances presented by an unnecessary pelvic exam.[167] The legal theories presented in negligent infliction of emotional distress often provide relief to plaintiffs who witness an atrocity rather than a patient who undergoes negligent medical care and experiences emotional distress and nothing more.[168] In addition, some jurisdictions require a physical manifestation of the emotional distress alleged, reinforcing a requirement that a plaintiff be physically injured.[169] Like the plaintiff in *Brashaw,* it is thus likely that a woman abused while seeking pelvic care would not

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158 *Id.*
159 *Id.*
160 62 N.Y.S.3d 251 (2017).
161 *Id.* at 251.
162 *Id.* at 252. The court describes the care as follows: "The mother had a history of difficult pregnancies and, after approximately 20 weeks, Cohen diagnosed her as having an incompetent cervix and the mother was admitted to the hospital. Three days later, the mother delivered the decedent. Doctors at the hospital told plaintiffs that the decedent would not survive because his lungs were not fully developed and, indeed, he died only an hour after delivery. During his short life, the decedent had a slow heartbeat, was breathing, and could grab his father's finger, but his skin remained pale blue in color, he did not cry, and he did not move his arms and legs." *Id.*
163 *Id.*
164 *Id.*
165 *Id.* ("Under such circumstances, the infant may commence an action seeking damages for his or her injuries. Absent an independent injury, the mother can recover damages for emotional injuries arising from medical malpractice that causes an in utero injury only if that malpractice results in miscarriage or stillbirth.").
166 *See* Ropiequet, *supra* note 157, at 59 ("Claims for emotional distress are being filed and pursued in many jurisdictions with significant success.").
167 *Id.* at 60, 81.
168 *Id.* at 61. For example, one theory of negligent infliction of emotional distress is the "zone of danger rule." Under the zone of danger rule, a plaintiff can recover for negligent infliction of emotional distress when: "(1) he had a reasonable fear for his own physical safety; (2) he was in such proximity to the accident which physically injured another that there was a high risk of impact on him; and, (3) his emotional distress resulted in physical injury or illness." *Id.*
169 *Id.*

prevail on a medical malpractice theory if she could only prove emotional damage.

B. The Doctrine of Informed Consent

Medical malpractice claims present difficulties for plaintiffs injured while receiving pelvic care. The doctrine of informed consent has the capacity to protect women seeking pelvic care not just by providing a mechanism of relief when a woman undergoes unnecessary pelvic care but by altering the practice around pelvic care. Indeed, if physicians had an affirmative obligation to inform their patients of the information the patient might like to know in advance of treatment, including the reason behind a pelvic exam, the benefits of the pelvic exam (of which there are few in asymptomatic patients), the risks associated with forgoing the pelvic exam, and standard procedure during the exam, there would be both a disincentive to tell patients they need unnecessary care on the part of physicians and women would be better equipped to discern for themselves when a pelvic exam would benefit them. The doctrine of informed consent is thus different from other tort theories that could provide relief to women abused at the hands of their physicians because it could prevent assaults and unnecessary pelvic exams from occurring *before* they happen.[170]

The concept of informed consent for medical procedures is a relatively new one—the doctrine was first introduced in the courts in the twentieth century.[171] The courts played a "leading role" in the development of the doctrine as the forum where its intricacies were litigated and articulated.[172] One of the first cases establishing that a patient "was an active participant in the treatment decision process" took place in 1914.[173] In *Schloendorff v. Society of New York Hospital*,[174] Justice Cardozo explained:

> In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.[175]

Thus, when a patient did not consent to a medical treatment, or a physician had obtained consent for one medical treatment and delivered another, the patient had a

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[170] *See* Hamilton, *supra* note 23, at 314 ("battery, assault, negligent hiring, and intentional infliction of emotional distress...ha[ve] no built-in mechanism to prevent the sexual assault from happening in the first place.").

[171] Peter M. Murray, *The History of Informed Consent*, 10 IOWA ORTHOPEDIC J. 104, 104 (1990) ("For thousands of years physicians felt that deception was an integral part of the practice of medicine."); Anthony Szczygiel, *Beyond Informed Consent,* 21 OHIO N.U. L. REV. 171, 171 (1994); Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L. J. 899, 900 (1994) (the concept of informed consent appeared in a "recognizable, relatively robust form" for the first time in 1957).

[172] Szczygiel, *supra* note 171, at 171.

[173] Murray, *supra* note 171, at 104. *See also* Szczygiel, *supra* note 171, at 183–84. "After 1904, medical consent cases began to appear in state courts, starting slowly and then gradually increasing in number after 1913. The issue in most cases was the extent to which surgeons could exercise their discretion to alter the surgical plan for anesthetized patients. . . Courts declined, however, to trust the surgeons with that decision making power in the absence of a medical emergency." *Id.*

[174] 211 N.Y. 125 (1914).

[175] *Id.* at 129–30.

cause of action for the intentional tort of battery.[176]

As the courts developed the doctrine, however, the cause of action shifted from the intentional tort of battery to one of negligence; courts found, in the absence of consent, that a physician breached "her professionally-defined duty to treat her patient with due care."[177] The duty of a physician to disclose risks associated with a medical procedure was famously articulated in *Salgo v. Leland Stanford Jr. University Board of Trustees*:[178]

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent.... The instruction given should be modified to inform the jury that the physician has such discretion consistent, of course, with the full disclosure of facts necessary to an informed consent.[179]

After *Salgo,* courts held physicians liable when their disclosures about invasive procedures "fell below the professional norm and serious harm resulted," though physicians were still allowed considerable discretion in determining what information to disclose.[180]

The doctrine of informed consent thus presents a negligence cause of action resting on the principle that "a patient has a right to receive relevant information from her doctor and a right to decide what treatment should be used."[181] The doctrine has four components: (1) the physician's duty to disclose information relevant to the proposed treatment plan; (2) breach of that duty; (3) causation (i.e., had a reasonable patient known of the undisclosed information, they would not have consented to the

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[176] Sharon Nan Perley, *From Control over One's Body to Control over One's Body Parts: Extending the Doctrine of Informed Consent*, 67 N.Y.U. L. REV. 335, 339 (1992). The central issue was whether a "touching" had occurred. Szczygiel, *supra* note 165, at 184. For example, in *Fox v. Smith*, the plaintiff asserted a claim for battery where she consented to a laparoscopy and, during the procedure, her physician removed her IUD. 595 So.2d 596, 604 (1992). The Court reversed a directed verdict and remanded the case for trial because there was a factual dispute as to whether the plaintiff had given the physician permission to remove the IUD (or at least implied it). *Id.* at 605. The Court assessed the claim in terms of battery, writing, "The foundation for the consent requirement applicable to medical practitioners is the tort law of assault and battery-the legal doctrine protecting the right of each individual to be touched only when and in the way authorized by that individual." *Id.* at 604.

[177] *Id. See also* Szczygiel, *supra* note 171, at 191 ("The state courts hearing these cases unanimously held that medical professionals had a legally enforceable duty to provide information to the patient on the nature and purpose of the procedure as well as its risks and alternatives.").

[178] 154 Cal.App.2d 560 (1957).

[179] *Id.* at 578.

[180] Szczygiel, *supra* note 171, at 191.

[181] Morrow, *supra* note 44, at 564. *See also* Perley, *supra* note 176, at 340 ("a physician must now disclose 'all information relevant to a meaningful decisional process,' including the nature and purpose of the contemplated procedures, the alternative available procedures, and the anticipated benefits and risks associated with such procedures.").

treatment); and (4) damages as a result the treatment they received.[182] To prevail on a negligence claim under the doctrine of informed consent, patients must prove either: they were injured by a medical procedure which they did not consent to (a clear breach of the physician's duty to disclose); or that their physician breached their duty to inform by not providing sufficient information, and that if a reasonable patient—not the individual plaintiff, but a reasonable patient—had the missing information, they would have opted out of the procedure.[183]

The question then becomes how to determine whether or not a physician had breached their duty to disclose pertinent information about a procedure; in other words, what standard to use to judge whether a physician's disclosures were sufficient.[184] There are two standards that persist in the present day: the "customary professional practice" standard and the "patient centered" standard, and there is roughly an even split amongst U.S. jurisdictions as to which standard applies.[185] Currently, 25 states and the District of Columbia have adopted the patient centered standard, while 23 states have adopted the customary professional practice standard.[186] As discussed below, the patient centered standard should be adopted by all jurisdictions as applied to pelvic care to ensure women are adequately informed of their treatment plans before consenting to pelvic exams.

1. The "Customary Professional Practice" Standard

The "customary professional practice" standard requires a physician to disclose information to a patient that "a reasonable practitioner in the same or similar circumstances would have disclosed."[187] This standard is thus essentially a matter of professional judgment on the part of physicians who compare their conduct to the conduct of other practitioners; in other words, it is the typical malpractice standard.[188]

In states that adopt the customary professional practice standard, plaintiffs are

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[182] William J. Morton, *The Doctrine of Informed Consent*, 6 MED. & L. 117, 118 (1987). Of course, the patient's ability to consent is dependent on whether the physician has provided sufficient information to the patient so that they may make an informed decision. *See* Perley, *supra* note 176, at 340. By grounding the claim in negligence, courts recognize the duty placed on physicians to disclose information to patients before obtaining consent. *Id.*

[183] Perley, *supra* note 176, at 341.

[184] *Id.* at 340–41 ("The courts are split, however, regarding what constitutes 'sufficient' information."). Some works frame the different standards for the doctrine of informed consent as the majority and minority rules. *See id.* at 340 ("The traditional view, held by a majority of the states..."); Morton, *supra* note 182, at 118 ("This is the prevailing view in the majority of jurisdictions in the United States."). This paper does not adopt this framing, instead viewing the split as between the statutory codification of the doctrine of informed consent and the doctrine at common law.

[185] Morton, *supra* note 182, at 118. *See also* Szczygiel, *supra* note 171, at 190 ("The jurisdictions are almost evenly split between the professionally oriented and the lay standard of disclosure.").

[186] Studdert *supra* note 91, at 105. The laws in the other two states (CO and GA) are not easily classifiable as one or the other. *Id.* These laws exist both in common law and in state statutes depending on the jurisdiction. *Id.*

[187] Morton, supra note 182, at 118. *See also* Schuck, *supra* note 171, at 916.

[188] Morton, supra note 182, at 118.

less likely to succeed in their suits.[189] For example, in *Foard v. Jarman,*[190] the plaintiff patient contacted the defendant physician regarding a surgical operation for her obesity concerns.[191] On her first visit, plaintiff's physician gave her a pamphlet entitled, "What You and Your Family Should Know about Gastric Operations for the Treatment of Obesity."[192] The plaintiff read the pamphlet multiple times, including the section about the risks associated with the procedure.[193] The plaintiff made the decision to proceed with the procedure, despite the stated risks in the pamphlet.[194] Following the surgery, the plaintiff fell extremely ill due to "complications resulting from a perforation in the stomach wall."[195]

In North Carolina, informed consent was codified in the statutory scheme using the customary professional standard; the statute provided that the actions of the health care provider in obtaining consent had to be "in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities" and a "reasonable person" would have an understanding of the procedure or would have undergone such treatment at the advisement of their physician.[196] In other words, the Court stated:

> To meet this statutory standard, the health care provider must provide the patient with sufficient information about the proposed treatment and its attendant risks to conform to the customary practice of members of the same profession with similar training and experience situated in the same or similar communities.[197]

At trial, the defendant physician had another general surgeon testify "it is my opinion that the surgery, care and treatment given the plaintiff by Dr. Jarman was, in every respect, consistent and in accordance with the standard of care."[198] This, in conjunction with the pamphlet the plaintiff read before agreeing to surgery, was sufficient evidence that the physician had met his duty to inform prior to the surgery and thus, the trial court's grant of summary judgment in favor of the defendant was affirmed.[199] As such, because the pamphlet noted the risks associated with surgery, the plaintiff could not be successful on an informed consent claim, even if her physician

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[189] Studdert, *supra* note 91, at 120 ("Our analysis of informed consent verdicts from 25 states—13 with patient standards in place and 12 with professional standards—found that when the verdicts were grouped according to the two types of jurisdictions, the groups were similar in virtually every respect except the odds of a verdict in the plaintiff's favor, which were more than twice as high in states with patient standards. Overall, plaintiffs' injuries were generally quite serious and payouts were large, averaging more than $1 million per compensated case.").
[190] 326 N.C. 24, 387 S.E.2d 162 (1990).
[191] *Id.* at 25, 387 S.E.2d at 164.
[192] *Id.* at 26, 387 S.E.2d at 164. The pamphlet, as is relevant here, stated that there was a 12% risk of "Wound infection," a 5% risk of "Leaks or perforations causing intestinal infection and the need for reoperation," and a 2% risk of "death." *Id.* at 28, S.E.2d at 165. The pamphlet did not detail what these risks meant. *Id.*
[193] *Id.* at 26, 387 S.E.2d at 164.
[194] *Id.*
[195] *Id.*
[196] *Id.* (citing N.C. Gen. Stat. § 90-21.13(a) (1985)).
[197] *Id.* at 26–27, 387 S.E.2d at 164.
[198] *Id.* at 28, 387 S.E.2d at 165.
[199] *Id.* at 29, 387 S.E.2d at 166.

failed to discuss the risks and benefits of the surgery with her and the concrete implications of those risks on her daily life.

Not all plaintiffs under the customary professional standard fail. In *Ipcock v. Gilmore*,[200] Judith Hill submitted to a laparoscopy for sterilization, an elective surgery that requires a few small incisions in the abdomen.[201] She "signed a written consent form authorizing the defendant, Dr. Samuel J. Gilmore, 'to perform the following operation and/or operations—Laparoscopy with Fulguration of Tubes or Application of Hulka Clips.'" [202] While Hill was under anesthesia, however, her physician determined she had adhesions in her pelvis that prevented the sterilization procedure.[203] Rather than awaken Hill and discuss further treatment options with her, he removed all her reproductive organs, a massive surgical undertaking.[204] After her surgery, Hill was denied pain medication and subsequently suffered brain damage due to loss of oxygen to the brain either during or immediately after surgery.[205]

At trial, Hill's physician argued that her consent form authorized him to perform additional surgical procedures to successfully sterilize her because it authorized him to perform the laparoscopy and any other procedures necessary to "accomplish such purpose."[206] The Court disagreed, determining that purpose was the laparoscopy, *not* sterilization.[207] Because the laparoscopy and the adhesions did not amount to a medical emergency, and the physician had not adequately obtained Hill's consent prior to removing all her reproductive organs, Hill prevailed on an informed consent claim under the customary professional standard.[208]

These two examples are from the same jurisdiction—North Carolina—and thus illustrate what showing is required on the part of a plaintiff to succeed under the customary professional standard. In *Foard*, the plaintiff was unsuccessful because the injury she sustained as a result of her surgery was a standard risk of the surgery that was noted in the pamphlet she read, and thus, her physician abided by the customary professional standard of disclosure even though he did not directly discuss the risks associated with the proposed surgery in person.[209] Conversely, in *Ipcock,* the plaintiff was successful under the customary professional standard, but in her case, the physician completely removed all her reproductive organs because he determined he could not successfully complete an elective sterilization procedure by laparoscopy.[210] There was no medical emergency warranting the removal of these organs without the plaintiff's consent.[211] Arguably, the outcome of Hill's procedure is *not* a standard risk of a laparoscopy—in fact, when the physician realized he could not complete the elective sterilization procedure because of the adhesions in the patient's abdomen, he could have simply ended the surgery and informed the patient when she woke up that he had been

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200 73 N.C. App. 182, 326 S.E.2d 271 (1985).
201 *Id.* at 183, 287 S.E.2d at 273.
202 *Id.*
203 *Id.*
204 *Id.*
205 *Id.*
206 *Id.*
207 *Id.* at 194–95, 287 S.E.2d at 279–80.
208 *Id.*
209 *Foard*, 326 N.C. at 29, 387 S.E.2d at 166.
210 *Ipcock,* 73 N.C. App. at 183, 287 S.E.2d at 273.
211 *Id.*

unsuccessful.[212]

The customary professional practice standard presents problems for patients seeking pelvic care. The customary professional practice standard does not require physicians to communicate directly the benefits or risks of a procedure to a patient; a generalized pamphlet could suffice. In addition, while the customary professional standard potentially affords severely injured plaintiffs, like Hill, relief when their physicians perform extreme and unwarranted surgeries, the standard does not require physicians to contemplate what a reasonable patient might like to know in advance of the procedure. As a result, because annual pelvic exams without much disclosure are arguably customary professional practice for OBGYNs, this standard does not require practitioners to disclose important information about the exams before obtaining patient consent. If physicians were asked to contemplate this in the arena of pelvic care, abuses and unnecessary surgeries may be avoided.[213]

2. The "Patient-Centered Standard"

The "patient-centered" standard for the doctrine of informed consent centers the needs of a patient.[214] It requires that a physician disclose the risks associated with a proposed treatment plan "that would be material to a reasonable and prudent person in the patient's position."[215] Prior to 1972, "courts adopted the customary professional practice... as the standard of disclosure."[216] In 1972, the courts took a "dramatic turn," instead imposing a patient centered standard.[217] After the courts began imposing the patient centered standard, physician lobbying groups took to the state legislatures, advocating for a statutory customary professional practice standard.[218] At the time, the state legislatures were handling a medical malpractice insurance crisis, and added informed consent to their debates as to what legislation should be adopted to address these matters.[219] Thus, between 1975 and 1977, "almost half the states enacted statutes that made the legal doctrine less threatening to the medical profession" by codifying the doctrine of informed consent using the customary professional practice standard.[220]

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[212] *Id.* at 195, 287 S.E.2d at 280 (concluding the "total abdominal hysterectomy was unnecessary surgery.").

[213] *See* Studdert, *supra* note 91, at 120, Nina A. Kohn, *Informed Consent in the New Restatement on Medical Malpractice: A Friendly Critique*, 52 SOUTHWESTERN L. REV. 478, 479 (2024).

[214] Morton, *supra* note 182, at 118.

[215] *Id.*

[216] Szczygiel, *supra* note 171, at 191.

[217] Before changing course and imposing the patient-centered standard, the court in *Canterbury v. Spence* noted, "The larger number of courts, as might be expected, have applied tests framed with reference to prevailing fashion within the medical profession. Some have measured the disclosure by "good medical practice," others by what a reasonable practitioner would have bared under the circumstances, and still others by what medical custom in the community would demand. We have explored this rather considerable body of law but are unprepared to follow it." Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir. 1972).

[218] Szczygiel, *supra* note 171, at 191.

[219] *Id. See also* Morrow, *supra* note 44, at 571 ("The term, medical malpractice "crisis," is used most commonly to refer to the urgent situation created within the medical profession due to the tremendous rise in the cost of professional liability insurance for physicians and surgeons. The insurance premiums paid by nonsurgical doctors rose 540.8% and those paid by surgeons rose 949.2% between 1960 and 1970."). The medical malpractice insurance crisis drove much legislative tort reform in the 1970s and 1980s. Studdert, *supra* note 85, at 105.

[220] Szczygiel, *supra* note 171, at 192. Georgia was the final state to codify informed consent, passing their legislation in 1988. *Id.*

In states where a common law standard was clearly articulated by the courts, these informed consent statutes "either froze those disclosure standards or replaced non-professional disclosure rules with professional practice standards."[221]

The classic articulation of the patient centered standard in 1972 comes from *Canterbury v. Spence.*[222] In *Canterbury v. Spence,* the plaintiff-patient, who suffered from back pain, "submitted to an operation without being informed of a risk of paralysis incidental thereto."[223] As a result of this procedure, the plaintiff was left paralyzed, and sued for damages arguing that he would not have agreed to the procedure if he had been adequately informed of the risks associated with it.[224] The Court thus had to determine "the scope of the disclosure the physician is legally obliged to make"—or the standard for defining the adequacy of the physician's disclosures.[225] The court opted for a standard that focused on the patient's "right of self-decision"—a right that only be effectively exercised "if the patient possesses enough information to enable an intelligent choice."[226] The Court articulated:

> The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked. And to safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.[227]

The Court thus remanded the case for a new trial, reversing the previous grant of a directed verdict in favor of the physician and hospital.[228]

The way the Court in *Canterbury* defined the patient centered standard does not protect the individual patient, but rather the "reasonable" patient. A few courts have gone further, creating a patient centered standard that does not ask whether a reasonable patient would consent to a procedure in similar circumstances, but rather whether the individual patient would have consented to a procedure if they had been given additional disclosures.[229] Regardless of whether the courts adopt the reasonable patient

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221 *Id.*
222 464 F.2d 772 (D.C. Cir. 1972).
223 *Id.* at 776.
224 *Id.*
225 *Id.* at 786.
226 *Id.*
227 *Id.* at 786–87.
228 *Id.* at 796.
229 *See* Scott v. Bradford, 606 P.2d 554 (Ok. 1979). "The Canterbury view certainly severely limits the protection granted an injured patient. To the extent the plaintiff, given an adequate disclosure, would have declined the proposed treatment, and a reasonable person in similar circumstances would have consented, a patient's right of self-determination is Irrevocably lost. This basic right to know and decide is the reason for the full-disclosure rule. Accordingly, we decline to jeopardize this right by the imposition of the "reasonable man" standard. If a plaintiff testifies he would have continued with the proposed treatment had he been adequately informed, the trial is over under either the subjective or objective approach. If he testifies he would not, then the causation problem must be resolved by examining the credibility of plaintiff's testimony. The jury must be instructed that it must find plaintiff would have refused the treatment if he is to prevail." *Id.* at 559.

or the individual patient standard within the patient centered standard, patient autonomy continues "to be the chief value honored by the courts."[230]

The patient centered standard is preferable to the customary professional standard in the realm of pelvic care because of the information that the standard often requires physicians to disclose to their patients. In states that adopt the patient centered standard, plaintiffs are often more successful.[231] For example, in *Hubbard v. Neuman,*[232] the Wisconsin courts sustained the denial of a motion to dismiss where the physicians failed to inform a patient that they would remove her ovaries during a surgical intervention to address concerns related to endometriosis.[233] In doing so, the Court articulated that physicians have a duty to provide "a reasonable disclosure to the patient of the significant risks in view of the gravity of the patient's condition, the probabilities of success, and any alternative treatment or procedures if such are reasonably appropriate," and since the removal of ovaries would be a material risk of the surgery that a reasonable patient would like to know prior to consent, the claim survived a motion to dismiss.[234] Because the patient centered standard requires physicians to at minimum disclose information a reasonable patient would find pertinent to their decision-making in their treatment plans, the patient centered standard is preferred by disability rights activists.[235]

The patient centered standard has a unique capacity to change the way that OBGYNs interact with patients seeking pelvic care. Indeed, while both standards require physicians to disclose pertinent information to patients, the patient centered standard asks what patients think they need to know when determining what specific alternatives, benefits, and risks need to be disclosed, rather than what a physician thinks is important. This is significant because, as explained above, historically, male physicians have dismissed and ignored the concerns of women seeking pelvic care. Requiring physicians to think about what patients might like to know—and perhaps even asking patients what they might like to know—would likely result in information sharing between the physician and the patient that would equip patients with the knowledge they need to make decisions about their pelvic exam before they consent simply because their physician recommended the exam. In addition, it would encourage physicians to further detail what patients can expect during the actual exam, which would help women immediately identify deviations from standard practice; to make those identifications, women must be informed what the standard practice is. While other criminal, civil, and disciplinary mechanisms can potentially offer relief to injured patients, the doctrine of informed consent with a patient-centered standard is the best mechanism for preventing unnecessary and potentially abusive pelvic care *before* it happens in the first place by requiring physicians to confront their standard practices and integrate current scientific recommendations for pelvic exams into their treatment plans with the patient's needs at the forefront.[236]

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[230] Szczygiel, *supra* note 171, at 193.
[231] Studdert, *supra* note 91, at 114–17.
[232] 411 Wis.2d 586 (2024).
[233] *Id.* at 598.
[234] *Id.*
[235] Studdert, *supra* note 91, at 109.
[236] *See supra* Part II for an in-depth discussion of the scientific research and recommendations around pelvic exams.

CONCLUSION: THE PATIENT CENTERED STANDARD FOR PELVIC CARE

As discussed above, the problems presented by pelvic exams in asymptomatic women without family histories of pelvic conditions are two-fold.[237] First, abusive physicians have extensive leeway to perpetrate their abuse because women often consent to pelvic exams simply because their physicians tell them to.[238] Second, despite changing recommendations from research groups including the ACOG and the ACP, physicians with the best of intentions continue to perform unnecessary pelvic exams on women with no knowledge that said exam is unnecessary.[239] This is problematic because pelvic exams have harms—they cause "fear, anxiety, embarrassment, pain, and discomfort" in patients, and often result in overdiagnosis and unnecessary surgeries due to their inaccuracies in diagnosing pelvic problems in women without symptoms.[240] Given the limitations of criminal charges, state disciplinary board charges, and medical malpractice lawsuits in civil court,[241] the doctrine of informed consent patient centered standard should be applied to pelvic care in customary professional standard jurisdictions.

The doctrine of informed consent is implemented across all fifty states at common law and by statute.[242] Some states have general informed consent statutes, while others have statutes specific to particular medical procedures.[243] For example, many states have implemented statutes to specifically cover pelvic examinations on patients who are under anesthesia.[244] Thus, it would not be abnormal nor unheard of for a state to implement a particular standard under informed consent for pelvic care. The adoption of the patient centered standard will not necessarily provide women with great relief when they undergo abusive or unnecessary pelvic exams; however, the patient centered standard has the capacity to shift the way that physicians interact with their patients, dismantling the historically paternalistic dynamic. Rather than continuing to abide by the idea that the physician knows best,[245] patients would have the information they need to make determinations for themselves regarding when to receive pelvic exams.

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[237] *See supra* Parts I and II.
[238] *See* Norell, *supra* note 20, at 3–5. *See also supra* note 20 for additional examples of abusive OBGYNs.
[239] *See supra* Part II.
[240] Qaseem, *supra* note 22, at 69.
[241] *See* Hamilton, *supra* note 23, at 311–17. *See also* Part III Section A for an in-depth discussion of the limitations of medical malpractice suits.
[242] Studdert, *supra* note 91, at 105.
[243] *See supra* note 92 for a discussion about informed consent statutes.
[244] *Id.*
[245] *See supra* Part II for a discussion on the paternalistic patient-patient relationship.

LEGAL BARRIERS TO MATERNAL HEALTHCARE EQUITY

Ashley L. Keith*

Abstract: In examining contemporary maternal healthcare inequity in clinical care delivery, we must study the critical role played by the legal institutions in creating and perpetuating this problem. Comprehensive systems within the United States require legal advocacy and judicial enforcement to take shape and maintain their structural integrity. Healthcare in this country is no different. Legal institutions helped form and further, both intentionally and inadvertently, the racial disparities that we currently battle. Legal history plays an integral role in understanding why racial disparities in maternal mortality persist. One way for legal professionals to contribute to the ongoing efforts to achieve maternal healthcare equity is to coordinate our efforts with clinical approaches and resources to create a cohesive legal and healthcare delivery model.

Keywords: Health Law; Healthcare Law; Maternal Health Equity; Health Equity; Healthcare Equity

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INTRODUCTION

Black women in this country are three to four times more likely to die during pregnancy and within the first-year post-partum than both Latine and non-Latine[1] White women.[2] States like Mississippi[3] or counties such as Harris County, Texas[4] have more bleak outcomes than the national median. In examining our nation's healthcare history, we have uncovered an undeniable truth: medical treatment and outcomes are heavily dependent on race.[5] Academic review on the role of clinical care delivery must likewise include the critical role played by the law in perpetuating maternal healthcare inequity. Contemporary discourse has often been critical of the current American healthcare system without historical contextualization, history plays an integral role in understanding why racial disparities in maternal mortality persist. Neutralizing the criteria for comparison to determine whether the root cause is socioeconomic and not on the basis of race has yielded a definitive determination. Even wealth is not an equalizer for outcomes because Black women are at a higher risk of mortality even with when controlling for economic circumstances.[6]

In January 2018, the analyses and criticisms of healthcare inequity boldly leapt into mainstream public discourse via an unlikely medium and with an unexpected messenger. Vogue Magazine interviewed internationally revered tennis player, Serena Williams, following the birth of her first child.[7] Following the interview, news outlets began to cover the topic of modern race-based healthcare disparities in maternal outcomes during pregnancy and the post-partum period *en masse*.[8] Serena Williams detailed her experience following her delivery via cesarean section and difficulty with breathing after undergoing the operation. At the time of her delivery, she was one of

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[1] This paper uses the word "Latine" to collectively encompass Latina, Latino, and non-binary Latinx people.

[2] Tara O'Neill Hayes & Carley McNeil, *Maternal Mortality in the United States*, September 9, 2019. (Americanactionforum.org).

[3] Emily Wagster Pettus, *Maternal mortality rate is much higher for Black women than white women in Mississippi, study says*, AP, December 7, 2023, https://apnews.com/article/mississippi-maternal-mortality-health-department-296067d522b89951280be2cd6f05c180 (last visited June 6, 2024).

[4] Monique Welch, *Harris County has had the highest Black maternal death rates in the U.S. for years. Here's why.*, Houston Landing: Diverse Communities, April 17, 2024, https://houstonlanding.org/harris-county-has-had-the-highest-black-maternal-death-rates-in-the-u-s-for-years-heres-why/ (last visited on June 6, 2024).

[5] Nikole Hannah-Jones, A New Origin Story: The 1619 Project, pp 318 – 322 (First Edition 2021).

[6] Claire Cain Miller, et. al., Childbirth Is Deadlier for Black Families Even When They're Rich Expansive Study Finds, February 12, 2023 (https://www.nytimes.com/interactive/2023/02/12/upshot/child-maternal-mortality-rich-poor.html) (last visited February 27, 2024).

[7] Rob Haskell, *Serena Williams on Motherhood, Marriage, and Making Her Comeback*, Vogue Magazine, January 10, 2018, https://www.vogue.com/article/serena-williams-vogue-cover-interview-february-2018 (last visited February 27, 2024).

[8] Serena Williams, *Serena Williams: What my live-threatening experience taught me about giving birth,* CNN, https://www.cnn.com/2018/02/20/opinions/protect-mother-pregnancy-williams-opinion/index.html (last visited January 23, 2024); *See* Maya Salam, *For Serena Williams, Childbirth Was a Harrowing Ordeal. She's Not Alone.*, The New York Times, January 11, 2018, https://www.nytimes.com/2018/01/11/sports/tennis/serena-williams-baby-vogue.html; *See also* Alex Porteé, *Serena Williams on her near-death experience after giving birth: 'No one was really* listening', Today; Women's Health, https://www.today.com/health/womens-health/serena-williamss-essay-black-pregnancy-rcna23328 (last visited January 23, 2024).

the most-recognizable women in the world with wealth, power, and access[9] to healthcare facilities and providers who can utilize advancements unimaginable to the general public.[10] Williams's socioeconomic status and resources did not automatically translate to an immediate and full evaluation of her concerns about a pulmonary embolism,[11] even though she has a history of blood clots.[12] Her own insistence that she receive a particular test called a computed tomography (commonly known as a CT scan) and diagnostic processes probably prevented a negative health outcome, or potentially saved her life.[13] Pre-existing conditions, in this instance a history of blood clots, is the leading cause of maternal mortality in the United States.[14]

As a healthcare attorney in Ohio, it is simultaneously encouraging and dispiriting to review and analyze the Centers for Disease Control's (CDC) data in juxtaposition to A Report on Pregnancy-Associated Deaths in Ohio 2008-2016, a synopsis of data and statistics published by The Ohio Department of Health.[15] The aforementioned report on Ohio's inequitable outcomes gathered more comprehensive data than is ordinarily available with national sources. This report allows healthcare attorneys in the state to provide well-informed and supported client advice than some of the less specific information otherwise available. The CDC's Pregnancy Mortality Surveillance System is based only on vital statistics (e.g., birth certificate, death certificate, etc.) data submitted to the CDC by states.[16] The Ohio Pregnancy-Associated Morality Review Committee instead utilizes more sources of information to obtain more detailed and comprehensive data on maternal mortality in a process dubbed "the gold standard" by the committee in their review of maternal deaths.[17] This precision in data acquisition and analysis shows that the increase over the last decade in the more

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[9] Ashley L. Parker, *Cultural Responsiveness in Assisted Reproductive Technology: Chapter 9 Racial Disparities in Adverse Pregnancy Outcomes*, 141 (Danielle A. Kaplan, ed., 2024).

[10] Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, Vol. 95 New York University Law Review No. 5 1229, at 1232 (November 2020).

[11] Fiona Miller and Pringl Miller, MD, *Transgenerational Trauma and Trust Restoration*, Vol. 23 AMA Journal of Ethics No. 6, 480 (June 2021).

[12] Serena Williams had been hospitalized in 2011 due to a pulmonary embolism, which is most-commonly caused by a blood clot making its way into the lungs. Foundation to Advance Vascular Cures, *Serena Williams and her Experience with Pulmonary Embolisms*, January 13, 2018, https://www.vascularcures.org/news/pad-online-facebook-community-r9lp9-6jaw8-w6bln#:~:text=Serena%20Williams%20was%20previously%20hospitalized,the%20doctors%20when%20it%20reoccurred. (last visited February 28, 2024).

[13] Haskell, *supra* Note 7.

[14] University of Michigan, Increasing rates of chronic conditions putting more moms, babies at risk, Medical Xpress, November 7, 2017, https://medicalxpress.com/news/2017-11-chronic-conditions-moms-babies.html (last visited February 27, 2024).

[15] A Report on Pregnancy-Associated Deaths in Ohio 2008-2016, The Ohio Department of Health (2019), available electronically at https://odh.ohio.gov/wps/wcm/connect/gov/f5f620c6-d444-4873-bbc8-bbc76bba1a71/A_Report_on_Pregnancy-Associated_Deaths_in_Ohio_2008-2016+website+version.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-f5f620c6-d444-4873-bbc8-bbc76bba1a71-nvUTYCq.

[16] Centers for Disease Control and Prevention, Pregnancy Mortality Surveillance System, May 15, 2024, https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance/index.html last accessed August 18, 2024.

[17] A Report on Pregnancy-Associated Deaths in Ohio 2008-2016, The Ohio Department of Health (2019), available electronically at https://odh.ohio.gov/wps/wcm/connect/gov/f5f620c6-d444-4873-bbc8-bbc76bba1a71/A_Report_on_Pregnancy-Associated_Deaths_in_Ohio_2008-2016+website+version.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-f5f620c6-d444-4873-bbc8-bbc76bba1a71-nvUTYCq.

broadly defined terms "pregnancy-associated death"[18] and "pregnancy-related death"[19] makes the revelation more sobering that in Ohio, Black women were more than 2.5 times as likely to die than White women.[20] It is with this lens and experience that I have observed the mainstream attention-shift to maternal and fetal health outcomes on the national stage.

On January 20, 2025, within the first days of the second Trump administration, an Executive Order titled Regulatory Freeze Pending Review was issued. Per this action, federal departments and agencies, such as the CDC, are unable to propose or implement new rules that were not already published in the Federal Register prior to noon on January 20, 2025, unless the proposed/new rule undergoes a process of review and approval by a person politically appointed or designated by this current administration.[21] It is unclear whether states like Ohio will continue to collect and distribute such comprehensive data for public review and use. Other states, such as Texas, have already faced public scrutiny[22] for its most recent Maternal Mortality and Morbidity Review Committee report[23] which omits data for maternal mortality following the Supreme Court *Dobbs v. Jackson Women's Health Organization*[24] decision which overturned *Roe v. Wade*.[25] Investigative claims suggest that the restrictive abortion ban in Texas[26] following the *Dobbs*[27] decision has resulted in additional fatal outcomes[28] and omitting this type of data from information from 2022 and 2023 will prevent this information from facing scrutiny or granting public access. As long-standing tools used by health law researchers are impacted by political shifts, it is imperative to accurately reflect historical practices and document the lessons learned to guide legal approaches of the future.

Many legal scholars have written about the ongoing battle for healthcare equity

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[18] "Pregnancy-associated death. The death of a woman while pregnant or anytime within one year of pregnancy regardless of cause." *Id*.

[19] "Pregnancy-related death. The death of a woman while pregnant or within one year of the end of the pregnancy, regardless of duration and site of pregnancy, from any cause related to or aggravated by her pregnancy or its management (e.g., from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by physiologic effects of pregnancy)." *Id* at 10.

[20] *Id* at 14.

[21] Executive Order, *Regulatory Freeze Pending Review* (January 20, 2025), available electronically at https://www.whitehouse.gov/presidential-actions/2025/01/regulatory-freeze-pending-review/ (last visited January 24, 2025).

[22] Elaine Mallon, *Texas Committee Won't Examine Maternal Deaths in First Years After Abortion Ban*, Washington Examiner (Nov. 27, 2024), available electronically at Texas health committee won't review maternal deaths in 2022, 2023 - Washington Examiner (last visited January 24, 2025).

[23] Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2024: As Required by Texas Health and Safety Code, Section 34.015, Texas Health and Human Services (September 1, 2024), available electronically at https://www.dshs.texas.gov/sites/default/files/legislative/2024-Reports/MMMRC-DSHS-Joint-Biennial-Report-2024.pdf (last visited January 24, 2025).

[24] 597 U.S. 215 (2022).

[25] 310 U.S. 113 (1973).

[26] Texas Health & Safety Code § 170A.002.

[27] Dobbs v. Jackson Women's Health Organization, 597 U.S. 215 (2022).

[28] Erika Edwards, Zinhle Essamuah and Jason Kane, *A dramatic rise in pregnant women dying in Texas after abortion ban*, NBC News (September 20, 2024) available electronically at https://www.nbcnews.com/health/womens-health/texas-abortion-ban-deaths-pregnant-women-sb8-analysis-rcna171631 (last visited January 24, 2025).

in America,[29] and maternal healthcare inequity follows a similar trajectory.[30] We have come to acknowledge and accept historical and contemporary[31] systemic inequity in healthcare access and outcomes in the United States. Current obstetrical guidelines[32] have recommended the implementation of comprehensive programs to standardize care, while Federal initiatives via executive actions[33] and passed legislation,[34] regulation of insurance coverage requirements,[35] and proposed legislation[36] attempt to reduce maternal inequity.

Americans spend nearly double the annual amount on healthcare expenses as the average per person expenditure than the median for other high-income developed countries.[37] In spite of, or perhaps in part due to, spending more per person on healthcare; the United States of America has become infamous for its maternal morbidity and mortality rates when compared to other nations with approximately 80% of pregnancy-related deaths determined as preventable.[38] Under the bright glare of international scrutiny of these statistics, the maternal mortality rate in the United States

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[29] The role of implicit bias in structural disparities in healthcare has been researched extensively by scholars such as Dayna Bowen Matthew, Dean of George Washington University Law School in books and articles cited throughout this publication. Dayna Bown Matthew, *Toward a Structural Theory of Implicit Racial and Ethnic Bias in Health Care*, Vol. 25 Health Matrix 61 (2015).

[30] United States Department of Health and Human Services, *Healthy Women, healthy Pregnancies, Healthy Futures: Summary of the U.S. Department of Health and Human Services' Action Plan to Improve Maternal Health in America*, December 2020 available electronically at https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//197501/hhs-maternal-health-action-plan-summary.pdf (last accessed September 16, 2024).

[31] Laura Specker Sullivan, *Trust, Risk, and Race in American Medicine*, Vol. 50 Hastings Center Report Issue 1, 18 (February 18, 2020).

[32] The 2022 American College of Obstetrics and Gynecologists, *Severe Hypertension in Pregnancy Safety Bundle (2022)*, Alliance for Innovation on Maternal Health (2022).

[33] Joseph Biden-Kamala Harris, President and Vice President of the United States, July 10, 2024, Statements and Releases from the White House Briefing Room, *The White House Blueprint for Addressing the Maternal health Crisis: Two Years of Progress*, https://www.whitehouse.gov/briefing-room/statements-releases/2024/07/10/the-white-house-blueprint-for-addressing-the-maternal-health-crisis-two-years-of-progress/ (last visited September 16, 2024).

[34] Preventing Maternal Deaths Acts of 2018, Pub. L. No. 115-344, 132 Stat. 5047 (2018).

[35] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010).

[36] Black Maternal Health Momnibus Act, S. 1606 (2023); Black Maternal Health Momnibus Act, H.R. 3305 (2023).

[37] Emma Wager, Matthew McGough, Shameek Rakshit, Krutika Amin, and Cynthia Cox, *How does health spending in the U.S. compare to other countries?*, Peterson-KFF Health System Tracker, https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/ (last visited June 6, 2024).

[38] Susanna L. Trost, Jennifer L. Beauregard, Ashley N. Smoots, Jean Y. Ko, Sarah C. Haight, Tiffany A. Moore Simas, Nancy Byatt, Sabrina A. Madni, and David Goodman, *Preventing Pregnancy-Related Mental Health Deaths: Insights from 14 US Maternal Mortality Review Committees, 2008-17*, 1551 Health Affairs Volume 40, Number 10 (October 2021).

is increasing.[39] In 2021,[40] Black non-Latine[41] people who gave birth[42] were 2.6 times more likely to die after delivery than their White counterparts.[43] In 2021, approximately 30% of material deaths were Black patients as recorded by the CDC with a significant percentage of these deaths occurring in the post-partum period.[44]

The existence of race-based healthcare disparities is not a new challenge, the American healthcare system was created and continually developed with the expectation of disparate care and outcomes which embedded racial bias within our healthcare delivery.[45] Consequently, past initiatives that singularly targeted a metric or subset of the population have been inadequate to eradicate the disparities.[46] "Recent efforts to identify root causes of maternal health inequity have highlighted how a focus on individuals and their experienced risk factors–clinical, behavioral, and even social determinants–reflect actions of the individual rather than the historical, systemic, structural, and political forces that created them."[47] Legal scholars have painstakingly documented the lingering inequity despite attempted remedial measures.[48] Systemic inequity remains because the healthcare, legal, and societal changes are too siloed to combat such a foundational and pervasive problem.

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[39] O'Neille Hayes, *supra* Note 2.

[40] There is a lag in data availability for maternal health outcomes, years are noted to provide context with the understanding that intervening years between their availability and this publication may vary.

[41] Other categories of non-Black patients also have heightened maternal mortality rates in comparison to their White counterparts, each marginalized group necessitates their own in-depth analysis rather than grouping them in this paper when I have not dedicated an adequate amount of time and research to their unique societal position. More information can be located on these statistics, as published by the United States Centers for Disease Control. Donna L. Hoyert, *Maternal mortality rates in the United States*, 2021. NCHS Health E-Stats. 2023 https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm (last visited June 6, 2024).

[42] Availability of statistics and further discussion may be limited to cis-gender categories as gathered and/or reported. This paper does not purport or assume that gender-diverse individuals or minors do not give birth, but due to the limitation of data the word "woman" may be used even if the imprecise data collection includes other groups.

[43] O'Neille Hayes, *supra* Note 2.

[44] Our current national tracking systems are limited to the time when the person is pregnant and within forty-two (42) days following the termination of the pregnancy which has been designated as a maternal death by the World Health Organization. As a result, this time period is used by the CDC in the publication of its statistics. While utilized as an international standard, the origins for that timeline is historically due to religious and cultural practices rather than medical reasons. Late maternal death is an expansion that encompasses the twelve (12) months following the pregnancy termination. *See.* World Health Organization's World Health Assembly, International Statistical Classification of Diseases, Tenth Revision (WHO WHA ICD-10). (https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf) (https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/j.1471-0528.2003.03007.x Maternal mortality: only 42 days?) (WHO ICD- Tenth Revision).

[45] Stephen C. Kenny, "A Dictate of Both Interest and Mercy"? Slave Hospitals in the Antebellum South, 65 Journal of the History of Medicine and Allied Sciences, 1 (January 1, 2010).

[46] The prohibition of race-based (among other forms) discrimination for entities that received federal funding pursuant to Title VI of the Civil Rights Act of 1964, did not resolve enduring problems to obtain healthcare equity. Sara Rosenbaum & Sara Schmucker, *Civil Rights and the Courts in Shaping Health Equity; Viewing Health Equity through a Legal Lens: Title VI of the 1964 Civil Rights Act*, 771 Journal of Health Politics, Policy and Law, Vol. 42, No. 5, October 2017.

[47] Joia Crear-Perry, MD, et al., *Social and Structural Determinants of Health Inequities in Maternal Health*, Vol. 30 Journal of Women's Health No. 2, 230 at 231 (2021).

[48] *See* Dayna Bowen Matthew, *Just Medicine: A Cure for Racial Inequality in American Health Care*, pp 9 – 31 (2015).

Comprehensive systems within the United States require legal advocacy and judicial enforcement to take shape and maintain their structural integrity. Healthcare in this country is no different. Legal institutions helped form and further, both intentionally and inadvertently, the racial disparities that are currently enmeshed.[49] Practitioners, legal academics, legislators with law education and backgrounds, and the judicial system have an obligation to work purposefully and systematically to undo the damage done by the legal profession that aided in the entrenchment of inequity in American healthcare. Such approaches require historical context with multi-faceted solutions.[50] The previous health law approach of evaluating the actions of healthcare practitioners at arm's length based on slotting the role of health law into existing clinical framework[51] is justifiably falling away to a more influential role which incorporates social justice and equitable outcomes in the field of health law.[52] One way to target and dismantle existing inequity, is to develop a comprehensive understanding of the historical practices used to build and sustain delivery of women's healthcare in this country.[53] With a historically-informed knowledge base, legal institutions should advocate for and provide legal solutions to advance maternal equity with a pathway to properly address these embedded disadvantages. To design and maintain the field of healthcare law, we must propose innovations detached from the tether to pervasive inequity to work toward a comprehensive reconfiguration of healthcare delivery.

There exists a commonality between the geographically diverse patient populations of the average pregnant Black American[54] woman, an internationally awarded tennis star, Black pregnant women in Mississippi, Ohio, and Harris County, Texas. The connecting thread is the shared history of racist discrimination which spans the country and is woven into the fabric of American healthcare. This is not a quilt of unrelated events leading to the same outcome, there is a single cord that creates the knit of congruity for all these patients. There is significant contemporary legal research with in-depth analyses on social, economic, and environmental factors that impact the health

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[49] Erin C. Fuse Brown, J.D., M.P.H & Aaron S. Kesselheim, M.D., J.D., M.P.H., The History of Health Law in the United States, Vol. 387 The New England Journal of Medicine No. 4 289 (July 28, 2022).

[50] Contextual understanding matters: "You think you just fell out of a coconut tree? You exist in the context of all in which you live and what came before you." Kamala Harris, Vice President of the United States, May 10, 2023, Remarks at the Swearing-In Ceremony of Commissioners for the White House Initiative on Advancing Educational Equity, Excellence, and Economic Opportunity for Hispanics, https://www.whitehouse.gov/briefing-room/speeches-remarks/2023/05/10/remarks-by-vice-president-harris-at-swearing-in-ceremony-of-commissioners-for-the-white-house-initiative-on-advancing-educational-equity-excellence-and-economic-opportunity-for-hispanics/ (last visited June 6, 2024).

[51] Mark A. Hall, *The History and Future of health Care Law: An Essentialist View*, 41 Wake Forest L. Rev 347 (2006).

[52] Lois Shepherd, *Assuming Responsibility*, 41 Wake Forest L. Rev. 445 (2006).

[53] Brue G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, Journal of Health and Social Behavior, 80 (1995); Dayna Bowen Matthew, *Just Medicine: A Cure for Racial Inequality in American Health Care* (2015); Dayna Bowen Matthew, *Just Health: Treating Structural Racism to Heal America* (2022).

[54] Throughout this text I will use the racial description Black rather than the nationality indicator African American. From my review of the data and texts included as sources, I have been unable to determine whether the Black patients and medical subjects did not have origins from other parts of the diaspora (e.g. South American, Caribbean, etc.). Use of African American would unintentionally equate all subjects with the common origin of the African continent whose ancestors arrived in North America via the trans-Atlantic slave trade, and I have not verified that to be an accurate descriptor.

of individuals and groups of patient populations.[55] Rather than social determinants of health, this article will instead focus on race-based historical events that created, solidified, or advanced inequitable healthcare outcomes as supported by legal institutions to illustrate the disparities still prevalent in our current healthcare delivery system and why health law should play a role in its remedy. The parallel development of medical advancements with the evolution of race-based discrimination serves as a microcosmic view of the foundational problems created and this paper offers a clinically informed legal solution to help address the deeply entrenched issue of inequitable outcomes for maternal health. Much of the legal scholarship has examined the events detailed in this article in an isolated vacuum with a desire to inform the legal profession and offer course correction on a singularly focused ill, but there is a lack of connective relation to the historical perspective which, in turn, encourages a piecemeal approach that has proven inadequate to-date. For example, medical experimentation[56] is often discussed in a context disconnected from employment-based discrimination[57] although the availability of healthcare services (including experimental treatment) and insurance coverage via employment are intertwined.[58] Since race-based partiality was the intent of the formation and design of the American healthcare system when chattel slavery was a significant component of the economy, the support of a multitude legal institutions in its establishment and maintenance was required. This paper will illustrate, via poignant points of our country's history, an explanation for the inadequacies of singularly focused solutions to disentangle the relationship between racist healthcare development and its modern-day outcomes.

Medical inequity persists in America, in part, due to the establishment (via drafting legislation, judicial decisions, and scholarly articles) of historical and modern legal precedent that perpetuates these outcomes. Those who have received legal education and training have an obligation to offer up insight and solutions to disassemble the mechanisms that enable race-based inequity rooted in the American healthcare system because our profession was instrumental in its creation and sustainability. This article seeks to unveil some widespread and seemingly disparate historical precedents related to medical research, the segregation of medical care for patients and training for practitioners, and the availability of health insurance coverage that have contributed to racial inequity in healthcare and prompt a broader conversation on the role of the law to work toward the disassembly of the portions of the healthcare delivery system that continue to bolster the disparities. Due to the role of our professional predecessors, legal institutions have an obligation to understand our historical role to effectively design wholistic and informed solutions to achieve impartiality for patient care and health outcomes. If we acknowledge and accept that American healthcare advanced and developed in tandem with purposeful race-based inequality, we can then focus on solutions to raze the interconnectivity between race

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[55] Frank Khalik & Alisa Lincoln, *Salus Populi*: Educating Judges on the Social Determinants of Health, 260 Journal of Legal Education, Volume 71, Number 2 (Winter 2002).

[56] Kenny, *supra* Note 36 at 12; Deleso Alford Washington, *Examining the "Stick" of Accreditation for Medical Schools Through Reproductive Justice Lens: A transformative Remedy for Teaching the Tuskegee Syphilis Study*, 26 J. Civ. Rts. & Econ. Dev. 153.

[57] Ronald L. Lewis, *Black Coal Miners in America: Race, Class, and Community Conflict, 1780-1980*, at 89 (1987).

[58] Madeline T. Morcelle, *Reforming Medicaid Coverage Toward Reproductive Justice*, 48 American Society of Law, Medicine & Ethics, 223 (2022).

and healthcare delivery in maternal care.

Part I of this article, *Building Blocks of American Race-Based Healthcare Inequity*, will discuss the early development of the American healthcare system and its coexistence with the establishment of a nation with a racial hierarchy. American medical professionalism and the establishment as a scientific field emerged alongside the widespread practice of enslavement of Black people in America, and thus it was impossible for the field to exist or develop without the societal ideas of racism and exclusion in the practice of medicine or treatment. Part II, *Frankenstein's Medicine: Experimentation, Eugenics & Treatment*, will highlight examples of inequity that impacted obstetrical health throughout the Colonial Period, in the Antebellum South, and during the Jim Crow Era following emancipation. The modernization of the healthcare system to one where practitioners increasingly provide services in hospital settings and push to learn from medical experimentation continued to incorporate racist attitudes and conduct of the larger society and were not appropriately addressed or eradicated following societal and medical integration. Part III, *The Birth of a Nation's Medical Insurance Industry*, will discuss the racial tensions as healthcare evolved payment mechanisms outside of direct cash payments from patients to healthcare providers. The health insurance industry emerged while tied to employment, which relied upon the existing race-based discriminations associated with labor in a country where slavery and professional exclusion were legally acceptable practices. In Part IV, *Potential for Comprehensive Solutions*, of the article I propose the alteration of current maternal safety bundles[59] to build upon these existing structures which authorize the collection of data and advocate for uniformity in obstetrical care practices to provide a legal solution that is historically informed and consistent with the self-interest of practitioners. My proposed alteration both furthers to goal for maternal healthcare equity as a connection with practitioner self-interest to make a workable solution anchored in an evidence-based clinical approach developed by medical practitioners.

I. BUILDING BLOCKS OF AMERICAN RACE-BASED HEALTHCARE INEQUITY

> *The work of dehumanization is to substantially and sufficiently distinguish oneself from another group of people, so that treatment that plainly would violate human decency if directed toward you becomes permissible, justified, or even desirable in light of the rationalization that the other group is nothing like you. If the other group is not human, then there is no need to treat its members as human.*[60]

A. Inferiority, an Exclusionary Bedrock

To evaluate the roots of purposefully discrimination in healthcare treatment in this country, we must go back to the infancy of the notion of the nation. A racial

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[59] Medicare and Medicaid Programs: Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals, 89 Fed. Reg. 59489 (July 22, 2024).

[60] Dayna Bowen Matthew. *Just Health: Treating Structural Racism to Heal America*, 58 (2022).

hierarchy[61] is among the foundational concepts within the creation of the American colonies, this ideology naturally translated to a difference between patient treatment and clinical services within the burgeoning American healthcare system. The enslavement and indentured servitude practices of European colonist [62] became enforceable within the bounds of the legal parameters established in the early creation of American jurisprudence.[63] Some of the original codified laws governing the colonies were contained in the Virginia Acts in the early eighteenth century included the legal solidification of inherited servitude for offspring,[64] which supports a theory that racial inequality was a primary societal concern addressed by colonists half a century before the Declaration of Independence was drafted.[65] Although indentured servants were not originally determined by race, there were even striations of servitude with Black indentured servants available for this life-long status and White servants exempt from this classification.[66] This foundational priority was thus recognized and upheld in the earliest iterations of the judicial system.[67] Courts continuously enforced the doctrine of inherited status of enslavement throughout the colonial period and after the founding of the United States of America.[68] The development of the practice of medicine happened alongside the widespread practice of enslavement and societal inequality.

In the early 1720s, the Smallpox virus was spreading internationally and

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[61] Entire races were prohibited from voting regardless of status as enslaved or free. General Assembly. ""An Act directing the trial of Slaves, committing capital crimes; and for the more effectual punishing conspiracies and insurrections of them; and for the better government of Negros, Mulattos, and Indians, bond or free" (1723)" Virginia Acts of 1723 Section XXII, pp 133-134.

[62] Early Colonial legislation established separate and distinct laws for people bound by indentured servitude and slavery. Warren M. Billings, *The Law of Servants and Slaves in Seventeenth-Century Virginia*, The Virginia Magazine of History and Biography, Vol 99 No 1, 45 (1991).

[63] William Goodell, *The American Slave Code in Theory and Justice; its Distinctive Features Shown by the Statutes, Judicial Decisions, & Illustrative Facts* (1853).

[64] General Assembly. "Negro womens (sic) children to serve according to the condition of the mother" Virginia Acts of 1662 Section XII, at 170.

[65] The Declaration of Independence was not adopted by the Continental Congress until July 4, 1776. National Archives, Declaration of Independence (1776), https://www.archives.gov/milestone-documents/declaration-of-independence (last visited on February 28, 2024).

[66] Bowen Matthew, *supra* Note 51 at 60.

[67] Howell v. Netherland, 1770 Va. LEXIS 1, *4-5 Samuel Howell, an indentured servant because his grandmother was white and his grandfather was black, argues the Virginia Act of 1723 should not apply to grandchildren. The court finds the Act of 1723 inapplicable and includes several quotes of the Virginia Act of 1705: "…c. 49. s. 18. 'If any woman servant shall have a bastard child, by a negro or mulatto, or if a free Christian white woman shall have such bastard child by a negro or mulatto; in both the said cases the churchwardens shall bind the said child to be a servant until it shall be of thirty-one years of age.' In other parts of the act, it is declared who shall be slaves, and what a manumission of them; from sect. 34. to 39. are regulations solely relative to slaves, among which is sect. 36. 'Baptism of slaves doth not exempt them from bondage; and all children shall be bond or free according to the condition of their mothers and the particular directions of this act.'…For having proved that servitude to be rightful, must be founded on either compact, or capture in war, he proceeds to shew that the children of the latter only follow the condition of the mother: for which he gives this reason, that the person and labor of the mother in a condition of perfect slavery, (as he supposes to be that of the captive in war) being the property of the master, it is impossible she should maintain it but with her master's goods; buy which he supposes a debt contracted from the infant to the master." Samuel Howell lost the case due to his inherited servitude. Samuel Howell was represented by future United States President, Thomas Jefferson. Thomas Jefferson's Argument in Howell v. Netherland (1770), Encyclopedia Virginia, Virginia Humanities, (07 Dec. 2020), https://encyclopediavirginia.org/primary-documents/thomas-jeffersons-argument-in-howell-v-netherland-1770/ (last visited January 17, 2024).

[68] Butler v. Boarman, 1 H. & McH. 371; Mahoney v. Ashton, 4 H. & McH. 295.

reached the metropolitan area of Boston, Massachusetts.[69] Although the process of acquired immunity had been documented and practiced in other parts of the world, variolation[70] (this would later evolve into the process of immunization) was an uncommon practice in the colonies.[71] During this time period, there were nearly forty-two thousand enslaved people living in the as-yet-unfounded United States of America.[72] As the medical community was gathering evidence and spreading knowledge about the practice of small pox inoculation, a minister in Boston Massachusetts confirmed efficacy of piercing small pox sores to inoculate healthy people to help them develop immunity. This minister, Cotton Mather, obtained this knowledge from an enslaved man named Onesimus[73] who was gifted to the minister by his parishioners in the early 1700s.[74] This method led to a wide-spread introduction of the procedure and this public health movement would later become the basis for George Washington's mandate to inoculate soldiers during the American Revolutionary War.[75] While unable to participate in the medical profession, Black people continually made significant contributions to the advancement of American healthcare. Medical knowledge was gained from people like Onesimus who willingly shared their unacknowledged expertise and from scores of known and many more unknown non-consenting patients whose contributions were forcibly obtained.[76]

B. Less of an Art, More of a Science

During the formative years of this nation, the profession and practice of medicine is likely unrecognizable to modern patients who are unfamiliar with its current evolutionary state. Circa the 1850s and 1860s, the practice of medicine begins to include an understanding of microscopic pathogens, preventative and interventionist management of overall health. This led to a scientific consensus that there is a link between specific diseases and microorganisms.[77] This connection is known as the "germ theory of disease" school of thought, which resulted in major advancements such

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[69] Brian D. Abramson et al., *Vaccine, Vaccination, and Immunization Law*, ch. 1, § 1.III.C. (2022) (ebook).

[70] The process of intentionally exposing healthy people to contagions to inoculate them against a more severe illness. *Id*.

[71] America founded with Declaration of Independence July 4, 1776 with the American Revolution fought from April 19, 1775 – September 3, 1783. 19 Stat. 216; 44 Pub. Res. 19; Demos v. Waddington, No. 03-489-S, 2004 U.S. Dist. LEXIS 654 (D.R.I. Jan. 20, 2004).

[72] This population increased by 60% by the end of the 1720s. J. David Hacker, *From '20. and odd' to 10 million: the growth of the slave population in the United States*, Slavery & Abolition, Vol 41 No 4, 840-855 (2020).

[73] Onesimus was gifted to Cotton Mather by his parishioners in 1707. Arthus Boylston, *The Origins of Inoculation*, 309 Journal of the Royal Society of Medicine, Volume 105, Issue 7 (July 28, 2012).

[74] The ability to give and received enslaved people as property was recognized and protected in the judicial system. Early colonial cases involved the resolution of disputes for the disposition of enslaved people or allocation of damages due to the loss of the value of those enslaved individuals. *See generally. Marston v. Parish*, 1730 Va. LEXIS 1; *Waddy v. Sturman*, 1731 Va. LEXIS 2 (Apr. 1, 1731).

[75] Boston National Historical Park, *Smallpox, Inoculation, and the Revolutionary War*, https://www.nps.gov/articles/000/smallpox-inoculation-revolutionary-war.htm (last accessed on March 4, 2024).

[76] L. Lewis Wall, *J. Marion Sims and the Vesicovaginal Fistula: Historical Understanding, Medical Ethics, and Modern Political Sensibilities*, 66 Issue 2, Volume 24 (March/April 2018).

[77] John Steele Gordon, *A Short History of American Medical Insurance*, Volume 47 Imprimis Issue 9 (September 2018).

as prevention of wound infection.[78]

In the United States, these medicinal marvels were unfolding in tandem with the trans-Atlantic slave trade. While the concept of bacteria and viruses were the direct causes for infections were taking hold in the development of modern medicine in 1860, there were approximately 4 million people enslaved in America.[79] During this era, care for enslaved people remained under the directive and non-regulation of slave-owners who could personally reject medical advancements and more costly treatment options while non-enslaved Black Americans could be denied care by facilities and practitioners based on their race. Physicians who were beginning to form professional training informed by scientific discovery were more likely to treat White Americans in more sanitary conditions.[80] It should be noted, that while the physicians treating White Americans were more likely to be informed by emerging professions standards, there were still many hurdles to clear for healthcare standardization.[81] "In 1850 the U.S. had 40,755 people calling themselves physicians…Few of this legion had formal medical education, and many were unabashed charlatans." [82] Society reinforced racial disparities in healthcare with the duality of these healthcare pathways and continued to interweave discriminatory treatment with scientific achievements.

With the passage of the 13th Amendment of the United States Constitution in 1865 to formally abolish slavery,[83] came an era of codified and *de facto* race-based discrimination with the purpose of keeping Black and White populations separated with limited instances of interaction without regard to emancipation status widely known as "Jim Crow."[84] This societal separation was, of course, recognized and enforced by the Supreme Court in the landmark decision of Plessy v. Ferguson which permitted "separate but equal accommodations" and those living within jurisdictions that enacted these rules were stripped of personal discretion to violate these regulations.[85] The end of slavery did not result in equal access to healthcare or universal ethical conduct within the healthcare system. Additionally, Jim Crow regulations required clinicians to use the substandard practices, locations, and medications as determined by racist ideologies commonly practiced or codified in the jurisdiction. Jim Crow discrimination was enmeshed within the fabric of American lifestyles, including the way in which individuals and groups sought and paid for healthcare.

The development of the germ theory accompanied the initial wave of the

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[78] *Id*.
[79] Khushbu Shah and Juweek Adolphe, *400 years since slavery: a timeline of American history*, The Guardian (August 16, 2019).
[80] Kenny, *supra* Note 36 pp 9 – 17.
[81] Whitfield J. Bell Jr., *A Portrait of the Colonial Physician,* Volume 44 Bulletin of the History of Medicine Number 6, 497 (November – December 1970).
[82] Gordon, *supra* Note 68.
[83] National Archives, 13th Amendment to the U.S. Constitution: Abolition of Slavery (1865), https://www.archives.gov/milestone-documents/13th-amendment#:~:text=Passed%20by%20Congress%20on%20January,slavery%20in%20the%20United%20States. (last accessed February 28, 2024).
[84] *303 Creative LLC v. Elenis*, 600 U.S. 570, 143 S. Ct. 2298 (2023).
[85] *Plessy v. Ferguson*, 163 U.S. 537, 16 S. Ct. 1138 (1896). The separate but equal doctrine would not be overturned until 1954 with the Brown v. Board of Education decision. *Brown v. Board of Education*, 347 U.S. 483, 74 S. Ct. 686 (1954).

transition[86] of the of the primary site of care for acute treatment from the home of the patients to a hospital setting. This advancement meant the cost to render care in a hospital increased healthcare expenditures for patients.[87] At the beginning of the twentieth century, the conundrum of additional cost with the shirking availability of nonhospital-based care[88] created an opportunity to innovate while in the climate of Jim Crow enforcement. Since this transformation coincided with legally enforceable racism, the advent of the American health insurance industry and societally acceptable Jim Crow norms resulted in an interknit relationship between the two further discussed in Section II of this article.

II. FRANKENSTEIN'S MEDICINE: EXPERIMENTATION, EUGENICS & TREATMENT

> *The systematic, institutionalized denial of reproductive freedom has uniquely marked Black women's history in America.*[89]

The care provided from the American Colonial Period and continuing thereafter included a fundamental attitude within the medical profession that Black people were physiologically and biological so dissimilar from White people, that medical advice and treatment had to be provided on the basis of these differences and under a separate set of conditions.[90] For centuries medical practice incorporated the ideas that Black people did not experience pain as acutely as White people.[91] This beliefs naturally lead to the desire to perform medical experiments on enslaved people in an attempt to substantiate the assertion and simultaneously advance medical knowledge for non-Black patients in direct contradiction to this inherent hierarchy claim.[92] The explicit acknowledgement of inferiority of Black people extended beyond the status of enslavement and was enforced within our legal system.[93] Legal support for this viewpoint, enabled other areas of society including healthcare delivery to continue with inequity as a foundational tenant to its existence. While enslaved, the care or absence of such for Black people was subject to the conditions and oversight of the owner of an enslaved person.[94] Enslavers provided medical care for the enslaved in various degrees and in different settings, including slave hospitals.[95] Fitness for manual labor tasks rather than healthy lifestyle would have been the focus of care (when allowed) for enslaved people[96] "Most slave hospitals in the American South, especially those with commercial and experimental roles, did not operate simply to provide patients with comfort, warmth, and light; rather they functioned as mechanisms for the maintenance,

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[86] *See* Barbara Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace, 1865 – 1925*, Chapter 3 (2005).
[87] Gordon, *supra* Note 68.
[88] *Id*.
[89] Dorothy Roberts. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, 4 (1997).
[90] Kenny, *supra* Note 36.
[91] Hannah-Jones, *supra* Note 5, at 318.
[92] Todd L. Savitt, *The Use of Blacks for Medical Experimentation and Demonstration in the Old South*, 48 The Journal of Southern History, 331 (August 1982).
[93] Collins v. Hall, 1 Del. Cas. 652 (Sup. Ct. 1793). A case in which Levin Thompson, a Black man who was born free with free parents in Maryland, was unable to serve as a judicial witness because he was deemed inferior and without significant rights by the court.
[94] Young v. Forgey, 5 Tenn. 9 (May 1, 1817).
[95] Kenny, *supra* Note 36.
[96] *See* Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (2006).

restoration, insurance, and enhancement of commercial value for the objectified chattel they housed, as well as to provide spaces in which southern doctors could develop their knowledge, raise their profile, and sharpen their professional skills."[97]

Even with documented contributions noted herein to medical advancement by Black people in America, racist discrimination often barred their contemporaneous acknowledgement or actively prohibited their official recognition. The first Black doctor in the United States opened his medical practice in 1839, but Dr. James McCune Smith could not obtain his medical degree in America.[98] Due to the ferocity of America's commitment to race-based inequality, Dr. McCune Smith was forced to earn his degree from the University of Glasgow in Scotland after he was denied the opportunity to attend in his country of birth.[99] Restrictions to development and training opportunities for Black healthcare professionals increased the likelihood that Black patient populations would encounter clinicians unwilling to treat them or increased the possibility that when treated they would receive inferior care. Dr. McCune Smith's achievements are in spite of and in defiance to all the American societal and legal barriers to success, others who lacked this same access were locked out of any viable pathway to formal medical education and training. This absence of Black practitioners meant medical care for Black patients was often rendered by practitioners who fervently believed these patients had physical and mental inferiorities.

Alongside the brutalism of American chattel slavery, scientific advancements were developing the nascent understanding that underlies our current system of the practice of medicine. Medical experimentation continued to develop as a necessary and respected form of the proliferation of scientific innovation.[100] One group subjected to forced experimentation were enslaved women who suffered from vesicovaginal fistulas[101] in the 1840s who were operated on, without anesthesia, by J. Marion Sims who received the moniker "The father of gynecology" for his surgical advancements in this area of medical practice.[102] Although the use of anesthesia was rare during this time for all patient populations, the forced procedures that were repeated on the same patients to create a new surgical approach is considered inhuman and barbaric by today's medical standards. There is a valid argument that the treatment would have been viewed at least unfavorably at that time, which is why the medical subjects were enslaved women and girls.[103]A statue depicting three of Sims's involuntary test subjects, enslaved girls Anarcha, Lucy, and Betsey, titled Mothers of Gynecology has been

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[97] Kenny, *supra* Note 36.

[98] Neil Krishan Aggarwal, *The Legacy of James McCune Smith, MD – The First US Black Physician*, The Arts and Medicine, November 29, 2021, https://jamanetwork.com/journals/jama/fullarticle/2786889, (last accessed on March 4, 2024).

[99] Bryan Greene, *America's First Black Physician Sought to Heal a Nation's Persistent Illness: An activist, writer, doctor and intellectual, James McCune Smith, born enslaved, directed his talents to the eradication of slavery*, Smithsonian Magazine, February 26, 2021, https://www.smithsonianmag.com/history/james-mccune-smith-america-first-black-physician-180977110/ (last accessed August 5, 2024).

[100] *See* Harriet A. Washington, *supra* Note 87.

[101] Vesicovaginal fistula is an abnormal opening between the bladder and the vagina that results in continuous and unremitting urinary incontinence, often resulting after a difficult birth with women who have nutritional deficiencies. Michael Stamatakos, Constantina Sargedi, Theodora Stasinou, & Konstantinos Kontzoglou, *Vesicovaginal Fistula: Diagnosis and Management*, 76 Indian Journal of Surgery 2, 131 (April 2014).

[102] Wall, *supra* Note 67.

[103] Washington, *supra* Note 87 at Part I Chapter 2.

erected in Montgomery, Alabama in acknowledgement of their contributions to this field.[104] While Sims documented his surgical experiments over a five-year period, it is only conclusively stated that Anarcha (who was subjected to 30 operations in a three year period)[105] received successful surgical treatment at the end of the trial. It is unclear if the other enslaved women ever received the corrective surgery once the approach and suture material were proven safe enough for White women.[106]

Not unlike the early development of gynecological medicine,[107] the specialty of gynecology continued to utilize nonconsenting Black women as subjects.[108] Widespread sterilization practices, often colloquially referred to as a "Mississippi appendectomy" [109] due to their frequent occurrence for poor Black women, implemented eugenic practices[110] and permitted inexperienced doctors the opportunity to learn how to perform the procedure.[111] In addition to medically unnecessary forced surgical sterilizations, passive eugenics and infertility were also permitted with other types medical experimentation. One of the most infamous clinical trials[112] occurring from 1932 through 1972, was the U.S. Public Health Service Syphilis Study at Tuskegee, Alabama,[113] which observed the progression of untreated syphilis.[114] Researchers designed an observational study for hundreds of Black male participants infected with syphilis.[115] These participants were not offered clinically appropriate treatment even though the correct treatment became widely available during the course of the study and were instead given non-treating injections.[116] The race and socioeconomic status of the medical study subjects supported the medical community's false inferiority view[117] of those patients. As a result of the inaction of those involved

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[104] Safiya Charles, *Event Honors Enslaved Women Subject to Gynecological Experiments in Alabama*, Southern Poverty Law Center (March 1, 2024) available electronically at https://www.splcenter.org/news/2024/03/01/event-honors-mothers-of-gynecology (last visited August 18, 2024).

[105] Joel D. Howell, *Understanding Black Distrust of Medicine*, Findings Magazine, University of Michigan School of Public Health (Spring 2021).

[106] *Id*.

[107] *See* Dineo Khabele, Kevin Holcomb, Ngina K. Connors & Linda Bradley, *A Perspective on James Marion Sims, MD, and Antiblack Racism in Obstetrics and Gynecology*, Volume 28 Journal of Minimally Invasive Gynecology Issue 2, 153 (February 2021).

[108] *See* Lutz Kaelber, *Eugenics: Compulsory Sterilization in 50 American States*, 2012 Social Science History Association presentation, available electronically at https://www.uvm.edu/%7Elkaelber/eugenics/ (last visited on August 9, 2024).

[109] Rebecca Skloot. *The Immortal Life of Henrietta Lacks*, 50 (2010).

[110] Bowen Matthew, *supra* Note 51 pp 122 – 123.

[111] Skloot, *supra* Note 100 at 50.

[112] James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (1993), 91.

[113] The study was named "The Tuskegee Study of Untreated Syphilis in the Male Negro." R.A. Vonderlehr, Taliaferro Clark, O.C. Wenger & J.R. Heller, Untreated Syphilis in the Male Negro: A Comparative Study of Treated and Untreated Cases, 107 JAMA 856-60 (1936). See Centers for Disease Control and Prevention, U.S. Public Health Service Syphilis Study at Tuskegee, available at http://www.cdc.gov/tuskegee/timeline.htm.

[114] Deleso Alford Washington, *Examining the "Stick" of Accreditation for Medical Schools Through Reproductive Justice Lens: A transformative Remedy for Teaching the Tuskegee Syphilis Study*, 26 J. Civ. Rts. & Econ. Dev. 153.

[115] Syphilis is a sexually transmitted disease that can cause health effects when it goes untreated and can be passed to unborn children by an infected pregnant person, infections in utero can result in an increased risk of stillbirth delivery or infant death. Centers for Disease Control and Prevention. https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm (last accessed March 14, 2024).

[116] 260 Conn. 785.

[117] Washington, *supra* Note 87.

in the conduct and oversight of the study, the males observed (along with the women and children excluded from the selection criteria who were infected by the study participants) experienced unnecessary disease progression and death within their families and communities.[118] We have an opportunity to examine "the biomedical significance of overlooking the women directly impacted from the study, both in the past and today."[119] Even though researchers excluded women from this experiment, their absence reveals the insignificance with which Black women were viewed by the medical profession in the observation of healthcare consequences and study.[120]

Dubiously structured medical tests were not limited to groups of similarly situated patient populations, some experimentation was limited to a single subject. Henrietta Lacks went to Johns Hopkins Hospital[121] in 1951 for cervical cancer surgery, and without her informed consent[122] the doctors involved in her surgery harvested her cancerous cells for medical research. The consent she signed was so lacking in detail, that Lacks did not realize the surgery left her unable to have more children.[123] It would not have been uncommon for a patient to lack informed consent for a procedure because the federal rules standardizing this requirement for medical research on human subjects[124] were not formalized until decades after this encounter,[125] but the concept to continuously inform a research subject of the proposed course of action, rationale for the clinical approach, and potential consequence[126] could have occurred if the medical staff had been willing.[127] Lacks became an unwitting, and long-time unrecognized,[128] contributor to one of the most impactful and wide-ranging set of global medical advancements.[129] Her harvested cells, coined HeLa cells by medical researchers,[130] led to a plethora of medical advancements. "[T]he polio vaccine, gene mapping, and in

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[118] Washington, *supra* Note 105.
[119] *Id* at 163.
[120] *Id* at 153.
[121] Johns Hopkins was the only major hospital in the area that treated Black patients, but the treatment was rendered in segregated wards. Skloot, *supra* Note at 15.
[122] Henrietta Lacks signed a general consent statement for treatment of her cervical cancer, but not for the subsequent experimentation with the use of the cells removed during her surgery. *Id* at 31.
[123] Skloot, *supra* Note at 47.
[124] 45 C.F.R § 46.116
[125] Public Law 93-348 § 202(a)(1)(B)(iv) (July 12, 1974) available electronically at https://www.govinfo.gov/content/pkg/STATUTE-88/pdf/STATUTE-88-Pg342.pdf (last accessed on August 18, 2024).
[126] *See* Washington, *supra* Note 87 at Chapter 2.
[127] Contemporarily, informed consent is not immune from societal pressures based on some internalized bias of physicians when considering women's healthcare decision-making process. *See* Amelia Landenberger, *Flattening Breast Cancer by Removing the Breasts: Protecting a Woman's Right to Choose Reconstruction of an Aesthetic Flat Chest after a Mastectomy*, 25 GEO. J. GENDER & L. 1197 at 1213 (Spring 2024).
[128] *See* Skloot, *supra* Note 100 at 4, pp 105 – 109.
[129] Law360 A LexisNexis Company, 5 Major Drug and Device Developments of 2022, January 6, 2023, https://plus.lexis.com/api/permalink/456d1a4a-90da-477f-988f-61575c7eaa8a/?context=1530671.
[130] Skloot, *supra* Note 100 pp 1 – 2, 37.

vitro fertilization" are among the most notable developments.[131] The profitability of Lacks's cells spurred medical dynasties and built infrastructure,[132] while she was buried in an unmarked grave[133] with her surviving family members impoverished.[134] Lacks's biological material was valued, but her humanity was discarded throughout her course of treatment and the postmortem cellular research conducted by countless academics and professionals. Not until decades after Lacks's death would we see a significant increase of federal regulation of medical research[135], which occurred shortly after the federal government began to supplement healthcare costs[136] for individuals to address continually rising expenses for patients who lacked private health insurance.

III. THE BIRTH OF A NATION'S MEDICAL INSURANCE INDUSTRY

> *[The] industrial sickness funds…formed the basis of the American system of associating health insurance benefits with the workplace. Because of such institutions Americans began to connect health insurance with their employer.*[137]

Among some of the early advancements in American healthcare, was the centralized delivery of medical care in a hospital setting. Operations began at a New York facility, which was the first hospital within the colonies beginning its operations in 1658. This facility treated soldiers and Black people enslaved in the service of the Dutch West Indian Company.[138] It would take time for the concept of hospital-based care to gain its foothold but even in the Philadelphia area, an early adapter of hospital-

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[131] Mary Anne Pazanowski, *Henrietta Lacks' Family Settles Lawsuit Over Use of Famed Cells*, Bloomberg Law, August 1, 2023, https://www.bloomberglaw.com/product/blaw/bloomberglawnews/bloomberg-law-news/X2BRVDKG000000?bc=W1siU2VhcmNoICYgQnJvd3NlIiwiaHR0cHM6Ly93d3cuYmxvb21iZXJnbGF3LmNvbS9wcm9kdWN0L2JsYXcvc2VhcmNoL3Jlc3VsdHMvN2NkYzBkMzFjYjAxMTZhNzEwODk3NzM0NjEwYjkzNGMiXV0--915c82a02dd7568b6fcede94f44e5d03e6bc27f8&criteria_id=7cdc0d31cb0116a710897734610b934c&search32=Mf-JIRP3MXHf_qQcsvgsgg%3D%3DNPqBIMGOR4CoGDLumUAMnlulCx68I9Q99VKRdY4A-P3yCTwrbTPx0l8ODfdFyz5sWqGlmq6sCvnjFa-kTqgMRG-Ut8_rPxlnZ1BFZ9AVsDHKbfRW3nENaOMs7EwrtaSu-PbiRuxmnyjrmj_Brh4Mee6bx8wPrRhI_uoiWel9lJ0%3D.

[132] Shortly after Lacks's death, a HeLa factory was built to produce cells to produce polio vaccines. Skloot, *supra* Note 100 at 91.

[133] *Id* at 121.

[134] *See Id.*

[135] *See* Pub. L. No. 93-348 § 202(a)(1)(B)(iv) (July 12, 1974) available electronically at https://www.govinfo.gov/content/pkg/STATUTE-88/pdf/STATUTE-88-Pg342.pdf (last accessed on August 18, 2024).

[136] Medicare, a health insurance program primarily for the elderly, and Medicaid, a health insurance program for people with limited income, were signed into law in 1965. Pub. L. No. 89-97 Social Security Amendments of 1965 (July 30, 1965).

[137] John E. Murray, *Origins of American health Insurance: A History of Industrial Sickness Funds*, 6 (2007). Although two types of industrial sickness funds (establishment funds and labor union funds) emerged and eventually evolved into the health insurance benefits more recognizable in this paper, I have conflated these two types of fundings into the single category of employer-provided health insurance due to their similar origins. *Id*.

[138] John E. Ransom, *The Beginnings of Hospitals in the United States*, Vol 13 Bulletin of the History of Medicine No. 5, 514, 521 (May 1943).

based care,[139] it would be centuries before a hospital for Black patients, unassociated with a relationship to a prominent captor, Douglass Hospital to begin operations. Douglass Hospital was established to address the segregated care delivered by the existing healthcare system when it was founded in Philadelphia in 1895. Douglass Hospital served as a facility to train Black physicians and nurses who were often prohibited from training at other facilities that treated White patients.[140] It would require much more progress to establish regulations related to medical best practices, licensure,[141] and professional ethics and expectations. These norms which developed the standard of care for the medical profession evolved alongside the legal acknowledgment and enforcement of the false assumption that Black people were interior to their White counterparts.[142] Outside of the original colonial territories, healthcare for the enslaved population in the southern region was offered through a variety of delivery systems, including, plantation hospitals, medical school hospitals, private infirmaries, and commercial hospitals.[143] It is of note that care provided to enslaved people in buildings that bore one of these labels could be more accurately described as out buildings or shacks and not consistent with the concept of a hospital setting for White patients.[144]

In the 1920s, employer-provided health insurance emerged independent of charitable and religious support[145] to address the cost concerns of workers who received treatment in hospitals.[146] A collective of approximately 1,500 schoolteachers in the Dallas, Texas area created a symbiotic relationship with Baylor University Hospital, this group paid an annual premium of six dollars in exchange for up to twenty-one days of hospital care at Baylor University Hospital.[147] Hospitals could attract better-trained personnel and provide more advanced courses of treatment than home visit physicians who were limited to tools which were mobile and limited by transportation hurdles.[148] Located in Texas, Baylor University Hospital was designated as a hospital for White patients where Black physicians were prohibited from the practice of medicine, serving in any staff role, and which only had minimal access for treatment of Black patients.[149] Insurance tied to labor,[150] which was already a deeply

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[139] William H. Williams, PhD, *The Early Days of Ango-America's First Hospital: The Pennsylvania Hospital, 1751-1775*, JAMA, Vol 220 No 1, 115 (1972).

[140]Russell F. Minton, M.D., *The History of Mercy-Douglass Hospital*, Vol 43 Journal of the National Medical Association No 3, 153 (May 1951).

[141] The Act of February 26, 1824 (Ohio), deprived persons who were not members of medical societies, nor licensed, from the aid of the law in the collection of their debts (e.g. voiding contract, imposing a fine for practicing medicine for pay). Nichols v. Poulson, 6 Ohio 305, 305 (1834).

[142] "Negro medicine" developed as a specialty based on this assumption. *See* Kenny, *supra* Note 36 at 12.

[143] Kenny, *supra* Note 36.

[144] Washington, *supra* Note 87 at Part I.

[145] Mann Wall, *supra* Note 77.

[146] Gordon, *supra* Note 68.

[147] Gordon, *supra* Note 68.

[148] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (2023).

[149] The predecessor for Baylor University Hospital, Texas Baptists Memorial Sanatorium, did have 250 beds with 1 reserved from Black patients as of records from October 1909, but it is unclear how many Black patients were admitted or treated there. Notably, Black patients had to have their physicians transfer their care to a White physician due to the prohibition on joining the medical staff. Lauren Fine MD, *We are our history: Baylor University Medical Center and Black physicians in Dallas*, v.37(2) Proc (Bayl Univ Med Cent) eCollection 2004 185, February 8, 2024, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10857562/ last accessed March 13, 2024.

[150] Ulrich Bonnell Phillips, *American Negro Slavery*, Chapter XIX Business Aspects of Slavery (1918).

segregated practice continuing after the abolition of slavery,[151] further coalesced the likelihood that mistreatment of Black patients would continue. Black people who resided in Dallas were more likely to receive treatment at a facility like Bluitt Sanatorium, which was more of an amalgamation of a Black professional office building with patient care on the top floor than a formal hospital environment.[152] As with the coupling of Jim Crow laws in response to emancipation, so too came the rise of Ku Klux Klan membership in Dallas in the 1920s as Black medical and other professionals attempted to gain a foothold in the area. Around the time of the Bluitt Sanatorium's opening, which was needed in response to the segregation enforced at Baylor University Hospital, the local Ku Klux Klan membership expanded and is estimated to have been the highest per capita membership of any US city with one-third of all eligible men in Dallas obtaining membership.[153] Not only were Black patients severely limited from receiving the care now pioneered by the region, they were also intimidated from legal recourse if their access to or use of the available care was hampered by the actions of the Ku Klux Klan.[154]

Also at the dawn of the twentieth century, in the Pacific Northwest area of the country the link between health and employment status was developing with the creation of Blue Shield.[155] Healthy workers are able to continue to perform services for their employer, so owners of logging operations and mines created a plan to pay both individual physicians and groups of practitioners a monthly fee to provide treatment on a *pro re nata* basis.[156] While discrimination in the region may not have been an exact

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[151] Ruqaiijah Yearby, Brietta Clark & José F. Figueroa, *Structural Racism in Historical and Modern US Health Care Policy*, Volume 41 Health Affairs Issue 2: Racism & Health, 157, at 188 (February 2022) available electronically at https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.01466 last accessed August 9, 2024.

[152]"The facility provided medical care for inpatients as well as office and clinic space for Dr. Bluitt and several other local African American physicians. The basement had a 'cleaning establishment' run by Bluitt's nephew, the second floor contained Dr. Bluitt's office as well as a dental office and an attorney's office, and the top floor was used for patient care." Lauren Fine, MD, We are our history: Baylor University Medical Center and Black physicians in Dallas, v.37(2) Proc (Bayl Univ Med Cent) eCollection 2004 185, February 8, 2024, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10857562/ last accessed March 13, 2024. (Includes a reference to and quote from - Solamillo S. Dallas Landmark Commission landmark nomination form: Bluitt's Sanitarium. Dallascityhall.com. https://dallascityhall.com/departments/sustainabledevelopment/historicpreservation/HP%20Documents/Landmark%20Structures/Bluitt%20Sanitarium%20Landmark%20Nomination.pdf (Accessed September 27, 2023).

[153] Lauren Fine, MD, We are our history: Baylor University Medical Center and Black physicians in Dallas, v.37(2) Proc (Bayl Univ Med Cent) eCollection 2004 185, February 8, 2024, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10857562/ last accessed March 13, 2024.

[154] With such an expansive membership base, locating non-members to serve on a jury for any action would have been difficult, and pursuing action included the knowledge that the sheriff, police commissioner, district attorney, and police chief were all members of this group. Lauren Fine, MD, We are our history: Baylor University Medical Center and Black physicians in Dallas, v.37(2) Proc (Bayl Univ Med Cent) eCollection 2004 185, February 8, 2024, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10857562/ (last accessed March 13, 2024).

[155] Blue Shield began as a California Physician Service plan in 1939 where the plan sent payments directly to the patients who were then responsible for payment to the physician. Michael A. Morrisey, *Health Insurance*, (2008) at 8.

[156] https://www.bcbs.com/about-us/industry-pioneer last accessed 2/27/2024.

equivalent to the experience in the South,[157] one source of racial tension was the intentional recruitment of Black workers to circumvent White workers engaged in employment strikes in the mining industry.[158] Utilizing labor disputes as a means to sow discord between White striking-workers and Black strike-breaking laborers, these conditions fostered untenable working conditions for Black employees after a strike. In addition to a tense work environment, such conditions could also result in denial of treatment by physicians who participated in the health insurance plan and whose medical livelihood was dependent upon the industry for which they provided treatment. Black people residing in the area at the time were discouraged from political participation [159] or conflict with the White population, and with so few Black inhabitants the ability to stand up against or ignore this tacit directive could have led to increased personal vulnerability. [160] Worker exploitation and striation equated to talented and well-trained physicians becoming selective about who received a steady income to ensure the health and welfare of White workers, with the remaining medical community free to refuse care to Black patients who had little social or political capital[161] to demand access to quality healthcare treatment. With the brief overview of the originating relationship between healthcare development and legal institutions described herein, although tattered and worn by centuries of progress you can still view the remaining threads of the intended inequity. There are pathways to rind the fabric that contains the pattern, to move forward to finally close the gap in maternal health outcomes and improve the chances for healthy pregnancy and delivery for all patients in this country.

IV. POTENTIAL FOR COMPREHENSIVE SOLUTIONS

> *We already know why women are dying, and we already know how to save them. In this way, the tragedy of maternal mortality in the United States is not a problem of information; it is a problem of political will.*[162]

We can never fully calculate the depth of the contributions to medical advancements by Black Americans, either by intellectual contributions or forceful clinical experimentation. Limited by literacy prohibitions and mischaracterizations by researchers; accuracy, transparency and prevalence of medical racism in the creation of the American healthcare system will remain somewhat opaque. As a result of historical knowledge gaps and differing clinical approaches by providers, our current attempts to yield more favorable and equitable outcomes emphasizes evidence-based solutions

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[157] Although protected from the possibility of enslavement, Black residents were still restricted or excluded from societal participation. *See* Leon F. Litwack, *North of Slavery, The Negro in the Free States, 1790-1860*, pp 69 – 74 (1965).

[158] Lewis, *supra* Note 48 at 89.

[159] In the establishment of Oregon Territory government, voting was limited to white males. Stella E. Pearce, *Suffrage in the Pacific Northwest: Old Oregon and Washington*, Vol. 3 The Washington Historical Quarterly No. 2, 106 at 107 (April 1912).

[160] Center for the Study of the Pacific Northwest, *Lesson Twenty-One: African Americans in the Modern Northwest*, https://www.washington.edu/uwired/outreach/cspn/Website/Classroom%20Materials/Pacific%20Northwest%20History/Lessons/Lesson%2021/21.html last accessed 3/1/2024.

[161] Quintard Taylor, *Slaves and Free Men: Blacks in the Oregon Country, 1840*-1860, Vol. 83 Oregon Historical Quarterly No. 2, 153 pp 156 – 157.

[162] Bridges, *supra* Note 9.

which require more extensive data and documentation.[163]

The U.S. Department of Health and Human Services utilizes the Centers for Medicare and Medicaid Services (CMS) to regulate provider and reimbursement rules for patients enrolled in these healthcare payment programs.[164] While private payers and providers play a significant role in healthcare delivery, the regulations and norms by CMS oft times shape the approach used by the private sector.[165] Where the CMS rules lead after public commentary periods and the apparatus of the federal government for implementation and enforcement, the private sector actors tend to follow.[166] Consequently, utilizing CMS quality tools which measure healthcare processes and patient outcomes[167] can shift the healthcare landscape to advance maternal equitable outcomes.

Currently, we incentivize healthcare providers who participate in Medicare, an insurance program administered by CMS,[168] with monetary payments tied to the achievement of healthcare quality metrics. This Quality Payment Program (QPP)[169] is one of CMS's efforts to improve quality but has failed to close the gap in health outcomes between different groups, or to improve the overall maternal mortality statistics as a developed nation.[170] These types of programs aim to implement comprehensive, data-driven, and systematic approaches to maintain and improve safety and quality in healthcare. Rather than over-pivoting on the admirable cause to collect additional data points, we can take advantage of this legal framework to bridge the gap between existing data to achieve the desired outcomes.

In 2023, U.S. Senator Cory Booker of New Jersey and U.S. Representative Lauren Underwood of Illinois re-introduced the Black Maternal Health Momnibus Act (Momnibus Act) in the 118th Congress after similar legislation failed to gain traction in both chambers of the 116th and 117th Congress.[171] With its failure to pass either chamber of the legislature, we must find ways to utilize other mechanisms to accomplish maternal health equity objectives. The Biden-Harris Administration's focus on improving maternal health equity included an approach to harvest the power of

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[163] Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Evidence-based best practices for hospitals in managing obstetric emergencies and other key contributors to maternal health disparities*, Ref: QSO-22-05-Hospitals (ADVISORY) (December 7, 2021) available electronically at https://www.cms.gov/files/document/qso-22-05-hospitals.pdf.

[164] The Medicare Act of 1965 established the Medicare and Medicaid programs and CMS was established as a subagency of the Department of Health and Human Services by the Reorganization Order of 1977. 79 Stat. 1432. 91 Stat. 29.

[165] Brietta R. Clark, et al., Health Law: Cases, Materials and Problems 596 (9th ed. 2022).

[166] Stanley B. Jones, *Medicare Influence on Private Insurance: Good or Ill?*, Vol. 18 Health Care Financing Review No. 2, 153 (Winter 1996).

[167] 42 CFR § 510.400(g).

[168] 42 CFR § 405.201.

[169] The Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015, 129 Stat. 87.

[170][170] World Health Organization, UNICEF, United Nations Population Fund & The World Bank, *Trends in Maternal Mortality: 2000 to 2020* (2023).

[171] The Momnibus Act is a combination of thirteen congressional bills "[t]o end preventable maternal mortality, severe maternal morbidity, and maternal health disparities in the United States, and for other purposes." Title VI of the Momnibus Act, Data to Save Moms, includes a review of current data collection with the aim to modify and refine its efficacy. Black Maternal Health Momnibus Act, H.R.3305 & S.1606, 118th Cong.

maternal data collection and leverage[172] the refinement of "maternal safety bundles" after they were implemented in California and internationally.[173] The clinically-based maternal safety bundles have been developed by the Alliance for Innovation on Maternal Health and developed in accordance with the clinical conditions of pregnant patients to deliver consistent care utilizing a five-prong process, referred to as the "Five Rs."[174] Upon implementation of these evidence-based clinical interventions, reduction in preventable maternal mortality attributable to obstetric hemorrhage, severe hypertension in pregnancy, and non-medically indicated cesarean section deliveries occurs. [175] Current maternal safety bundles are divided into 5 categories for simultaneous implementation to improve outcomes: Readiness; Recognition & Prevention; Response; Reporting and Systems Learning; and Respectful, Equitable, and Supportive Care.[176] The first four "Rs" of the safety bundles were originally included, and the category for Respectful, Equitable, and Supportive Care was added in 2022.[177] "Each of these steps should integrate equity, which means taking deliberate steps to value each mother's life equally, appreciating the impact of historical trauma and institutional racism along with patient and community perspectives."[178]

Brief Description of the Five Rs

1. Readiness – Every Care Setting: A guideline to develop standard protocols based on the patient's condition that includes timely evaluation and an escalation plan.

2. Recognition & Prevention – Every Patient: A call to review a 12-month patient documentation history to screen for additional risks and provide patient education.

3. Response – Every Event: A directive to utilize the standardized protocols and checklists to evaluate current symptoms with postpartum follow-up and ongoing support.

4. Reporting and Systems Learning – Every Unit: A call to establish and interdisciplinary care team to receive expert feedback and incorporate population disparities into the clinical review.

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[172] The White House, *White House Blueprint for Addressing the Maternal Health Crisis* (2022) available electronically at https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf.
[173] Jennifer M. Banayan & Barbara M. Scavone, *National Partnership for Maternal Safety: Maternal Safety Bundles*, Vol. 7 Obstetric Anesthesia, 67 (February 10, 2017).
[174] Health Resources and Services Administration of the U.S. Department of Health and Human Services, American College of Obstetricians and Gynecologists & Alliance for Innovation on Maternal Health, *Patient Safety Bundle* (2022).
[175] Medicare and Medicaid Programs: Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals, 89 Fed. Reg. 59489 (July 22, 2024).
[176] The 2022 American College of Obstetrics and Gynecologists, *Severe Hypertension in Pregnancy Safety Bundle (2022)*, Alliance for Innovation on Maternal Health (2022).
[177] Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Evidence-based best practices for hospitals in managing obstetric emergencies and other key contributors to maternal health disparities*, Ref: QSO-22-05-Hospitals (ADVISORY) (December 7, 2021) available electronically at https://www.cms.gov/files/document/qso-22-05-hospitals.pdf.
[178] Marla Shauer, Amy Nichols, & Audrey Lyndon, *Maternal Safety*, Department of Health & Human Services, Agency for Healthcare Research and Quality (2024).

5. Respectful, Equitable, and Supportive Care – Every Unit/Provider/Team Member: Encouragement to incorporate the patient in the decision-making process with the care team to establish patient trust and confidence.

When performed collectively, these categories have improved maternal clinical outcomes, but there is no universal adoption of these clinical standards even though this approach is supported by the American College of Obstetricians and Gynecologists (ACOG).[179] ACOG is the largest professional organization for obstetricians and gynecologists in the United States.[180] I offer for consideration the addition of a sixth R to the maternal safety bundles, "Record the Rationale," to improve the likelihood that medical professionals will consistently implement and thoroughly adhere to the guideline contained within the safety bundles. Part of the strength, and concurrent potential shortcoming, of the maternal safety bundles is the ability to modify or disregard them based on the clinical judgement of the practitioner. This flexibility allows the clinical staff to adjust their response based on their professional experience and situational differences but also allows the opportunity for implicit bias to continue to impact outcomes.

A "Record the Rationale" component would allow medical professionals to exercise the elasticity necessary in the exercise of their independent judgment, with the legal obligation to record within the patient's medical record their reasoning when they either fail to implement a safety bundle or deviate from one or more of the existing five Rs. Mandating a notation in the patient's record will serve as a consideration for clinicians who wish to stray from an emerging national standard of care for streamlined obstetrical practice. Unlike the payment of additional funds to clinicians via the bifurcated Quality Payment Program administered by CMS which issues funds via the Merit-Based Incentive Payment System (MIPS) or Advanced Alternative Payment Model (APM),[181] the sixth R ("Record the Rationale") would incentivize the course of action by non-monetary means. Rather than paying clinicians who supply eligible data under the MIPS criteria or providing increased reimbursement percentage amounts with patient risk pools for APM participation, the "Record the Rationale" component would instead factor into medical malpractice insurance premium pricing, licensure actions, medical facility privileging, insurer network credentialing, and malpractice litigation due diligence. This allows the provider's self-preservation interest to coincide with the government's equity objectives.

As a long-term outlook, practitioners, legal academics, and lawmakers should support the passage of complex maternal equity legislation, like the Momnibus Act to purposefully and systematically undo the damage legally permitted to establish and continue the maternal inequity still evidenced today. Legislation, such as the Momnibus Act, could advance the objectives included in this article and remove additional barriers to equity. In the interim, the modification of non-binding rules like the maternal health bundles to include a compliance component with chart notation is immediately adoptable and within the scope of practice for obstetric clinicians without becoming overly burdensome to a specialty already implementing this practice who have an

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[179] Caitlin Baptiste MD and Mary E. D'Alton MD, *Applying Patient Safety to Reduce Maternal Mortality*, Vol. 46 Obstetrics and Gynecology Clinics of North America Issue 2, 353 (June 2019)
[180] Michael J. Myers, *ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?*, 49 S.D. L. Rev. 526 (2004).
[181] 42 C.F.R. §414(O).

existing legal obligation to notate patient charts and to make those notes accessible to patients.[182] Health professionals relied upon the protection of legal institutions to perpetuate racist practices, contemporary legal apparatuses can work in collaboration with medical experts to strengthen efforts that address disparities while contextualizing historical factors. The implementation of clinical tools established and supported by clinicians with legal guidance to modify the five Rs to incorporate Record the Rationale is a pathway for healthcare legal professionals and scholars to positively impact patient outcomes without the need for immediate legislative action and can continue in the event executive branch's support for such endeavors shifts or lacks financial support via federal grants or reimbursement mechanisms.

A colleague, who does not practice healthcare law, was concerned about a potential chilling effect on practitioners who would leave the field or emerging professionals who would shy away from obstetrics in healthcare facilities that implemented Record the Rationale practices. The concern about the impact on the medical provider's decision to practice is real[183] and a valid point of consideration. However, I contend that inaction to curb avoidable maternal fatalities due to a fear of potential clinical objection is an insufficient argument against implementation. Medical care already includes a complex and layered ecosystem of federal and state regulations, professional licensure review, employer guidelines, and medical malpractice policy considerations. A non-legislative course of action which was developed by clinical experts that align with the practitioner's self-interest is a better tool than one solely designed by legal experts who may lack the technical and scientific expertise to accomplish the outcomes proven by the established five Rs of the maternal safety bundles. This approach bridges the gap between legal analysis and scientific expertise to accomplish the common desired result of reduced maternal health inequity.

CONCLUSION

We cannot solve the contemporary concern about the maternal health crisis in America without acknowledging and confronting the legal legacy of permitting our healthcare delivery system to emerge and continue with interwoven components of the deplorable racist ideologies that permeated society at-large. Current medical practices and legislative solutions that are singly focused cannot address a centuries-long problem that was knitted into every aspect of our nation, and in turn our healthcare and legal institutions. Historical accountability, starting from the earliest iterations of the professional practice of medicine through time to include the payment mechanisms currently functioning in the twenty-first century, is necessary to adequately redress the wrongdoings of the past. It is only with this lens that we can properly course-correct for the underlying origins for this ongoing medical injustice. When advancing or advocating for legal solutions, those positions require historical framing.

In our more recent reflections on the realities of maternal healthcare inequity, we have stitched together our modern understanding of medical benevolence with past

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[182] 42 C.F.R. §41, 413 & 495.

[183] Julie Rovner and Rachana Pradhan, *Medical residents are starting to avoid state with abortion bans, data shows*, NPR (May 9, 2024) available electronically at https://www.npr.org/sections/health-shots/2024/05/09/1250057657/medical-residents-starting-avoid-states-abortion-bans (last visited January 24, 2025).

atrocities.[184] Unfortunately, this conduct was permitted without shame and with the tacit or explicit consent of medical[185] and legal institutions.[186] "Access to health care depends on finding providers who are willing and able to treat you. But some people are refused medical care or given inadequate treatment for economic and social reasons unrelated to medical need."[187] One way for legal professionals to contribute to the ongoing efforts to achieve maternal healthcare equity is to coordinate our efforts with clinical approaches and resources to create a cohesive legal and healthcare delivery model. American medical professionalism and its establishment as a scientific field emerged alongside the practice of chattel slavery, and thus it was impossible for the field to exist without the societal ideas of racism and exclusion of people medical treatment. As the practice of medicine developed and modernized, the healthcare system incorporated the racist attitudes and conduct of the larger American society, these were not eradicated with societal and medical racial integration. As legal institutions shift focus toward health justice and equity,[188] we can propose solutions that are historically informed and in conjunction with the practitioners who develop clinical guidelines while legal institutions continue to respect practitioner autonomy to achieve our goal of maternal healthcare equity.

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[184] Gretchen Long. *Doctoring Freedom: The Politics of African American Medical Care in Slavery and Emancipation* (2012).
[185] Robert B. Baker, PhD, *History of Medicine: The American Medical Association and Race*, Vol. 16 Virtual Mentor: American Medical Association Journal of Ethics No. 6 479 (June 2014).
[186] Alyson Reed, *Women's Healthcare Disparities and Discrimination*, 4 C.R.J. 42 (1999)
[187] Brietta R. Clark, et al., Health Law: Cases, Materials and Problems 285 (9th ed. 2022).
[188] Fuse Brown, *supra* Note 40.

CHIROPRACTIC EVIDENCE IN 18-WHEELER COLLISION LITIGATION: FROM TREATMENT TO TESTIMONY

Soft Tissue, Hard Truths: An Ethical Overview of Case Management and a Call to Reject Overtreatment

Pankti Fadia; Walter Champion*

Abstract: This paper explores the evidentiary role of chiropractic treatment in commercial motor vehicle collision (MVC) litigation, with a focus on its effectiveness in proving causation and damages while avoiding the pitfalls of overtreatment often associated with invasive medical procedures such as injections and unnecessary surgeries. This paper is a practical guide for attorneys to successfully incorporate research-based chiropractic treatment for 18-wheeler collision victims. The paper provides an in-depth analysis of chiropractic practice in the context of personal injury. It examines the whole arch of case management, from evidence-based, cost-effective, non-invasive, drug-free chiropractic rehabilitation treatments to ascertaining valuable expert testimony in jury trials. The paper further evaluates the admissibility of chiropractic testimony under Daubert and Rule 702 of the Federal Rules of Evidence, and considers the challenges posed by insurance bias and jury skepticism toward chiropractic professionals. Despite these hurdles, chiropractors play a critical role, providing long-term, function-focused rehabilitation that juries increasingly accept when properly presented. Using case law, scholarly sources, and clinical research, this analysis demonstrates that chiropractic evidence is not only legally valid but ethically preferable in commercial vehicle collision litigation. The paper serves as a practical and ethical guideline for personal injury attorneys to successfully leverage chiropractic care to prove causation and damages effectively and persuasively in court.

Keywords: Personal Injury; Chiropractic, Chiropractors; Expert Witness; 18-Wheeler, Motor Vehicle Collision; Medical Bills and Records; Past Medical Damages; Daubert Qualification; Chiropractic Practice; Commercial Collision Cases; Auto Insurance; Mass Torts; Plaintiff Personal Injury; Case Management; Medical Management; Doctors of Chiropractic; Physical Therapy; Rehab; Health; RICO; Insurance Fraud; Ethics

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INTRODUCTION

The United States has experienced a significant increase in 18-wheeler crashes or similar commercial vehicle collision litigation in recent years.[1] According to the Federal Motor Carrier Safety Administration, the US has recorded between 143,000 and 166,000 truck accidents annually in recent years.[2] Of the approximately 494,000 police-reported crashes involving large trucks in 2021, there were 5,149 fatal crashes and 110,000 injury crashes.[3] The substantial size and velocity associated with these crashes frequently result in extensive property damage and severe injuries to those involved.[4] These automobile crashes are often associated with tort claims involving negligent driving.[5] Depending on the state and federal regulations, these trucking companies are required to carry liability insurance policies with substantially higher commercial policy limits than standard passenger vehicles.[6] Therefore, commercial motor vehicle crashes represent a popular choice of tort claim for personal injury lawyers.[7]

In the realm of commercial vehicle collisions, the role of chiropractic care has become increasingly significant in establishing medical causation and proving damages. As plaintiff attorneys seek to secure compensation for clients by pursuing liability against insurance carriers, chiropractic treatment often serves as the foundational medical evidence in soft-tissue injury claims.[8] This article explores the intersection of chiropractic care and personal injury law, beginning with a brief overview of what chiropractors do for plaintiffs following vehicular trauma, especially during early-stage evaluation of injuries, to conservative, non-invasive, drug-free treatments for car crash victims.[9]

This paper examines how comprehensive chiropractic treatment documentation establishes the essential chain of causation, mechanisms of injury, and demonstrates medical necessity for treatment. These are important components in ascertaining past and future medical expenses in estimating damages for negligent driving claims and related mass tort actions.

Further, the paper differentiates chiropractic from physical therapy and highlights the chiropractor's unique capacity to co-manage care, coordinate referrals, and act as a central figure in multidisciplinary treatment frameworks.[10] The strategic

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[1] Sarah Edwards, *How Many Truck Accidents Per Year? Chart,* CONSUMERSHIELD (June 6, 2025), https://www.consumershield.com/articles/semi-truck-accidents-per-year.
[2] *Id.*
[3] U.S. DEP'T OF TRANSP., FED. MOTOR CARRIER SAFETY ADMIN., *Large Truck and Bus Crash Facts 2021* (last updated July 31, 2024), https://www.fmcsa.dot.gov/safety/data-and-statistics/large-truck-and-bus-crash-facts-2021.
[4] *Id.*
[5] *Id.*
[6] TRUCK SAFETY COALITION, *Minimum Insurance Levels for Motor Carriers,* https://trucksafety.org/minimum-insurance-levels-motor-carriers/ (last visited June 29, 2025).
[7] *Id.*
[8] S. Dies & J. W. Strapp, *Chiropractic Treatment of Patients in Motor Vehicle Accidents: A Statistical Analysis*, 36 J. CAN. CHIROPR. ASS'N 139 (1992).
[9] *Id.*
[10] *Id.*

utilization of chiropractic evidence in tort proceedings requires a sophisticated understanding of both clinical methodology and evidentiary standards.

Additionally, the paper analyzes the legal admissibility of chiropractic testimony under the *Daubert* standard, featuring the scope of the testimony, common jury misconceptions related to chiropractic, and methods for enhancing the credibility of chiropractic expert witnesses.[11] Lastly, the paper highlights the darker undercurrents of PI litigation, specifically the ethical concerns surrounding overtreatment and financial incentives that may lead to "bad faith", inflated claims.

Personal Injury lawyers frequently advertise their specialization in handling these cases, often employing compelling marketing strategies through billboards, radio, and television commercials. Most of these personal injury lawyers work on a contingency fee schedule, meaning the higher the medical bills, the higher the attorney's fee.[12] This financial dynamic creates a concerning trend where economic incentives may override optimal medical judgment.

Consequently, patients may be steered toward costly surgical interventions, extensive diagnostic imaging, or aggressive pain management protocols involving epidural injections and other invasive procedures, even when conservative treatments such as chiropractic care, physical therapy/rehab interventions, or medication management would be equally or more effective.[13] The preference for expensive treatments is further reinforced by the perception that higher medical costs suggest more severe injuries, potentially leading to larger jury awards or settlement offers from insurance companies.

Moreover, this overtreatment phenomenon is not merely theoretical but has documented real-world consequences. Studies indicate that unnecessary medical interventions not only inflate healthcare costs but can also expose patients to additional risks, complications, and prolonged recovery periods.[14] The paper will conclude with recommendations for an ethical, evidence-based personal injury practice.

I. LEGAL & MEDICAL FRAMEWORK OF 18-WHEELER INJURY CASES

A. The Litigation Landscape: Causation & Damages as Battlegrounds

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[11] *Daubert v. Merrell Dow Pharms, Inc*., 509 U.S. 579, 589 (1993).

[12] Ronald V. Miller, Jr., *What Are the Lawyer Fees in Personal Injury Cases?,* MD. ACCIDENT LAW. BLOG (Jan.13,2022), https://www.marylandaccidentlawyerblog.com/lawyer-fees-injury-cases/.

[13] S. Dies & J.W. Strapp, *Chiropractic Treatment of Patients in Motor Vehicle Accidents: A Statistical Analysis*, 36 J.CAN. CHIROPR.ASS'N 139 (1992).

[14] *See Overtreatment in the United States*, PLOS ONE (2017), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970 (finding that physicians report approximately 20.6% of overall medical care is unnecessary); *Presenting a Comprehensive Definition of Unnecessary Healthcare Services and Their Drivers: A Systematic Review and Meta-synthesis*, NAT'L CTR. FOR BIOTECHNOLOGY INFO. (Nov. 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10657265/ (defining overtreatment as "unnecessary clinical services or interventions that provide negligible benefit").

The fundamental challenge in 18-wheeler collision litigation centers on two critical elements: establishing causation and quantifying damages.[15] Once liability (fault) is accepted by the insurance companies, the battleground turns to challenging causation and attacking damages by discarding medical treatment as unnecessary to limit damages.

Insurance carriers often deploy sophisticated strategies to contest medical causation and challenge treatment necessity. The economic stakes in commercial vehicle litigation create powerful incentives for insurers to scrutinize every aspect of medical treatment.[16] Therefore, it is vital to use scientifically evidence-based treatments to treat injuries sustained in the collision. This evidence-based foundation is crucial for establishing treatment necessity and defending against insurance company arguments that characterize conservative care as unnecessary or excessive.

Defense counsel will routinely challenge the causal relationship between collision forces and claimed injuries, question the medical necessity of prescribed treatments, and argue for alternative causation theories, including pre-existing conditions or intervening causes.[17] This adversarial environment demands that plaintiffs' attorneys present compelling medical evidence supported by appropriate medical notes and qualified experts who can withstand rigorous cross-examination under Daubert standards.[18]

B. Injury Patterns & Severity in Commercial Vehicle Collisions

The massive size differential and kinetic energy involved in 18-wheeler collisions create severe economic property damage and result in significant trauma and injuries to the human body. Commercial vehicles weighing 80,000 pounds or more generate exponentially greater impact forces, resulting in complex injury presentations that often require extended treatment periods and comprehensive rehabilitation protocols. Many of these injuries are permanent and often require lifelong maintenance.[19]

The spectrum of injuries in 18-wheeler cases typically encompasses both catastrophic and moderate trauma. Severe injuries frequently include traumatic brain injury, spinal cord damage, vertebral fractures, and multiple extremity fractures—conditions that may result in permanent disability and require lifelong medical management.[20] These catastrophic injuries often necessitate immediate surgical intervention, extended hospitalization, and comprehensive rehabilitation services,

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[15] *See generally* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 26 (AM. LAW INST. 2010) (discussing factual causation requirements).
[16] Steven Heimberg, *Medical-Care Issues That Can Kill Your Personal-Injury Case*, ADVOCATE, Mar. 2014, https://www.advocatemagazine.com/article/2014-march/medical-care-issues-that-can-kill-your-personal-injury-case.
[17] *Id.*
[18] *Daubert v. Merrell Dow Pharms., Inc*., 509 U.S. 579, 589 (1993) (establishing standards for scientific evidence admissibility).
[19] Samir Alghnam et al., *Disability Among Adults Injured in Motor-Vehicle Crashes in the United States*, NAT'L LIBR. MED.: PUBMED (2004), https://pubmed.ncbi.nlm.nih.gov/15474547/.
[20] *Id.*

generating substantial medical expenses that form the foundation of significant economic damage awards.

However, the majority of 18-wheeler collision victims present with moderate neuromusculoskeletal injuries that, while less dramatic than catastrophic trauma, nevertheless cause significant pain, functional limitation, and disability. Such common injuries involving the neuro-musculoskeletal system are popularly known as "whiplash injury" of the spine.[21] Whiplash-associated trauma often includes soft tissue strains or sprains of the cervical, thoracic, and lumbar spine, along with extremity injury such as shoulder sprain or labrum tears, knee sprains or meniscus tears, hip sprain or dislocation, elbow sprain, wrist sprain, and ankle sprains. Moreover, high velocity impact from the 18-wheeler crash often results in spinal disc bulges or disc herniations, myofascial pain syndrome, joint dysfunctions, and other postural and functional deficits from trauma.[22]

The preponderance of scientific evidence demonstrates that mild to moderate neuromusculoskeletal injuries respond favorably to conservative, non-invasive treatment approaches.[23] Most of these whiplash-associated injuries are typically well within the scope of chiropractic care and respond extremely well to non-invasive chiropractic treatment modalities.[24] Additionally, many spinal or extremity fractures do not require surgical intervention. Chiropractic treatment, physical therapy, and rehab modalities provide the much-needed non-invasive, drug-free approach to health and recovery in these cases.

Patients are often co-managed with orthopedic or other medical specialists to ensure that recovery is smooth, and the patient can resume their activities of daily living in a pain-free capacity.[25] This collaborative care model, where chiropractors work in conjunction with orthopedic surgeons, neurologists, and other medical specialists, provides comprehensive treatment while maintaining conservative approaches whenever clinically appropriate.[26] This chiropractic and medical co-management of the patient's treatment provides the best outcome to the patient's overall long-term recovery and subsequently demonstrates a foundation for treatment necessity arguments by the auto insurance defense counsel.

C. The Foundation of Damage Recovery in Commercial Vehicle Cases

The plaintiff bears the burden of proving that the defendant's negligent driving proximately caused the plaintiff's injuries and that the resulting medical treatment was both medically necessary and reasonable, thereby establishing the monetary damages

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[21] J. Augenstein et al., *Injuries in Near-Side Collisions*, 43 ANN. PROC. ASS'N FOR THE ADVANCEMENT OF AUTOMOTIVE MED. 139 (1999), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10706493/.

[22] *The Impact of Musculoskeletal Injuries Sustained in Road Traffic Crashes on Work-Related Outcomes: A Protocol for a Systematic Review*, NAT'L LIBR. MED.: PUBMED CENT. (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6247704/.

[23] *Id.*

[24] *Chiropractic Treatment of Chronic "Whiplash" Injuries*, NAT'L LIBR. MED.: PUBMED (1996), https://pubmed.ncbi.nlm.nih.gov/9039361/.

[25] *Id.*

[26] *Id.*

recoverable under applicable tort law.[27] Thus, the assessment and proof of damages in 18-wheeler collision cases requires a complex understanding of both legal standards and medical documentation requirements. Unlike property damage calculations that rely on objective repair costs or replacement values, personal injury damages depend heavily on medical evidence that establishes the extent, causation, severity, and permanence of injuries sustained in the collision.

Personal injury damages generally include economic and non-economic damages.[28] Commercial vehicle cases typically fall into three primary categories: past medical expenses, future medical expenses, and general damages for pain and suffering. Each category requires distinct types of medical documentation and expert testimony to establish compensability.[29]

Past Medical Expenses encompass all reasonable and necessary medical treatment from the date of collision through trial.[30] This includes emergency room visits, diagnostic imaging, hospitalization, surgical procedures, chiropractic care, physical therapy, prescription medications, and medical equipment.[31] The plaintiff must demonstrate that each treatment was causally related to the collision and medically necessary for the diagnosed injuries. Future Medical Expenses require expert medical testimony to establish the probable need for continued treatment, the recommended treatment modalities, and the associated costs over the plaintiff's projected lifespan.[32] This category often represents the largest component of damage awards in severe injury cases, making accurate medical documentation and expert testimony crucial for maximum recovery.[33]

General Damages (non-economic damages) for pain, suffering, and loss of enjoyment of life rely on subjective testimony supported by objective medical evidence documenting the plaintiff's functional limitations and decreased quality of life.[34] While these damages are inherently subjective, medical records indicating the plaintiff's pain levels, functional restrictions, and psychological impact provide the foundation for substantial general damage awards.[35]

Chiropractic documentation plays a critical evidentiary role in establishing all three damage categories. The documentation requirements for establishing treatment

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[27] *Sisters of Charity of the Incarnate Word v. Gobert*, 992 S.W.2d 25, 28 (Tex. App.—Houston [1st Dist.] 1997, no pet.) ("To establish liability based on negligence, a plaintiff must prove the defendant did something an ordinarily prudent person exercising ordinary care would not have done under the same circumstances").

[28] *Tex. Civ. Prac. & Rem. Code Ann.* § 41.001(12) (defining "Noneconomic damages" as "damages awarded for the purpose of compensating a claimant for physical pain and suffering").

[29] *Tex. Civ. Prac. & Rem. Code Ann.* § 41.001(4) (defining "Economic damages" as "compensatory damages intended to compensate a claimant for actual economic or pecuniary loss").

[30] *Lutkus v. Garcia*, No. 01-24-00115-CV, 2025 Tex. App. LEXIS 4719 (Tex. App.—Houston [1st Dist.] July 3, 2025, no pet. h.).

[31] *Id.*

[32] *Hahn v. Union Pac. R.R. Co.*, 352 Ill.App.3d 922 (5th Dist. 2004) (holding that expert medical opinions about future medical care costs are admissible without requiring "reasonable degree of medical certainty" language).

[33] *Id.*

[34] *Primoris Energy Servs. Corp. v. Myers*, 569 S.W.3d 745, 761 (Tex. App.—Houston [1st Dist.] 2018, no pet.).

[35] *Id.*

necessity in 18-wheeler cases demand comprehensive record-keeping that demonstrates both the clinical rationale for treatment and the patient's functional improvement over time.[36] Objective measures such as range of motion assessments, muscle testing, sensory nerve testing, pain scales, functional capacity evaluations, and return-to-work documentation, provide quantifiable evidence of treatment effectiveness that strengthens causation arguments and supports damage calculations.[37]

From a litigation perspective, the cost-effectiveness of chiropractic care presents compelling arguments for both treatment necessity and damage quantification. Conservative treatment approaches typically cost a fraction of invasive procedures while achieving comparable or superior functional outcomes for appropriate injury types. This economic advantage becomes particularly significant in the context of future medical expenses, where lifetime care projections can vary dramatically based on treatment modality selection.

D. Documentation Requirements to Prove Causation

Causation represents one of the most challenging aspects of collision litigation. It requires medical evidence that links the plaintiff's injuries directly to the collision forces and mechanics. Effective medical documentation must establish both factual causation (but-for causation) and legal causation (proximate cause) through detailed clinical observations and expert medical opinions.[38] Initial medical records must document the mechanism of injury, correlating the collision dynamics with the specific injury patterns observed.[39] Emergency room records, ambulance reports, and initial treating physician notes provide crucial contemporaneous evidence of injury causation.[40]

Subsequent medical records must demonstrate a consistent pattern of symptoms and clinical findings that support the causal relationship between the collision and ongoing medical treatment.[41] The temporal relationship between the collision and symptom onset becomes particularly important in cases involving soft tissue injuries or delayed symptom presentation. Medical records must document the progression of symptoms from the collision date through ongoing treatment, establishing a clear causal chain that withstands defense challenges regarding alternative causation theories such as age-related musculoskeletal injuries, prior injuries, or other co-morbidities.[42]

Treating doctors must establish findings that differentiate patients' acute injuries from the crash, as compared to chronic injuries from before the crash. This is often difficult to chart but an experienced doctor with radiological findings can distinguish acute injuries from chronic past injuries. Apart from the objective findings

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[36] *Chiropractic Records as Legal Evidence*, COMFORT REHAB & CHIROPRACTIC CTR., (May 2024), https://dallasaccidentandinjuryrehab.com/chiropractic-records-as-legal-evidence/.
[37] *Id.*
[38] John Kortbeek et al., *On Matters of Causation in Personal Injury Cases: Considerations in Forensic Examination*, PAIN RES. MANAG. (2014), https://pmc.ncbi.nlm.nih.gov/articles/PMC5042245/ (discussing legal principles of causation including factual causation and proximate cause in personal injury cases).
[39] *Id.*
[40] *Id.*
[41] *Bullard v. Lynde*, 292 S.W.3d 142 (Tex. App.—Dallas 2009, no pet.).
[42] *Id.*

from a doctor's report and assessment, a good patient history can also lead to evidence of acute vs chronic conditions.[43] History of past collision, any other known co-morbidities, the patient's age, and other genetic factors can make a huge difference in the assessment of acute vs chronic pain.[44] The more medical findings that can show acute injury, the easier it is to establish the causation element for these tort cases. Chiropractic evaluation describing the mechanism of injury, the collision impact on the patient's vehicle, the forces resulting in whether airbags deployed, to seatbelt or seat malformation, to documenting acute physical injury findings and charting acute radiological findings in the patient's medical records can be used as strong evidence to support causation in 18-wheeler collision litigation.[45]

II. CHIROPRACTIC PRACTICE — IN PERSONAL INJURY (PI) REALM

A. Chiropractic Education & Training in Treating 18-Wheeler PI Cases

Chiropractors are doctors of alternative medicine. Doctor of Chiropractic (DCs) represents a distinct category of healthcare professionals specializing in the diagnosis and treatment of neuromuscular disorders, with particular emphasis on spinal/extremity injuries and biomechanical dysfunction. The educational pathway to becoming a licensed chiropractor requires extensive academic preparation comparable to traditional medical education.

Prospective chiropractic students must complete a minimum of 90 semester hours of undergraduate coursework, and most states require a bachelor's degree along with the successful completion of a Doctor of Chiropractic program to get licensed.[46] The prerequisite curriculum mirrors pre-medical requirements and includes rigorous coursework in human anatomy and physiology, general and organic chemistry, physics, biology and microbiology, mathematics and statistics.[47] This foundational education ensures that chiropractic students possess the scientific knowledge base necessary for advanced clinical training.

Following undergraduate preparation, students must complete a four-year Doctor of Chiropractic program at an institution accredited by the Council on Chiropractic Education (CCE). This intensive curriculum encompasses over 4,200 hours of classroom, laboratory, and clinical instruction, including: advanced anatomy and neuroanatomy, physiology and pathophysiology, biomechanics and orthopedics,

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[43] Grant Schneider, *Evidence-Based Chiropractic*: *The Key to Personal-Injury Cases*, CHIROPRACTIC ECON., Feb. 21, 2024, https://www.chiroeco.com/evidence-based-chiropractic-the-key-to-personal-injury-cases/.
[44] *Id.*
[45] *Id.*
[46] *Study Chiropractic*, ASS'N OF CHIROPRACTIC COLLS. (Feb. 19, 2024), https://www.chirocolleges.org/students/study-chiropractic/ ("90 hours includes a minimum of 24 semester hours in life and physical science courses").
[47] *Id.*

neurology and neurological assessment, diagnostic imaging and radiological interpretation.[48]

Furthermore, students are trained in Chiropractic manipulative therapy and adjustive techniques, rehabilitation and physical medicine modalities, clinical diagnosis of neuromusculoskeletal conditions and patient management.[49] Some chiropractors also specialize in reading advanced radiological findings of CT scans and MRIs. Upon graduation, chiropractic candidates must pass the National Board of Chiropractic Examiners (NBCE) examination series, consisting of four comprehensive national board exams covering basic sciences, clinical sciences, practical skills, and case management.[50]

Additionally, practitioners must obtain state licensure by passing jurisdiction-specific examinations covering state laws and regulations governing chiropractic practice. To maintain licensure, chiropractors must complete mandatory continuing education credits annually, ensuring their knowledge remains current with evolving treatment protocols and legal standards.[51] A typical chiropractor is more advanced in training of the musculoskeletal system than a typical primary care physician due to their expertise in treating neuromusculoskeletal injuries.

B. Comparative Analysis: Chiropractors Versus Physical Therapists (PTs)

Chiropractors are often compared with physical therapists when it comes to the treatment modalities they render to a typical car collision patient. While both chiropractors and physical therapists treat musculoskeletal injuries common in vehicular crashes, significant differences exist in their educational backgrounds, scope of practice, and clinical autonomy.

Chiropractors have more training and education as compared to a three-year physical therapy program.[52] Unlike PTs, Chiropractors are independent and can see a patient directly without needing a referral from a medical doctor's office. Chiropractors can begin evaluation and treatment immediately following an accident, eliminating delays associated with physician referrals required for physical therapy clients. Furthermore, Chiropractors, unlike PTs, can order advanced imaging studies (MRI, CT scans) to identify and document the full extent of client injuries without requiring additional medical consultations, expediting case development and settlement negotiations.[53]

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[48] *Chiropractic Education* – NAT'L BD. OF CHIROPRACTIC EXAM'RS (Apr. 12, 2024), https://www.nbce.org/about-nbce/chiropractic-care/chiropractic-education/. ("Each program's curriculum must include at least 4,200 instructional hours of course credits").

[49] *Id.*

[50] *Links to NBCE Exams*, NAT'L BD. OF CHIROPRACTIC EXAM'RS (Feb. 10, 2025), https://www.nbce.org/links-to-nbce-exams/ ("all 50 states either accept or require candidates to pass NBCE exams Parts I, II, III, and IV for licensure").

[51] *Educational Requirements For Chiropractors*, CORE CHIROPRACTIC (Mar. 14, 2022), https://www.corechiropractic.net/articles/educational-requirements-for-chiropractors/.

[52] *Admissions Process for Doctor of Physical Therapy Education Programs*, AM. PHYSICAL THERAPY ASS'N, https://www.apta.org/your-career/careers-in-physical-therapy/pt-admissions-process.

[53] *Vuagniaux v. Department of Professional Regulation*, 208 Ill.2d 173 (2003) ("the Medical Practice Act treats [chiropractic physicians] as full and equal members of the medical profession").

PTs lack education and training in diagnosis and radiological interpretation. PT's scope typically excludes diagnostic imaging orders and independent diagnostic determinations. This is a crucial distinction in the treatment of 18-wheeler collision patients. Physical therapists in most jurisdictions operate under physician supervision or require medical referrals to initiate treatment.[54] This lack of autonomy and codependence on the medical doctors becomes problematic in rendering necessary care to the patients and providing expert testimony regarding causation and damages in the trial. While physical therapists are dependent on MDs, chiropractors are not.

Chiropractors' diagnostic training and educational background often qualify them as expert witnesses in personal injury litigation, providing valuable testimony regarding injury causation, treatment necessity, and long-term prognosis.[55] As expert witnesses, their testimony backed up with proper documentation can add significant value to the case. The comprehensive documentation standards required in chiropractic practice—including detailed biomechanical analysis, functional assessment metrics, and objective outcome measures—provide the evidentiary foundation necessary for successful personal injury litigation.[56] This documentation capability, combined with the profession's diagnostic authority and treatment autonomy, positions chiropractors as essential healthcare partners in 18-wheeler personal injury cases.

Moreover, chiropractors, just like physical therapists, can prescribe rehab exercises to the car collision patients and can monitor their recovery with the most advanced evidence-based PT guidelines. Chiropractic practice encompasses both passive treatments (manual adjustments, soft tissue therapies) and active rehabilitation (therapeutic exercises, functional restoration), providing comprehensive care management within a single provider relationship. The integration of chiropractic care into personal injury practice thus represents not merely a treatment option but a strategic advantage in case development, evidence compilation, and client advocacy. Hence, chiropractors are preferred over physical therapists in working these 18-wheeler personal injury cases.

III. CHIROPRACTIC EVALUATION & TREATMENT FOR PI PATIENTS

A. New Patient Intake & Evaluation Protocols

The comprehensive medical evaluation of commercial vehicle collision victims begins with a structured new patient intake process. This initial assessment encompasses several critical components: a detailed collision questionnaire documenting the mechanics of the crash, comprehensive medical history review, standardized pain scale assessment, anatomical pain mapping, systematic symptom documentation, compilation of prior emergency room or hospital records, analysis of existing radiological findings, and review of documentation from other treating physicians. This multifaceted approach ensures a thorough understanding of the

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[54] Scope Of Practice, N.C. BD. OF PHYSICAL THERAPY EXAM'RS, https://www2.ncptboard.org/app/LandingPages/ScopeOfPracticeHome.php.

[55] *Daniels v. Bernard*, 270 S.C. 51, 240 S.E.2d 518 (1978) ("The S.C. Supreme Court ruled...holding for the first time that a Chiropractor could be used as an expert or medical witness in a Court trial")

[56] *Id.*

patient's post-collision medical status and provides the foundation for subsequent treatment planning.[57]

Following completion of the intake documentation, the provider conducts vital sign monitoring and performs a comprehensive physical examination. During this phase, Doctor of Chiropractic undertakes extensive musculoskeletal evaluations, including muscle strength testing, sensory nerve function assessment, range of motion measurements, orthopedic diagnostic testing, and balance evaluation. The examination protocol extends beyond musculoskeletal assessment to document other physical trauma manifestations, such as contusions, lacerations, edema, discoloration, and visible deformities.[58]

The evaluation process includes a baseline mental status assessment to identify neurological complications or psychological impacts from the collision. Chiropractors can document symptoms including memory impairment, personality changes, post-traumatic anxiety, and alterations in mental capacity or alertness. Additionally, practitioners assess functional limitations affecting quality of life, work capacity, and social activities. Documentation of work absence and activity restrictions provides crucial evidence for economic damage calculations.

Chiropractors will have an initial exam documentation with all the clinical findings and spinal listing that needs correction. This document will also have any diagnostic imaging recommendations, such as X-rays, CT scans, and MRI orders, in furtherance of confirming the doctor's working diagnosis and monitoring the patient's treatment.[59]

B. Scientific Research & Evidence-Based Chiropractic Treatment Modalities

Following the initial evaluation, providers will turn to scientific research-based chiropractic treatment protocols specifically designed for collision-related injuries. These interventions include spinal manipulation and adjustments, extremity joint mobilization, and various soft tissue modalities. The treatment arsenal encompasses manual therapy techniques, therapeutic massage, cupping therapy, thermal modalities (both heat and cold applications), spinal traction, therapeutic ultrasound, laser therapy, prescribed therapeutic exercises, kinesiology taping, and comprehensive patient education programs. Each of these interventions has demonstrated clinical efficacy in peer-reviewed research literature.[60]

Depending on the severity of injuries, patients are typically seen for a course of 3-4 sessions a week for 4-5 weeks, then 2-3 sessions for 3-4 weeks, then once a week for 3-4 weeks, followed by once a month for 2-3 months as per Chiropractic/PT

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[57] J.J. Wong et al., *Clinical Practice Guidelines for the Management of Conditions Related to Traffic Collisions: A Systematic Review by the OPTIMa Collaboration*, 37 DISABILITY & REHABIL. 471 (2015), https://doi.org/10.3109/09638288.2014.932448.

[58] H. M. Hinton, R. McLeod, B. Broker & C. E. MacLellan, *Outcome Measures and Their Everyday Use in Chiropractic Practice*, 54 J. CAN. CHIROPR. ASSOC. 118 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2875909/.

[59] *Id.*

[60] Hawk, C. et al., *Best Practices for Chiropractic Management of Patients with Chronic Musculoskeletal Pain: A Clinical Practice Guideline*, 43 J. ALTERNATIVE COMPLEMENTARY MED. 850-67 (2021).

guidelines. The frequency of treatments varies depending on the patient's progression and the provider's medical decision-making. Every patient is unique, and their recovery can fluctuate based on many factors, so the guidelines are helpful but not mandatory to follow. Each treatment session generates detailed documentation through SOAP (Subjective, Objective, Assessment, Plan) notes that chart the patient's daily recovery progress. These records serve as vital evidence for both economic and non-economic damage calculations.[61]

When patient recovery fails to progress as anticipated or injuries prove severe, such as acute disc herniations or complex fractures, chiropractors will refer the patient to appropriate specialists. These referrals may include pain management physicians, orthopedic surgeons, or neurologists, depending on the specific clinical presentation. This co-management approach ensures timely, appropriate medical intervention while maintaining proper legal standards of care.

Upon reaching maximum medical improvement, patients typically transition to maintenance care protocols. However, symptom exacerbation frequently occurs as patients resume normal daily activities and work responsibilities. Physical demands, particularly lifting and heavy-duty activities, often precipitate pain flare-ups and can impede recovery progress. The healing process rarely follows a linear trajectory; patients commonly experience periods of improvement followed by temporary setbacks throughout their recovery journey.[62]

C. SOAP Notes & Objective Outcome Assessment to Prove Medical Necessity & Economic & Non-economic Damages

Chiropractors possess unique capabilities in tracking patient progress through comprehensive, standardized assessment protocols that provide objective measurement of recovery trajectories. This systematic approach involves multiple validated assessment tools, including numerical pain rating scales, functional capacity evaluations, range of motion measurements using inclinometry and goniometry, and standardized disability questionnaires such as the Neck Disability Index and Oswestry Low Back Pain Disability Questionnaire. These instruments create quantifiable baseline measurements that allow for precise tracking of improvement or deterioration throughout the treatment process.[63]

Additionally, SOAP notes document patients' pain level assessments, functional capacity changes, muscle tone improvements, range of motion modifications, work capacity, recreational activities, sleep quality, and psychological well-being, providing a holistic view of treatment effectiveness. Furthermore, diagnostic imaging findings receive comprehensive documentation within the treatment records. For instance, positive MRI findings are thoroughly described, leading to appropriate diagnostic coding and treatment plan modifications based on patient recovery patterns and prognosis indicators. Chiropractors meticulously describe treatment modalities and ensure compliance with state billing standards and timing requirements. This ability to correlate specific treatment interventions with measurable outcomes creates compelling

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[61] *Id.*
[62] *Id.*
[63] H. Vernon & S. Mior, *The Neck Disability Index: A Study of Reliability and Validity*, 14 J. MANIPULATIVE PHYSIOL. THER. 409 (1991).

evidence for both the medical necessity of care and the economic value of treatment investments.[64]

Comprehensive documentation of patient recovery and treatment processes serves as the foundation for establishing past medical expenses in economic damage calculations. Some of the injuries sustained in a heavy 18-wheeler crash are permanent in nature. Spinal disc herniations often require lifelong maintenance care, and most 18-wheeler crashes leave the patient with multiple herniated discs. Future medical expense projections derive from careful estimation of ongoing treatment costs, including similar modalities and maintenance care requirements.[65]

IV. DAUBERT CHALLENGE — LEGAL ADMISSIBILITY & EXPERT TESTIMONY

A. The Daubert Revolution and Its Impact on Chiropractic Testimony

The Supreme Court's decision in *Daubert v. Merrell Dow Pharmaceuticals, Inc* transformed trial judges into "gatekeepers" responsible for ensuring that expert testimony meets reliability standards before reaching the jury.[66] For chiropractic practitioners serving as expert witnesses in commercial motor vehicle collision litigation, the Daubert standard presents both unprecedented opportunities and formidable challenges that require careful navigation. Federal Rule of Evidence 702, as interpreted through the Daubert trilogy, establishes a four-pronged test for the admissibility of expert testimony.[67] The testimony must be: "(1) based on sufficient facts or data; (2) the product of reliable principles and methods; (3) the result of reliable application of those principles and methods to the facts of the case; and (4) helpful to the trier of fact."[68]

The modern trend in federal and state courts nationwide reflects an increasingly favorable disposition toward chiropractic expert testimony when a proper foundation is laid.[69] Courts have progressively recognized that chiropractors possess specialized knowledge regarding spinal biomechanics, musculoskeletal injuries, and conservative treatment approaches that is particularly relevant to motor vehicle collision litigation.[70] This judicial acceptance enables plaintiff attorneys to effectively utilize chiropractic experts to establish both causation and damages in commercial vehicle accident cases.[71]

However, significant challenges persist that can undermine the effectiveness of chiropractic testimony. Primary obstacles include lingering jury perceptions regarding the professional credibility of chiropractors as qualified medical experts. Additionally,

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[64] M. Schneider, *Outcome Measures and Their Everyday Use in Chiropractic Practice*, 33 CHIROPR. OSTEOPATH. 12 (2010)

[65] R. Farabaugh et al., *Cost of Chiropractic Versus Medical Management of Adults with Spine-Related Musculoskeletal Pain: A Systematic Review*, CHIROPR. MAN. THERAP. (2019) (finding cost savings of $2,385 per patient with chiropractic care including advanced imaging).

[66] *Daubert v. Merrell Dow Pharms, Inc*., 509 U.S. 579 (1993).

[67] FED. R. EVID. 702.

[68] *See Sheng v. Bissonnette*, No. 1:17-cv-03864-JRS-TAB, 2019 U.S. Dist. LEXIS 91299, at *3-4 (S.D. Ind. 2019).

[69] *Infinity Physical Therapy, LLC v. Meemic Ins. Co.*, No. 365767, 2025 Mich. App. LEXIS 806, at *1 (Ct. App. 2025).

[70] *Id.*

[71] *Whittaker v. Houston*, 888 A.2d 219, 220 (Del. 2005).

there are instances where practitioners offer non-evidence-based medical opinions. Finally, the most common reason behind the court excluding the chiropractic expert testimony is when chiropractors venture beyond their recognized scope of practice.[72]

Chiropractic experts, with their comprehensive education in spinal anatomy, specialized experience in treating high-impact neuromusculoskeletal trauma, and advanced training in spinal biomechanics, represent a valuable asset when properly utilized in the litigation process.[73] The Daubert decision explicitly identified peer review and publication as critical factors in assessing scientific reliability.[74] The quality and scope of chiropractic research have improved substantially in recent decades, with prestigious journals such as the *Journal of Manipulative and Physiological Therapeutics*, *Spine*, *Manual Therapy*, and *Accident Analysis & Prevention* now publishing high-quality studies that provide robust scientific support for expert opinions.[75] Chiropractic experts must demonstrate comprehensive familiarity with this evolving literature and possess the analytical skills to distinguish between studies of varying methodological quality and relevance.

To enhance their expertise and credibility in personal injury litigation involving 18-wheeler collision dynamics, many chiropractors pursue additional certification and training in accident reconstruction methodologies.[76] This specialized education significantly enhances their credibility when testifying as expert witnesses regarding causation-related opinions. Such training typically encompasses collision dynamics analysis, biomechanical force calculations, and understanding the long-term effects of traumatic forces on human tissues, including the development of permanent arthritis, chronic pain syndromes, and other conditions that substantially diminish quality of life.[77]

Numerous board-certified continuing education programs are available to chiropractors specializing in personal injury practice.[78] These advanced training opportunities enable practitioners to provide more sophisticated testimony regarding causation analysis and both economic and non-economic damages. Experts who can demonstrate that their opinions align with systematic reviews, clinical guidelines and are backed up by higher medical specialists, such as orthopedic surgeons, are significantly more likely to satisfy judicial scrutiny under the Daubert standard.[79]

The biomechanical analysis of injury mechanisms in commercial vehicle collisions has gained increasing acceptance in courts, particularly when supported by comprehensive crash reconstruction data and validated through peer-reviewed research. Chiropractic experts who can effectively correlate clinical findings with established biomechanical principles of high-velocity impact trauma consistently satisfy Daubert's

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[72] *Yagodinski v. Sutton*, 309 Neb. 179, 181, 959 N.W.2d 541, 544 (2021).
[73] *See* Scott Haldeman et al., *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, 18 J. MANIPULATIVE & PHYSIOLOGICAL THERAPEUTICS 1 (1995).
[74] *Daubert*, 509 U.S. at 593.
[75] *See* generally J. MANIPULATIVE & PHYSIOLOGICAL THERAPEUTICS; SPINE; MANUAL THERAPY; ACCIDENT ANALYSIS & PREVENTION (2020-2024 issues).
[76] *Certificate in Chiropractic Personal Injury Specialty (CPIS) Program Details*, CCEDSEMINARS, https://ccedseminars.com/pages/certification-program-details.php?Id=10 (last visited July 6, 2025).
[77] *Id.*
[78] *Id.*
[79] *Powell v. Hudson*, No. 99C-07-039, 2002 Del. Super. LEXIS 189, at *1 (Super. Ct. 2002).

reliability requirements more readily than those relying solely on clinical experience or intuition.[80]

B. Documentation & Strategic Information to Strengthen Expert Testimony

The foundation of legally admissible chiropractic testimony rests upon meticulous documentation that features appropriate objective findings, detailed examination procedures, comprehensive diagnostic protocols, and clear, scientifically-based rationale for diagnostic conclusions.[81] Chiropractic experts must maintain comprehensive documentation that includes initial injury assessments, serial examination findings, objective measurement data, imaging study correlations, treatment response documentation, and detailed progress evaluations.[82] This documentation must be contemporaneous, thorough, and scientifically defensible to withstand aggressive cross-examination.[83]

Commercial vehicle collision cases often involve delayed onset of symptoms, which requires careful analysis of the injury mechanism, inflammatory response, and natural history of specific injury types.[84] Chiropractic experts must be prepared to explain why certain injuries may not manifest immediately and how the collision forces could have initiated a cascade of pathophysiological changes.

Defense counsel will invariably challenge causation through systematic differential diagnosis arguments, typically attributing injuries to pre-existing conditions, prior trauma history, or alternative causation mechanisms. The differential diagnosis process in commercial vehicle cases must comprehensively account for pre-existing conditions, age-related degenerative changes, and alternative trauma mechanisms while demonstrating the relationship between the specific collision and the plaintiff's injuries.[85]

Given the severe forces involved in 18-wheeler collisions, the primary challenge often lies not in establishing that trauma occurred, but rather in differentiating between new injury and pre-existing pathology, and determining the precise extent of trauma-related exacerbation of existing conditions. Chiropractic experts must demonstrate systematic consideration of alternative causes and provide logical, evidence-based elimination of less likely explanations.[86]

The expert must be prepared to address the concept of "aggravation of pre-existing conditions" with scientific precision, explaining how traumatic forces can accelerate degenerative processes, destabilize previously asymptomatic conditions, or create new injury superimposed upon existing pathology.[87]

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[80] *Pruneda v. Columbia Steel Casting Co.*, 2007 UT App 371.
[81] *In re Paoli R.R. Yard Pcb Litig.*, 35 F.3d 717, 735 (3d Cir. 1994).
[82] *Id.*
[83] *Hayhoe v. Henegar,* 172 S.W.3d 642 (Tex. App.—Eastland 2005, no pet.).
[84] N. Bogduk & S. Mercer, *Biomechanics of the Cervical Spine. I: Normal Kinematics*, 15 CLIN. BIOMECH. (BRISTOL) 633 (Nov. 2000), https://pubmed.ncbi.nlm.nih.gov/10946096/.
[85] *Westberry v. Gislaved Gummi AB*, 178 F.3d 257 (4th Cir. 1999).
[86] *Schreib v. Whitmer*, 2016 UT App 61, 370 P.3d 955.
[87] *Bongiovanni v. Cavagnuolo*, 2016 NY Slip Op 00638, 138 A.D.3d 12, 24 N.Y.S.3d 689 (App. Div.).

C. Challenges to Daubert Compliance & Common Causes for Expert Disqualification

One of the most frequent reasons for excluding chiropractic expert testimony involves exceeding the recognized scope of chiropractic practice.[88] This typically occurs when chiropractic experts venture inappropriately into specialized areas such as complex accident reconstruction mathematics, metallurgical analysis of vehicle damage, advanced neurological assessment beyond their training scope, or pharmaceutical and surgical treatment recommendations.[89]

Plaintiff attorneys frequently seek chiropractic opinions regarding the necessity or appropriateness of surgical interventions, epidural steroid injections, nerve blocks, or other invasive medical treatments.[90] Such testimony violates chiropractic scope of practice limitations and can result in immediate expert disqualification. Legal counsel must exercise careful judgment in limiting chiropractic testimony to appropriate areas of expertise while avoiding the temptation to use chiropractors to justify medical interventions beyond their professional scope.[91] The distinction between biomechanical analysis of human injury mechanisms (appropriate for chiropractic experts) and engineering analysis of vehicle dynamics or metallurgical failure analysis (potentially inappropriate without additional qualifications) represents a critical boundary that must be respected.[92]

Chiropractors frequently encounter Daubert challenges when relying on generic or template-based expert opinions rather than conducting thorough case-specific analysis. Chiropractic experts must demonstrate that their opinions are specifically tailored to the particular collision circumstances rather than offering general statements about 18-wheeler collisions. The analysis must comprehensively account for the specific collision type (rear-end impact, side-impact, T-bone collision, head-on collision, rollover), airbag deployment status, braking system engagement, cargo distribution effects, and other commercial vehicle-specific factors that distinguish these cases from ordinary motor vehicle accidents.[93]

D. Strategic Recommendations for Maximizing Chiropractic Expert Testimony

Chiropractors can establish strong credibility as expert witnesses in 18-wheeler crash cases when they are properly qualified through a comprehensive presentation of their credentials, emphasizing current licensure in good standing, specialized training in motor vehicle collision biomechanics, continuing education in personal injury practice, and relevant clinical experience treating commercial vehicle collision

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88 *Torres v. Stein*, No. N21C-06-202 FWW, 2023 Del. Super. LEXIS 102 (Super. Ct. 2023).
89 *Cantrell v. Eshelman*, 67 Va. Cir. 214 (Cir. Ct. 2005).
90 *Id.*
91 *Yagodinski v. Sutton*, 309 Neb. 179, 959 N.W.2d 541 (2021).
92 See *Mall v. Horton*, 292 Ore. App. 319, 423 P.3d 730 (2018) (Chiropractor disqualified as expert witness).
93 *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999).

victims.[94] This information must be effectively presented to the jury to enhance credibility and demonstrate specialized expertise.

Chiropractic experts must utilize validated, evidence-based scientific research in formulating their testimony and opinions. They must demonstrate familiarity with current literature regarding collision biomechanics, injury mechanisms, treatment protocols, and outcome studies. Citations to systematic reviews, meta-analyses, and high-quality clinical trials substantially strengthen the scientific foundation of expert testimony.[95]

Expert testimony must strictly adhere to the recognized scope of chiropractic practice, focusing exclusively on musculoskeletal injury assessment, spinal biomechanics analysis, conservative treatment modalities, and functional capacity evaluation. Testimony should avoid recommendations regarding surgical interventions, pharmaceutical treatments, invasive procedures such as epidural steroid injections or nerve blocks, as these fall outside chiropractic scope and can result in expert disqualification.[96]

The causation analysis must address the relationship between the specific collision forces, the resulting injury mechanisms, and the plaintiff's clinical presentation through scientifically sound methodology. This requires integration of crash reconstruction data, biomechanical principles, clinical findings, and outcome assessment. The chiropractor must demonstrate comprehensive familiarity with the specific collision details of the case and not rely on generalized 18-wheeler collision statistics or generic template-based causation theories in formulating their expert opinion.[97]

V. JURY CHALLENGES — BIAS AGAINST CHIROPRACTORS

Doctors of Chiropractic are board-certified, licensed health care providers who undergo rigorous training in soft tissue injury/trauma diagnosis and treatment of neuromusculoskeletal conditions. Despite meeting the educational requirements and the Daubert standard for expert testimony, chiropractors face persistent jury perception challenges.[98] The traditional medical community is notorious for bringing the reputation of chiropractors down by false accusations against them. Some jurors may have a personal bias against chiropractic, assuming that they are not “real doctors” or skilled healthcare professionals. Unfortunately, in some jurisdictions, the traditional bias towards chiropractors can affect jury verdicts.[99]

Defense counsel and insurance companies exploit these biases by attacking the negative jury perception of chiropractors. They may attack the credibility of the

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[94] *See generally* DAVID L. FAIGMAN ET AL., MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF EXPERT TESTIMONY § 1:36 (2021-2022 ed.).
[95] *Id.*
[96] *Moreno v. Ingram*, 454 S.W.3d 186 (Tex. App.—Dallas 2014, no pet.).
[97] *See Westberry v. Gislaved Gummi AB*, 178 F.3d 257, 261 (4th Cir. 1999) (requiring that causation opinions be based on “more than subjective belief or unsupported speculation” and must demonstrate “good grounds” for the expert's conclusions).
[98] *See generally* FED. R. EVID. 702; *Daubert v. Merrell Dow Pharms, Inc.*, 509 U.S. 579 (1993).
[99] *Morris v. Bonner*, 183 Ga. App. 499, 499, 359 S.E.2d 244, 244 (1987) (removing a prospective juror for being anti-chiropractic).

chiropractic expert by insinuating that chiropractors are inferior to other medical doctors with similar education and training. These false claims and inflammatory tactics aim to undermine causation and damage testimony. Skilled plaintiff attorneys can counter this through effective voir dire, eliminating biased jurors through challenges for cause or peremptory strikes.[100]

Plaintiff's counsel must lay a strong foundation for the chiropractor expert by demonstrating the expert's licensing requirements, educational background, clinical experience in treating trauma-based injuries, and specialized training in whiplash-related injuries.[101] Counsel should emphasize the value and need for non-invasive conservative care and that Chiropractic/rehab treatment is the gold standard for soft tissue injuries.[102] Chiropractors must establish that the corresponding treatment rendered was per the national guidelines, meeting the evidence-based standard of diagnostic and treatment protocols.[103]

In an 18-wheeler collision case, where the crash dynamics matter, plaintiff lawyers should share data of crash dynamics, vehicle information and other crash specific information to the chiropractor. The expert should go over the patient's other medical records to be familiar with the plaintiff's injuries, such as ER records and any other diagnostic imaging records and records from any other healthcare provider the patient may have been to post-collision. Proper documentation and knowledge of the case specifics can counter the defense narrative of exaggerated injuries and unnecessary chiropractic treatment.[104]

Experts are encouraged to use visuals such as anatomical models to explain to the jury their clinical findings and demonstrate their detailed knowledge of human anatomy and the pathophysiology of injuries sustained from motor vehicle collisions. Lay analogy and charts showing the patient's limitations in performing their activities of daily living post-collision can also be very helpful.[105]

Because chiropractors see the plaintiffs' multiple times a week for months, they are excellent witnesses to discuss patients' limitations in their quality and enjoyment of life due to pain.[106] Plaintiff's attorney should highlight chiropractic experts' testimony around the impact on daily life, like the ability to work, sleep, lift items, tend to childcare, drive, cook, and or care for family. This can make the injury real to the jury, and they can resonate with the plaintiff's pain and suffering.[107]

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[100] *Id.*
[101] *Reardon v. Larkin*, 2010 ME 86, 3 A.3d 376.
[102] *See Clinical Practice Guidelines for the Management of Acute and Chronic Neck Pain*, 43 J. MANIPULATIVE & PHYSIOLOGICAL THERAPEUTICS 449 (2020)
[103] *Id.*
[104] *Edwards v. Louy*, 2002-Ohio-3818, ¶ 1 (Ct. App.).
[105] *Demonstrative Evidence: Benefits & Admissibility in Expert Testimony*, EXPERT INST. (Apr. 12, 2023), https://www.expertinstitute.com/resources/insights/demonstrative-evidence-expert-testimony/.
[106] *See Expert Witnesses*, GEORGE SALINAS INJURY LAWYERS (Apr. 2, 2025), https://www.salinastriallaw.com/personal-injury-resources/expert-witnesses/ (noting rehabilitation experts can testify about loss of abilities preventing work, activities of daily living, or quality of life enjoyment).
[107] *See Personal Injury*: *Chiropractors as Expert Medical Witnesses in Court Trials*, THE FLOYD LAW FIRM PC (Mar. 1, 2024), https://www.floydlaw.com/information/personal-injury-chiropractors-as-expert-medical-witnesses-in-court-trials/.

VI. MULTIDISCIPLINARY CASE MANAGEMENT IN 18-WHEELER CASES

Considering the high velocity impact and magnitude of forces involved in a commercial vehicle crash, patients commonly sustain severe injuries requiring co-management across multiple medical specialties. While there is a special place for chiropractors in the treatment umbrella, patients are often referred to other medical providers, such as pain management MDs, orthopedic surgeons, and neurologists, depending on the severity of the patient's injuries and medical necessity.[108] It is well within the scope of chiropractic to make necessary referrals to other medical professionals when clinical findings exceed chiropractic treatment parameters. This referral authority distinguishes chiropractic practice from physical therapy and creates important legal implications for case management.[109]

A vast majority of these 18-wheeler crash victims go to the hospital or emergency room (ER) for initial trauma assessment.[110] The primary goal is for the ER doctor to rule out any internal bleeding or complex fractures that would require immediate surgery.[111] It is very important to rule out any other life-threatening injuries to vital organs, including traumatic brain injury, depending on the type of trauma sustained from that specific collision.[112]

Emergency physicians employ comprehensive diagnostic imaging protocols that reflect the complexity of such injuries. Head computed tomography (CT) scans are routinely ordered to evaluate traumatic brain injury, particularly when patients report loss of consciousness or altered mental status.[113] Chest and abdominal CT are the next common type of diagnostic imaging ordered by ER physicians to rule out rib fractures or collapsed lung from seatbelt-associated trauma, or any abdominal bleeding or internal bleeding from the high-velocity impact.[114] Further injury-specific imaging may be ordered at the ER, including cervical and lumbar CT scans or X-rays to rule out spinal fractures sustained from a severe whiplash injury.[115] The emergency department evaluation establishes not only the immediate medical treatment plan but also creates the foundational medical record that will support future treatment decisions and legal claims.[116]

While emergency evaluation is not mandatory, it remains highly recommended to exclude life-threatening injuries.[117] If patients have not received emergency evaluation before chiropractic assessment, chiropractors can refer patients to medical

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[108] Minjeong Chang, *The Chiropractic Scope of Practice in the United States: A Cross-Sectional Survey*, 37 J. MANIPULATIVE & PHYSIOL. THERAPEUTICS 363 (2014), https://doi.org/10.1016/j.jmpt.2014.05.003.
[109] *Id.*
[110] *See* 42 U.S.C. § 1395DD (2023).
[111] *2023 Emergency Department Evaluation and Management Guidelines FAQs*, AM. COLL. OF EMERGENCY PHYSICIANS (Nov. 2023), https://www.acep.org/administration/reimbursement/reimbursement-faqs/2023-ed-em-guidelines-faqs/ (last visited July 9, 2025).
[112] *Id.*
[113] *See* CTR. FOR DISEASE CONTROL & PREVENTION, *Traumatic Brain Injury Guidelines* (2023).
[114] *See* AM. COLL. OF RADIOLOGY, *Appropriateness Criteria for Imaging in Trauma* (2023).
[115] *Id.*
[116] *See* FED. R. EVID. 803(4); 45 C.F.R. § 164.501 (2023).
[117] *See* 42 U.S.C. § 1395DD

doctors for pain management and order imaging studies to rule out complicated fractures or life-threatening internal bleeding from trauma.[118] As shock and adrenaline subside following a collision, patients frequently develop additional symptoms missed during emergency evaluations, necessitating secondary comprehensive evaluation by chiropractors to document all impact-related injuries.[119]

During the patient's ongoing treatment, a chiropractor may order further advanced imaging to supplement emergency department studies, especially to evaluate severe soft tissue injuries that may not need immediate surgery but require complex medical treatments.[120]A magnetic resonance imaging (MRI) is designed to evaluate soft tissue injuries not visible on CT scans or radiographs. MRI studies reveal disc herniations, ligamentous injuries, and neural compression that may develop over time as inflammation and scar tissue formation progress.[121] Based on patient needs and MRI clinical findings, chiropractors may refer patients to other medical specialties.

Pain management represents the most commonly utilized intervention as an extension of conservative chiropractic care /physical therapy.[122] If the patient's symptoms are not improving with conservative care, or if the patient has a substantially large disc herniation or compressed nerve roots or spinal nerve, the pain management physicians will prescribe Epidural steroid injections (ESI).[123] While most patients recover well with a few rounds of ESI along with traditional chiropractic rehabilitation, some patients need more invasive surgical interventions.[124] Some of the most common surgical interventions include partial discectomy, complete discectomy, lumbar laminectomy, lumbar fusion, cervical fusion, shoulder and hip labrum repairs, or spinal decompression surgeries.[125] The clinical decision to proceed with surgeries should be based on objective clinical findings, exhaustion of non-invasive medical treatments, MRI evidence of highly symptomatic disc herniation or neural compression resulting in severe pain or muscle weakness limiting the quality of life and activities of daily living.[126]

Chiropractors may continue to treat patients simultaneously as they seek medical intervention from other providers. Depending on the case specifics, chiropractors may provide pre-surgical strength and range of motion treatments and

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[118] 22 TEX. ADMIN. CODE § 78.1 (2025) (scope of chiropractic practice).
[119] D. Kok et al., *Delayed-Diagnosed Injuries in Trauma Patients After Initial Trauma Assessment with a Total-Body Computed Tomography Scan*, 55 INJURY 111304 (2024), https://pubmed.ncbi.nlm.nih.gov/38171970/.
[120] *Id.*
[121] *See* NORTH AM. SPINE SOC'Y, *MRI Guidelines for Spinal Injuries* (2023); AM. ACAD. OF ORTHOPEDIC SURGEONS, *Soft Tissue Injury Assessment Standards* (2023).
[122] *See* AM. PAIN SOC'Y, *Pain Management Guidelines* (2023); CTR. FOR DISEASE CONTROL & PREVENTION, *Opioid Prescribing Guidelines* (2023).
[123] *See* AM. SOC'Y OF INTERVENTIONAL PAIN PHYSICIANS, *Epidural Steroid Injection Guidelines* (2023); CTR. FOR MEDICARE & MEDICAID SERVS., *Medicare Coverage Determinations for Pain Management* (2023).
[124] *See* AM. ACAD. OF ORTHOPEDIC SURGEONS, *Surgical Outcome Studies* (2023); NORTH AM. SPINE SOC'Y, *Spine Surgery Guidelines* (2023).
[125] *See* AM. ASS'N OF NEUROLOGICAL SURGEONS, *Spinal Surgery Classification* (2023); AM. ACAD. OF ORTHOPEDIC SURGEONS, *Orthopedic Surgery Standards* (2023).
[126] *See* AM. COLL. OF SURGEONS, *Surgical Indication Guidelines* (2023); INST. OF MED., *Evidence-Based Medicine Standards* (2023).

post-surgical rehabilitation when properly coordinated with the primary surgeon.[127] The collaborative care model requires clear communication between providers and documentation of each provider's specific contributions to patient care.[128]

The legal implications of collaborative care extend beyond clinical outcomes to include expert testimony and case presentation.[129] When multiple providers coordinate patient care effectively, their combined testimony creates a more credible and comprehensive presentation of medical necessity and treatment effectiveness under Daubert standards.[130] The collaborative care model also demonstrates appropriate medical decision-making and reduces the appearance of overtreatment.[131]

VII. OVERTREATMENT IN 18-WHEELER COLLISION CASES

The substantial damages typically associated with commercial vehicle crashes create powerful financial incentives that can lead to medical overtreatment.[132] This phenomenon occurs when healthcare providers, often under pressure from personal injury attorneys, recommend unnecessary medical procedures or excessive treatment regimens to artificially inflate damages.[133] This unethical practice undermines both patient welfare and the integrity of the legal system.[134]

Plaintiff's damage recovery in these 18-wheeler collision cases relies heavily on documented medical expenses.[135] Auto insurance settlement offers are typically calculated based on the patient's past medical costs.[136] This creates a perverse incentive structure for personal injury attorneys who are working on contingency fee arrangements.[137] The attorney's financial stake in the outcome is typically 33-40% of any settlement or jury award.[138] They may encourage clients to pursue more expensive treatment options to maximize potential recovery, crossing the ethical boundary by dictating medical treatments.[139]

Some of the common examples of overtreatment in such cases include pushing for unnecessary epidural steroid injections or multiple rounds of injections in a plaintiff

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[127] *See* AM. PHYSICAL THERAPY ASS'N, *Pre- and Post-Surgical Rehabilitation Guidelines* (2023).
[128] *See* JOINT COMM'N, *Coordination of Care Standards* (2023).
[129] *See* FED. R. EVID. 702; *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579 (1993).
[130] *Daubert v. Merrell Dow Pharms, Inc*., 509 U.S. 579 (1993); *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999).
[131] *Chambers v. Graybiel*, 639 So. 2d 361 (La. Ct. App. 1994) (the court's ruling on overtreatment in bad faith not to be compensated).
[132] *See* David A. Hyman and Charles Silver, *Medical Malpractice Litigation and Tort Reform*: *It's the Incentives, Stupid,* 59 *VAND. L.REV. 1085* (2006),https://scholarship.law.vanderbilt.edu/vlr/vol59/iss4/4.
[133] *See* Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 LAW & SOC'Y REV. 275, 287-89 (2001).
[134] *Id.*
[135] *See* Douglas A. Kysar, *The Expectations of Consumers*, 103 COLUM. L. REV. 1700, 1750-52 (2003).
[136] *Id.*
[137] *See* LESTER BRICKMAN, *Lawyer Barons: What Their Contingency Fees Really Cost America* 89-112 (2011).
[138] *Id.*
[139] MODEL RULES OF PRO. CONDUCT r. 5.4(c) (AM. BAR ASS'N 2020).

whose symptoms do not warrant such an aggressive, invasive approach.[140] These procedures carry significant risks and should only be considered after conservative treatment options have been exhausted.[141] Similarly, some healthcare providers push a patient to opt for premature surgery before fully exhausting all non-invasive options.[142] This violates established medical protocols and clinical guidelines that require a graduated approach to surgical interventions in neuro-musculoskeletal injuries.[143]

Additionally, some providers opt for unnecessary advanced imaging studies, including MRI and CT scans that serve no legitimate treatment purpose but are ordered to document subtle soft tissue changes or simply to generate additional medical expenses.[144] This practice not only increases costs but also exposes patients to unnecessary radiation and potential false-positive findings that can lead to further unnecessary interventions and anxiety in patients.[145]

Chiropractic overtreatment represents another significant concern, with some practitioners providing "bad faith" high-frequency treatment sessions without proper re-evaluation or medical justification.[146] Chiropractic treatment plans must be based on objective medical necessity and should demonstrate measurable progress toward functional improvement.[147] Absent special circumstances such as post-surgical rehabilitation, such extensive treatment frequencies typically exceed accepted standards of care.[148]

Medical overtreatment violates fundamental principles of both medical and legal ethics. Healthcare providers must adhere to recommendations based solely on medical necessity rather than financial considerations.[149] Similarly, attorneys are prohibited from improperly influencing medical treatment decisions, as this constitutes a violation of professional conduct rules.[150]

There are dire consequences for such unethical practices. Insurance companies and state regulatory bodies have increased scrutiny of attorney-driven medical clinics, leading to numerous investigations and enforcement actions.[151] Many facilities have been flagged for suspicious billing patterns, resulting in civil lawsuits alleging common

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[140] *See* SHANNON BROWNLEE, *Overtreated: Why Too Much Medicine is Making Us Sicker and Poorer* 156-78 (2007).
[141] *See* INST. OF MED., *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* 87-89 (2011).
[142] *See* AM. SOC'Y OF INTERVENTIONAL PAIN PHYSICIANS, *Guidelines for the Performance of Fusion Procedures for Degenerative Disease of the Lumbar Spine*, 10 PAIN PHYSICIAN 219, 225-27 (2007).
[143] *Id.*
[144] Rebecca Smith-Bindman et al., *Radiation Dose Associated with Common Computed Tomography Examinations*, 169 ARCH. INTERN. MED. 2078, 2082-84 (2009).
[145] *Id.*
[146] *Dotson v. Balsamo*, 307 So. 3d 1131 (La. Ct. App. 2d Cir. 2020) (malingering plaintiff receives reduced compensation due to "bad faith" overtreatment)
[147] *Id.*
[148] *Keil's Wholesale Tire v. Marion*, 518 A.2d 91 (Del. 1986) (excessive treatment may be proper if palliative as corroborated by other physicians on case by case basis).
[149] *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *Principles of Biomedical Ethics* 149-65 (8th ed. 2019).
[150] MODEL RULES OF PRO. CONDUCT r. 5.4(c) (AM. BAR ASS'N 2020).
[151] *See* NAT'L INS. CRIME BUREAU, *Insurance Fraud in Personal Injury Cases: Annual Report* 34-36 (2023).

law fraud and violations of the Racketeer Influenced and Corrupt Organizations (RICO) Act.[152] These enforcement actions have resulted in significant financial penalties and, in some cases, the loss of professional licenses.[153]

Furthermore, these "kickback schemes" can cause economic losses for everyone in the long run.[154] Insurance fraud drives up premiums for all consumers, creating a hidden tax on legitimate policyholders. Moreover, the erosion of credibility in the personal injury system can prejudice juries against legitimate claims, potentially denying appropriate compensation to truly injured plaintiffs.

Plaintiff attorneys and healthcare providers must follow the ethical trajectory of a typical 18-wheeler collision case. Healthcare providers must adhere to evidence-based treatment protocols that prioritize patient welfare over financial considerations. This includes implementing proper documentation procedures, conducting regular treatment plan reviews, and maintaining clear communication with patients about treatment necessity and alternatives.[155]

Personal injury attorneys must maintain appropriate boundaries with healthcare providers, avoiding any conduct that could be construed as improperly influencing medical treatment decisions.[156] This includes refraining from financial arrangements or "kickback" referral schemes that create conflicts of interest and ensuring that referrals are based on medical qualifications rather than willingness to provide extensive treatment.[157]

Both attorneys and healthcare providers should maintain transparent communication with patients about treatment options, risks, and the relationship between medical expenses and potential recovery. Patients have a right to understand the medical necessity of proposed treatments and should never be pressured into unnecessary procedures.

CONCLUSION

Chiropractors are doctors of alternative medicine; they are licensed healthcare professionals who render non-invasive, drug-free, safe, and effective treatment for collision victims. Chiropractors, unlike physical therapists, can add great value to the personal injury case management by their ability to co-manage these patients with multiple medical specialties as needed. They can independently refer for diagnostic imaging and co-manage these patients pre- and post-surgical status in collaboration with orthopedic or neurosurgeons.

From treatment to testimony, when used ethically and within an evidence-based framework, chiropractic care serves as a credible foundation for establishing causation,

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[152] *See* 18 U.S.C.S. § 1962(c); *Allstate Ins. Co. v. Lint Chiropractic P.C.*, 735 F. Supp. 3d 833 (E.D. Mich. 2024).
[153] *Allstate Ins. Co. v. Plambeck*, 802 F.3d 665 (5th Cir. 2015).
[154] *Liberty Mut. Fire Ins. Co. v. Acute Care Chiropractic Clinic P.A.*, 88 F. Supp. 3d 985 (D. Minn. 2015).
[155] *See* AM. MED. ASS'N, *Code of Medical Ethics* § 2.09 (2021).
[156] *See* MODEL RULES OF PRO. CONDUCT r. 1.1 cmt. 6 (AM. BAR ASS'N 2020).
[157] *Gov't Emples. Ins. Co. v. Mayzenberg*, No. 17-CV-2802, 2018 U.S. Dist. LEXIS 195890 (E.D.N.Y. 2018).

damages, and medical necessity in soft-tissue injury claims. This paper has explored how chiropractors contributed meaningfully in establishing causation and to the substantiation of economic and non-economic damages through evidence-based treatment protocols, standardized documentation, and qualified expert testimony under the Daubert standard.

The medical community and insurance providers have historically viewed chiropractors as less credible than traditional physicians, but this perception is shifting as research validates chiropractic effectiveness and state licensing establishes professional standards. Since jury bias against chiropractic care can significantly impact litigation outcomes, personal injury attorneys must carefully screen potential jurors during voir dire to identify and exclude those with anti-chiropractic prejudices. Meanwhile, chiropractors serving as expert witnesses should strengthen their credibility by providing well-documented, evidence-based testimony that follows established clinical guidelines and stays within their professional scope of practice.

The integrity of the personal injury system depends on the ethical conduct of both legal and medical professionals. While commercial vehicle collision cases often involve significant injuries requiring substantial medical intervention, treatment decisions must be based on medical necessity rather than financial considerations. Only through adherence to established ethical standards and evidence-based practices can the system maintain its legitimacy and ensure that truly injured plaintiffs receive appropriate compensation while protecting against fraudulent claims.

The legal profession must remain vigilant in ensuring that lawyers do not improperly influence medical care, and healthcare providers must adhere strictly to treatment guidelines that reflect clinical necessity rather than legal strategy.

By fostering collaboration rooted in ethical standards and clinical integrity, chiropractors and attorneys can together ensure that personal injury litigation reflects both patient well-being and evidentiary truth. This article calls for greater accountability, training, and oversight to prevent abuse and preserve the rightful place of chiropractic testimony in commercial vehicle litigation.

THE CRIMINALIZATION OF HEALTHCARE WORKERS BEING CRUEL & UNUSUAL

Trinh N. Chow*

Abstract: The term scapegoat has come to mean a person who bears the blame for others. RaDonda Vaught was designated as the scapegoat for the medication error that resulted in the death of Charlene Murphey on Dec. 26, 2017. Ms. Vaught mistakenly administered vecuronium bromide, a paralytic medication, instead of midazolam (Versed®). Vanderbilt University Medical Center (VUMC) did not report the patient's death to state or federal officials, as required by law. However, Ms. Vaught was terminated by VUMC, and Vanderbilt negotiated a confidential out-of-court settlement with Ms. Murphey's family. The Tennessee Board of Nursing revoked Ms. Vaught's license indefinitely. On Feb. 4, 2019, Ms. Vaught was arrested and criminally charged with reckless homicide and impaired adult abuse. On May 13, 2022, Ms. Vaught was convicted of negligent homicide and of gross neglect of an impaired adult. The judge sentenced Ms. Vaught to three years of probation, instead of prison time. Catapulting from the facts and reasoning of this case, the article will lay out what is considered the duty of care for nurses. Then the current systems used to combat medication errors will be discussed. The remainder of the article will focus on the criminalization of healthcare workers, address the liability of healthcare institutions, and evaluate new models to assess negligence versus culpable homicide. Lastly, healthcare reform in the form of new legislation will be explored.

Keywords: Medication Error; Charlene Murphey; Vanderbilt University; Reckless Homicide; Nurses; Nursing; Healthcare Workers; Healthcare Institutions; Healthcare Reform

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INTRODUCTION

"I think RaDonda Vaught is…the scapegoat in the Old Testament...."

- Peter Strianse, Esq., RaDonda Vaught's Defense Attorney[1]

The term scapegoat has come to mean a person who bares the blame for others.[2] The origins of word "scapegoat" originates from the Old Testament, in which a goat was released into the wilderness to atone for all of Israel's sins.[3] RaDonda Vaught was designated as the scapegoat for the medication error that resulted in the death of Charlene Murphey on Dec. 26, 2017.[4] Ms. Vaught mistakenly administered vecuronium bromide, a paralytic medication, instead of midazolam (Versed®). Vanderbilt University Medical Center (VUMC) did not report the patient's death to state or federal officials, as required by law.[5] However, Ms. Vaught was terminated by VUMC, and Vanderbilt negotiated a confidential out-of-court settlement with Ms. Murphey's family. The Tennessee Board of Nursing revoked Ms. Vaught's license indefinitely.[6] On Feb. 4, 2019, Ms. Vaught was arrested and criminally charged with reckless homicide and impaired adult abuse.[7] Ms. Vaught was convicted of negligent homicide, instead of reckless homicide, and of gross neglect of an impaired adult. On May 13, 2022, the judge sentenced Ms. Vaught to three years of probation, instead of eight years of prison time.[8]

Returning to Ms. Vaught being the "scapegoat," Ms. Vaught's attorney, during his closing arguments reminded the jury of the absence at the trial of Vanderbilt University Medical Center, the physician who wrote the medication order, and the healthcare workers who cared for Ms. Murphey in the Neurology Intensive Care Unit (NICU) and in positron emission tomography (PET) scan.[9] His point was a team of healthcare workers managed the care of Ms. Murphey. However, at the homicide trial of RaDonda Vaught, "the scapegoat" was the only one to bear the mistake and consequences of Ms. Murphey's death. Ms. Vaught's sensational trial brings to mind several questions. What is the standard of care expected of a nurse? Were there other factors that could have contributed to the medication error? Should the liability of Ms.

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[1] WKRN News 2, *RaDonda Vaught Trial: Defense's Closing Arguments*, YOUTUBE (Mar. 25, 2022), https://www.youtube.com/watch?v=tAjZrGsnB2o&list=PLEuNc TRksDr4-D3hSCkL Xeowc_FWXWQ1Z&index=2&t=1s.

[2] Merriam-Webster Dictionary, Scapegoat Noun, https://www.merriam-webster.com/dictionary/scapegoat (last visited Feb. 17, 2023).

[3] *Leviticus 15-16: The Day of Atonement*, THE CHURCH OF JESUS CHRIST OF LATTER-DAY SAINTS (last visited Feb. 17, 2023, 2:50 PM), https://www.churchofjesuschrist.org/manual/old-testament-seminary-student-study-guide/the-book-of-leviticus/leviticus-15-16-the-day-of-atonement?lang=eng.

[4] WKRN News 2, *supra* note 1.

[5] Donna J. Craig RN, JD, *The Case of Nurse RaDonda Vaught: How Administering the Wrong Medication Resulted in a Criminal Conviction*, THE IOWA NURSE REP. 12 (2022).

[6] State of Tennessee v. RaDonda L. Vaught, No. 2019-A-76 (D. Tenn. May 13, 2022).

[7] *TN Board of Nursing's Unjust Decision to Revoke Nurse's License: Travesty on Top of Tragedy*, INST. For SAFE MEDICATION PRACTICES (ISMP) Aug. 12, 2021, https://www.ismp.org/resources/tn-board-nursings-unjust-decision-revoke-nurses-license-travesty-top-tragedy.

[8] Gabriel Cripe, *Analyzing Abuse of Prosecutorial Discretion in the RaDonda Vaught Verdict*, UNIV. OF CINCINNATI L. REV. (2022), https://uclawreview.org/2022/05/12/analyzing-abuse-of-prosecutorial-discretion-in-the-radonda-vaught-verdict/.

[9] *Supra* note 1.

Murphey's death rest on just her and/or the hospital for Ms. Murphey's death? In other words was RaDonda Vaught's criminalization as a healthcare worker cruel and unusual? Lastly, should healthcare workers in the future be concerned if they will be arrested and criminally charged for medication errors that result in the death of a patient?

Part I of this Article will lay out what is considered the duty of care for nurses. Part II will discuss the current systems used to combat medication errors. Part III will consider the criminalization of healthcare workers. Part IV will address the liability of healthcare institutions. Part V will evaluate new models to assess negligence versus culpable homicide. Lastly, Part VI will explore future healthcare reform.

I. NURSES' DUTY OF CARE

Nurses in California administer medications necessary to treat, prevent, or rehabilitate patients.[10] In doing so, nurses are to observe signs and symptoms of illness and reactions to treatments, to determine whether the signs, symptoms, reactions, behavior, or general appearances are abnormal. Standardized procedures should be based on policies and protocols developed by the health facility where a nurse practices.[11] The standardized procedures are approved by the Medical Board of California, or by the Board of Registered Nursing.[12] In addition to the duties, nurses have the responsibility of direct patient care and collective patient care.[13] Direct patient care is the care related to one patient, such as assisting with bathing, eating, or changing bed linen. Collective patient care includes tasks that are not necessarily done for one patient, such as preparation of medications, handover of the patients to the next shift nurse, and bringing a collection of samples to the laboratory.[14] As the challenges nurses face to administer medications via the "five rights" is discussed, it will become evident how nurses struggle to fulfill their duties, negatively impacting their patients' care.

A. Challenges of Medication Administration Using the Five Rights

A core responsibility of registered nurses is medication administration.[15] In the RaDonda Vaught case, the prosecutor repeatedly mentioned that Ms. Vaught failed to utilize the "Five Rights" in fulfilling her duty of medication administration.[16] The framework known as the "five rights" refers to giving, "the right patient the right drug at the right time in the right dose and by the right route." The right patient means identifying the patient before administration, either by asking the patient identification questions or reading identity bracelets and medication chart labels. Checking for the right drug entails reading the medication chart and medication packaging to match the

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[10] California Nursing Practice Act, Bus. & Prof. Code § 2725, State of California, Department of Consumer Affairs (DCA), https://www.rn.ca.gov/pdfs/regulations/npr-i-15.pdf.
[11] *Id.*
[12] *Id.*
[13] WFJM van den Oetelaar, et al., *Balancing nurses' workload in hospital wards; study protocol of developing a method to manage workload*, BMJ OPEN 5 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5129129/.
[14] *Id.*
[15] Julie-Anne Martyn et al., *The safe administration of medication: Nursing behaviors beyond the five-rights*, NURSE EDUC. IN PRACTICE 109-112 (2019), https://pubmed.ncbi.nlm.nih.gov/ 31132586/.
[16] WKRN News 2, *RaDonda Vaught Trial: State's Rebuttal Following Defense's Closing Arguments*, YOUTUBE (last visited Mar. 25, 2022), https://www.youtube.com/watch?v= KG4bNuNJYJ g&list= PLEuNcTRksDr4-D3hSCkLXeowc_FWXWQ1Z&index=2.

drug name. The right dose includes looking at the medication chart, and calculating the right dose is given. The right route involves crosschecking with the prescriber order and the medication form before administration. Lastly, the right time suggests facilitating timely medication administration when it is due to be given.[17] Clinical competence can be measured and audited for errors by assessing all five steps.[18]

Even with the "five rights" framework, safe medication administration is a challenge. In an observational study of 176 nurses, medication administration was rarely straightforward.[19] For example, in trying to identify the right patient, patients in the emergency department did not have identification bracelets, or the bracelet details were incorrect. Other times, the patient chart label was wrong. In addition, patients either displayed cognitive impairment, hearing impairment, or reduced levels of consciousness when asked identification questions about themselves by the nursing staff. The study found that nurses had to go beyond the five rights framework by applying their clinical judgment to administer medication safely.[20] With the "five rights" being held as the standard for administering medications, the framework needs to be reevaluated to account for variables.

B. Heavy Workload Contributing to Medication Error

Nurses often report heavy workload as a reason for medication errors.[21] Heavy workload consists of the ratio of demands to available resources.[22] In an observational one-month study involving a 267-bed Swiss hospital and 110 nurses, the study concluded a correlation between workload and medication errors.[23] Nurses were asked to report workload as follows: no workload, low workload, medium workload, high workload, and very high workload. An increase in workload by one unit leads to a rise in making medication errors by approximately two times more.[24] The three main reasons provided by the nurses for high or very high workload included large numbers of patients for nurses to monitor, caring for complex multimorbid patients, and being responsible for patients with complications post-surgery.[25] The study confirmed a relationship exists between reported workload and frequency of medication errors.

In a second study involving a 25-bed hospital and 23 nurses over two months, the focus was on "near misses," meaning errors that were caught before the injury occurred to a patient.[26] Workload as a variable significantly contributed to "near misses." The study evaluated the following workload factors: patient count (nurse-to-

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[17] Martyn, *supra* note 15.
[18] Martyn, *supra* note 15.
[19] Martyn, *supra* note 15.
[20] Martyn, *supra* note 15.
[21] Benjamin D. Rapphold et al., *Medication Errors Caused by Nurses and Physicians in a Swiss Acute Care Community Hospital: Frequency and Correlation to Nurse's Reported Workload*, INT'L J. OF HEALTH PROFESSIONS 14-17 (2018), https://sciendo.com/article/ 10.2478/ijhp-2018-0002.
[22] Rapphold et al., *supra* note 21.
[23] Rapphold et al., *supra* note 21.
[24] Benjamin D. Rapphold et al., *Medication Errors Caused by Nurses and Physicians in a Swiss Acute Care Community Hospital: Frequency and Correlation to Nurse's Reported Workload*, INT'L J. OF HEALTH PROFESSIONS 20 (2018), https://sciendo.com/article/ 10.2478/ijhp-2018-0002.
[25] *Id.*
[26] Amy A. Campbell et al., *Nurse's Achilles Heel: Using Big Data to Determine Workload Factors That Impact Near Misses*, J. OF NURSING SCHOLARSHIP 337-339 (2021), https://pubmed.ncbi.nlm.nih.gov/33786985/.

patient ratio), medication count, task count, call light count, average sepsis score, and 2-hr periods worked. The first five factors were shown to be statistically significant during the 2-hr periods in which "near misses" occurred ($p < .0001$). Medication count was the most effective prediction of "near misses," referring to the overall volume of medications a nurse must administer within a shift.[27] The study concluded that systematic and organizational changes need to address more than one workload factor to have an impact on reducing medication-related errors, along with recognizing the strengths and weaknesses of the individual nurses. Heavy workload contributes to medication errors and needs to be addressed to reduce the possibility of medication errors.

C. Negative Impact of Workload on Patient Outcomes

The nursing workload can be broken up into direct patient care, indirect patient care, and nonpatient care.[28] Nonpatient-focused workload is the time spent waiting for a returned page, troubleshooting, task switching, interruptions, tracking down equipment, or finding a policy needed for a care decision. In acute care, the nursing workload is used to determine staffing needs.[29] Therefore, the connection between workload and patient outcomes is straightforward because the ability to provide quality care relies on enough staff to complete all the required work. However, current workload measurement systems do not consider patient characteristics, provider capabilities, and unit or facility factors that impact workload.[30]

To illustrate, in a cross-sectional correlational study of 472 acute care nurses, heavy workloads resulted in nurses leaving essential tasks undone, and negative nurse and patient outcomes.[31] Nurse outcomes were emotional exhaustion and job satisfaction. Patient outcomes were nurse-reported frequencies of medication errors, patient falls, and urinary tract infections. Specifically, higher patient acuity was associated with medication errors and patient falls. Patient acuity refers to characteristics such as complexity and unpredictability that require nurse surveillance and intervention of a patient.[32] Nurses who experienced heavy workloads daily were six times more likely to report patient falls than nurses who experienced heavy workloads less frequently. Similarly, nurses who experienced daily interruptions were three times more likely to report patient falls on a weekly basis. Interruptions can cause a lack of focus, a delay in treatment, and an increase in the amount of time it takes to complete a task.[33] Compromised professional nursing standards on a daily basis were a strong predictor of job satisfaction. For nurses to carry out their duty of care, nursing leadership needs to identify better ways to manage nurse workload rather than leaving it to the individual nurse to fix the problems.[34] In summary, nurses face numerous challenges while administering medications following the "five rights" framework,

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[27] *Id.*
[28] Swiger et al., *Nursing workload in the acute-care setting: A concept analysis of nursing workload*, NURSING OUTLOOK 247-49 (Feb. 2016), https://pubmed.ncbi.nlm.nih.gov/26944266/.
[29] *Id.*
[30] MacPhee et al., *The Impact of Heavy Perceived Nurse Workloads on Patient and Nurse Outcomes*, ADM. SCI. 1-4 (2017), https://www.mdpi.com/2076-3387/7/1/7.
[31] *Id.*
[32] *Id.*
[33] Swiger et al., *supra* note 28.
[34] Swiger et al., *Nursing workload in the acute-care setting: A concept analysis of nursing workload*, NURSING OUTLOOK 252 (Feb. 2016), https://pubmed.ncbi.nlm.nih.gov/26944266/.

resulting in medication errors, compromised nursing standards, and adverse effects on patient outcomes.

II. ADDRESSING MEDICATION ERRORS

Medical errors are the third leading cause of death in the United States after heart disease and cancer. A 2008 report reviewed that medical errors cost the healthcare system more than seventeen billion dollars.[35] A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is controlled by the healthcare professional.[36] The U.S. Food & Drug Administration (FDA) receives over 100,000 reports each year regarding suspected medication errors. Several ways the FDA prevents medication errors include reviewing the package and product design of all new drugs, reducing similar names of old drugs with new drugs names, differentiating labels for multiple strengths of the same medication, and creating barcode technology for healthcare professionals to scan the medications that will be administered. The FDA collaborates with patient safety organizations, such as the Institute for Safe Medication Practices (ISMP).[37] In trying to apply the goals set by safety organizations such as the FDA and ISMP, the issues contributing to medication errors need to be understood. In addition, the failure to report medication errors needs to be examined. With the failure to report medication errors, there needs to be interventions to help reduce errors, and improve patient outcomes. The goal is to create a safety culture that encourage nurses to report errors and to stay in the profession.

A. Issues Contributing to Medication Errors

The most common medication errors (MEs) are wrong patient, wrong medication, wrong time, wrong dosage, and wrong route; factors are discussed above of the "five rights" framework of drug administration.[38] Issues contributing to MEs include physicians' intelligible handwriting, employees' fatigue, carelessness and distraction, inadequate pharmacological knowledge, and similarity in the names, shapes, and packaging of medications.[39] Based on a cross- sectional study of twelve hospitals and the review of 366 nurses' questionnaires, the total average of MEs for each nurse was 6.27 ± 11.95 per month. In addition, nurses with second jobs had more MEs, probably due to fatigue. Also, there was a significant correlation (p-value 0.001) between lack of work experience and several night shifts with total MEs. The increase in MEs seemed logical for night shifts due to the unconventional time of work and the tiredness of personnel.[40] By understanding the reasons contributing to MEs, institutions

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[35] Salim Aljabari & Zuhal Kadhim, *Common Barriers to Reporting Medical Errors*, HINDAWI THE SCI. WORLD J. 5 (2021), https://doi.org/10.1155/2021/6494889.
[36] *Id.*
[37] FDA, *Working to Reduce Medication Errors*, U.S. FOOD & DRUG ADMIN.,https://www.fda.gov/drugs/information- consumers-and-patients-drugs/working-reduce-medication-errors (last visited Aug. 23, 2019).
[38] Martyn, *supra* note 15.
[39] Bakhtiar Piroozi et al., *Frequency and potential causes of medication errors from nurses' viewpoint in hospitals affiliated to a medical sciences University in Iran*, INT'L J. OF HUM. RTS. IN HEALTHCARE 268-69 (2019).
[40] *Id.*

can try to implement interventions to assist nurses in reducing and preventing these errors.

B. Failure to Report Medical Errors

The most reported reason for underreporting medication errors (MEs) is fear of consequences, which includes fear of being blamed, losing one's job, legal matters, and losing the respect of coworkers.[41] Another critical reason for failure to report medication errors is administrative or organizational.[42] The administrators' responses to medication errors determines if there is an unsupportive atmosphere and a culture of blame and shame, which does not encourage incident reporting.[43] Additional reasons MEs are not reported include failure to recognize that an error occurred, or the error was not necessary to report.[44] Lastly, barriers to reporting include nurses' perception that reporting takes too much time from direct patient care or that contacting the physician to fix the error takes too long.[45] If medication errors continue to be unreported, the exact rate will remain concealed, and the leading causes of these errors will not be discovered.[46] Alternatively, some hospitals are utilizing voluntary incident reporting. Voluntary incident reporting could serve as a valuable tool to not only alert of one-time incidents but also identify and solve the causes of ongoing medication related problems.[47]

C. Plan for Reducing Medication Errors

Since 2002, the California Department of Public Health has required every acute care hospital to establish a Medication Error Reduction Plan (MERP).[48] The framework includes maintaining a medication error reporting system, creating interdisciplinary teams to analyze medication risks and errors, and annually reviewing strategic plans to reduce medication errors. The interdisciplinary medication safety committees should include pharmacists, nurses, physicians, and administrators. Past interventions have included replacing physician-written orders with computerized physician order entry (CPOE) systems, using bar-coding technology to scan for the right medication before administration, and completing medication reconciliation by nurses. Lastly, a

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[41] Baraa M. Hammoudi et al., *Factors associated with medication administration errors and why nurses fail to report them*, SCAN. J. CARING SCI. 1039-44 (2018). *See also* Salim Aljabari & Zuhal Kadhim, *Common Barriers to Reporting Medical Errors*, HINDAWI THE SCI. WORLD J. 5-6 (2021), https://doi.org/10.1155/2021/6494889.

[42] Aljabari, *supra* note 35.

[43] Aljabari, *supra* note 35.

[44] Aljabari, *supra* note 35.

[45] Aljabari, *supra* note 35.

[46] Aljabari, *supra* note 35.

[47] Gillian F. Cavell & Deepal Mandaliya, *Magnitude of error: a review of wrong dose medication incidents reported to a UK hospital voluntary incident reporting system*, EUROPE ASS'N. HOSPITAL PHARMACISTS 260-61 (Aug 2019), https://ejhp.bmj.com/content/28/5/260.

[48] Institute for Safe Medication Practice (ISMP), *ISMP Encourages Adoption of Medication Error Reduction Plans,* YAHOO! (Nov. 30, 2022), https://www.ismp.org/news/ismp-encourages-adoption-medication-error-reduction-plans.Harmeet S. Rehan & Shashikant Bhargava, *Medication Errors Are Preventable*, PHARMACOVIGILANCE (2015), https://www.walshmedicalmedia.com/open-access/medication-errors-are-preventable-2329-6887-S2-005.pdf.

medication error reporting system should provide clear information on how to report a medication error, followed by feedback.[49]

In addition, a Comprehensive Unit-based Safety Program (CUSP) encourages a local safety culture. Safety culture is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to an organization's health safety management.[50] Strategies of CUSP include educating staff members about patient safety, empowering staff to address patient safety problems on their unit, building relationships between executive leadership and unit staff, and providing tools to investigate errors.[51] The goal is to provide nurses with more education and encouragement to report medication errors. With establishing a safety culture, nurses will be encouraged to report errors. In addition, healthcare organizations will better understand the root cause of medical errors to make improvements that will decrease medication errors as a whole, improve patient outcome, and lower healthcare system costs.

III. CRIMINALIZATION

American law requires "beyond a reasonable doubt" in criminal cases to convict, "preponderance of the evidence" in most civil litigation, and "clear and convincing evidence" in a few civil matters.[52] In *Tenn. v. RaDonda Vaught*, the defendant was charged with a criminal proceeding, in which the prosecutor had the burden to prove "beyond a reasonable doubt" that Ms. Vaught was guilty of reckless homicide and gross neglect of an impaired adult.[53] The evidence must be so strong that the judge or jury is nearly certain the defendant is guilty.[54] When it comes to healthcare professionals, judges should consider first-time offenders versus repeat offenders when deciding on a judgment. In addition, courts should not be so quick to criminalize healthcare workers, keeping in mind the intent or lack thereof.

A. First-Time Offender Versus Repeat Offender

Ms. Vaught was a first-time offender with no prior criminal record.[55] The judge, considering this being her first-time offense, ordered a judicial diversion instead of a prison sentence.[56] Judicial diversion is a lesser consequence for first-time offenders, available by judicial discretion.[57] After the prosecution argued against diversion, probation was granted with the possibility of Ms. Vaught's record being expunged after

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[49] Julius Cuong Pham et al., *Reducing Medical Errors and Adverse Events*, ANNU. REV. MED. 448-56 (2012), https://pubmed.ncbi.nlm.nih.gov/22053736/.
[50] *Id.*
[51] JOHN E.B. MYERS, CALIFORNIA CRIMINAL LAW: CASES, PROBLEMS, AND MATERIALS 33 (3d ed. 2019).
[52] MYERS, *supra* note 51.
[53] Nashville.gov., *Radonda Vaught - Davidson County Criminal Court Clerk*, Nashville, Davidson County (2023), https://sci.ccc.nashville.gov/Search/CriminalHistory?P_CASE_IDENTIFIER=RADONDA%5EVAUGHT%5E01251984%5E586540.
[54] Tennessean, *RaDonda Vaught sentenced to three years probation on a diverted sentence could wipe record clean*, YOUTUBE, https://www.youtube.com/watch?v=C9fdh17EK0s (last visited Mar. 25, 2022).
[55] Vincent Maher & Mark Cwiek, *Criminal Liability for Nursing and Medical Harm*, HOSPITAL TOPICS 3-5 (2022), https://doi.org/10.1080/00185868.2022.210157.
[56] *Id.*
[57] Tennessean, *supra* note 54.

the successful completion of probation.[58] During her judgment, the judge emphasized more than once the fact that Ms. Vaught took responsibility for her actions immediately after she realized her mistake and never intended to break a law.[59]

In contrast, consider the track record of Christopher Duntsch, also known as Dr. Death.[60] From the period of 2011 to 2013, Dr. Duntsch operated on thirty-eight patients, thirty-three of which resulted in two deaths and neurologic severe injuries to the others. Dr. Duntsch clearly displayed a reckless indifference to the outcome of his surgeries. Beyond a reasonable doubt, Dr. Duntsch was found guilty of being reckless and was sentenced to life imprisonment. Thus, it is necessary for the courts to look at the facts of whether a defendant is a first-time offender or has a track record when deciding on the punishment in a criminal case.

B. Not Criminalizing Healthcare Workers

Criminal liability occurs when there is a violation of statutory criminal law, and a demonstration of mens rea, the "malice aforethought" state of mind of intent to engage in a criminal act and the actual commission of a criminal act.[61] According to the facts in Ms. Vaught's case, a routine situation became emergent when an order for versed was delayed by both the doctor who entered the orders and the first nurse who could not give the medication.[62]

Then Ms. Vaught, training another nurse, was asked to go to the positron emission tomography (PET) scan area to administer the medication. Not only was Ms. Vaught unfamiliar to where the PET scan area was, but the medication room also needed a scanner for Ms. Vaught to verify the proper medication pulled was versed, instead of vecuronium. One variable after another contributed to Ms. Vaught pulling the wrong medication. Ms. Vaught's attorney importantly pointed out the lack of "malice aforethought," when he stated, "how could a person that has no idea that they had the wrong medication when they administered it be acting with conscious disregard."[63] Yet, the prosecutor tried to convince both the jury and the judge to evaluate the facts of Ms. Vaught's case, despite no intent to harm her patient, the same as a criminal who had "malice aforethought." In the future, prosecutors should not be so quick to criminalize healthcare workers without proving intent. Allowing the precedence of the criminalization of medical errors would undermine the goal of building safety culture and non-punitive environments in hospitals.[64]

IV. LIABILITY

Malpractice claims occur when a medical provider has failed to follow a reasonable standard of care, causing patient harm. Civil malpractice cases are brought

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[58] Tennessean, *supra* note 54.
[59] Maher, *supra* note 55.
[60] Maher, *supra* note 55.
[61] Maher, *supra* note 55.
[62] WKRN News 2, *supra* note 1.
[63] WKRN News 2, *supra* note 1.
[64] Eli Y. Adashi & Glen Cohen, *Criminalizing medical errors will undermine patient safety*, NATURE MED. 2241(2022), https://doi.org/10.1038/s41591-022-01982-149.

by individuals to be awarded damages.[65] Criminal medical malpractice cases are brought before the court by government prosecutors to punish with incarceration.[66] In response, medical providers may obtain malpractice insurance, but the healthcare system bears the costs.[67] During the late 70s, mid-eighties, and early 21st century, the increase in medical malpractice suits resulted in insurance premiums going up, sometimes causing the unavailability of malpractice liability insurance.[68] In response to the "medical malpractice crisis," many states passed legislation for changes to limit the amount which could be received for pain and suffering or the total amount that could be recovered in the malpractice action, to reduce limitation periods, and to require arbitration.[69] To explore liability, it is worth learning how licensed nurses are disciplined by the board for medical errors, the type of nurse encouraging malpractice claims, and how healthcare institutions contribute.

A. The Norm for Disciplining Licensed Nurses

The California Board of Registered Nursing has the authority to discipline California- licensed nurses who are in violation of the Nursing Practice Act, under Business and Professions Code § 2750.[70] The Board of Registered Nursing looks at several factors before deciding on a disciplinary penalty: severity and recency of offense, rehabilitation evidence, current ability to practice safely, mitigating factors, and past disciplinary history.[71] An accusation must be filed to formally charge a registered nurse (RN) and to notify the public that a corrective action is pending against that nurse. Reasons to file an accusation can be for crimes ranging from embezzlement, child abuse, battery, theft from a patient, and failure to report abuse. The board applies the standard of "gross negligence," the repeated failure, to provide the required nursing care or failure to provide care or exercise precaution in a single situation in which the nurse knew or should have known, could result in patient harm.[72]

Under California Penal Code § 23, during a criminal proceeding, a judge may order that a licensee be suspended from practice as a registered nurse or be restricted in how they may practice. If probation is ordered, a RN may practice under certain restrictions for a set period of time. A suspension results in the licensee being unable to practice as a registered nurse for a set or indefinite period. Harsher actions include revoking a license temporarily until successful completion of probation or revoking or surrendering the license in which the licensee no longer has the right to practice as an RN. Licensees may file an appeal in Superior Court, requesting the Board to overturn disciplinary action.[73] In the case of Ms. Vaught, The Tennessee Board of Nursing filed

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[65] James S. Barry et al., *Is medical error a crime? The impact of the State v. Vaught on patient safety?,* J. OF PERINATOLOGY (2002), https://doi.org/10.1038/s41372-022-01481-8.
[66] PROQUEST, *Malpractice Nursing Claims Rise with Experience*, HEALTHCARE RISK MGMT. (Oct. 2018), https://www.proquest.com/docview/2114567475/AEBF7FDFAAE0489BPQ /1?Account id=14749.
[67] SCHWARTZ ET AL., PROSSER, WADE, AND SCHWARTZ'S TORTS CASES AND MATERIALS, (14th ed. 2020).
[68] *Id.*
[69] CA.Gov. *Disciplinary Actions and Reinstatements*, CA. BOARD OF NURSING (2022), https:// www.rn.ca.gov/enforcement/dispaction.shtml.
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *Id.*

a disciplinary action against her on Sep. 27, 2019 for three violations: 1) unprofessional conduct related to nursing practice and the five rights of medication administration, 2) abandoning or neglecting a patient requiring nursing care, and 3) failure to maintain a record of interventions.[74] Ultimately, the nursing board chose to discipline Ms. Vaught by revoking her nursing license indefinitely.[75] The norm for disciplining nurses ranges from probation to revoking a nurse's license permanently.

B. Malpractice Nursing Claims

Contrary to intuition, one would think a new nurse would be more likely to be sued since they would not be familiar with policies and procedures, or take longer with patients and not recognize signs of distress compared to a more experienced nurse.[76] Research by the Nurses Service Organization (NSO) shows "the more experienced a nurse is, the more likely he or she is to have malpractice claims." Several factors contribute to this finding: experienced nurses become too comfortable in their environment and let their guard down, take on more complicated cases, or become vulnerable while mentoring younger nurses.[77] Not only is there an increased likelihood for a claim to result from the negligence of an experienced nurse, the payment made to the injured third party also increases. Regarding Ms. Vaught, she had been a nurse for fourteen years. She pulled and mixed the medication without asking for a second nurse to check her. Lastly, she was training a new hire.[78] All of these factors contributed to Ms. Vaught's fatal medication error. However, NSO's research also shows that nurses who take continuing education and risk management courses have a lower incidence of malpractice lawsuits, and the payouts on claims are lower. This last finding reiterates the need for institutions to provide continuing education for both new and experienced nurses to ensure fewer malpractice nursing claims.[79]

C. The Role of Healthcare Institutions

Along with the Board of Nursing's role in disciplining nurses, healthcare institutions have a role in how they deal with the liability of healthcare professionals that cause injury to patients. Healthcare institutions vary on how they decide to handle an injury to a patient due to a practitioner's error. While one healthcare institution may provide settlements to the injured party without disciplining the healthcare professional, another hospital may only fire the practitioner or report them to the appropriate medical boards. With lack of consistency in how liability is dealt with, healthcare professionals are encouraged to carry their own malpractice insurance.[80]

Even if liability is shifted to the healthcare professional, healthcare institutions should acknowledge and take responsibility in their role, especially when they have failed to act against a negligent healthcare provider. Referring again to Dr. Duntsch, Baylor Regional Medical Center allowed Dr. Duntsch to continue operating on patients,

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[74] Craig RN, JD, *supra* note 5.
[75] Craig RN, JD, *supra* note 5.
[76] PROQUEST, *supra* note 66.
[77] PROQUEST, *supra* note 66.
[78] PROQUEST, *supra* note 66.
[79] PROQUEST, *supra* note 66.
[80] PROQUEST, *EPs, Hospitals Face Liability for ED Nurse Practitioners*, ED LEGAL LETTER (Apr. 2019), https://www.reliasmedia.com/articles/144142-eps-hospitals-face-liability-for-ed-nurse-practitioners-negligence.

despite having received warnings about his lack of competence, questionable mental stability, alcoholism, and possible drug addiction.[81] To illustrate the harm done to his patients, Jerry Summers, 2012 woke up with no movement in his limbs after Dr. Duntsch sliced an artery while performing a spinal fusion. That same year, Kellie Martin died during a laminectomy, normally usually a simple 45-minute procedure, but Dr. Duntsch sliced one of the arteries along her spine. After Ms. Martin's incident, Dr. Duntsch resigned from Baylor with full clinical privileges. Duntsch went on to operate at other facilities in the area until the Texas Medical Board suspended his license on June 26, 2013.[82] With this example, a strong argument could be made that healthcare institutions should be obligated to inform other hospitals about reckless practitioners.[83]

In Ms. Vaught's case, she continued to work at Vanderbilt University Medical Center after the death of Ms. Murphey. The hospital did not require Ms. Vaught to participate in additional education. Only when an anonymous tipster reported the institution did the institution fire Ms. Vaught.[84] In the criminal proceeding, the institution not prosecuted for their role was not reporting the sentinel event when it occurred and not disciplining Ms. Vaught immediately after the medical error. In his closing statement, Ms. Vaught's defense attorney reminded the jury of the lack of VUMC's shared liability with Ms. Vaught, the "scapegoat," the only defendant in the criminal trial.[85] Ultimately, the lesson here is for hospital credentialing and peer review committees to take a comprehensive and serious approach to review errors of healthcare professionals and to take appropriate action immediately, along with additional training for healthcare providers when sentinel events occur.

D. Criminal Liability of Hospitals

At this point, the question is to what extent are hospitals, and legal persons, responsible for the fault of a healthcare professional who injures a patient?[86] Modern criminal jurisprudence recommends establishing the criminal responsibility of legal persons by stipulating that responsibility and determining the procedure of the trial and penalties of the legal persons. Both public and private hospitals need to be responsible for the doctor's fault. Hospitals may be held criminally accountable for the crimes of the healthcare professional by means of fines and preventive measures, i.e., dissolution and suspension. The judiciary would determine the ability to pay and the return from the violation. Also, the publication of the conviction would be a way to affect the hospital's reputation. In extreme incidences, hospitals may be asked to temporarily or permanently close.[87] Lastly, healthcare institutions that do not report negligence do not deserve to have their credentials renewed or to receive government funding, i.e., Medicaid, and Medicare.

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[81] HCPro, *Malpractice lawsuits against Baylor neurosurgeon implicate hospital,* CREDENTIALING & PEER REV. LEGAL INSIDER (Jun. 2014).
[82] *Id.*
[83] *Id.*
[84] Bob Aller, *Vanderbilt Failed to Report Unnatural Patient Death*, HOSPITAL WATCHDOG (2019), https://hospitalwatchdog.org/vanderbilt-med-center-cover-up/.
[85] WKRN News 2, *supra* note 1.
[86] Dr. Khalid sabri hasani, *Criminal Liability of Hospital for Physician Error*, 19; 6 WEBOLOGY 926-31 (2022).
[87] *Id.*

In the case of Ms. Vaught, VUMC did not notify the family of the medical error or report the incident to the state for ten months, despite being legally required by the Tennessee Department of Health to report within seven days of an incident of "neglect," according to T.C.A. 68-11-211.[88] After being reported to the Centers for Medicare and Medicaid Services (CMS), VUMC cooperated in the federal investigation. According to recent updates, Vanderbilt submitted a corrective plan to CMS to address the prevention of future medication errors, but the plan has not been made public.[89] VUMC continues to receive federal funding from CMS. To this date, VUMC has not been held criminally liable, fined as a legal person, or temporarily closed. Lastly, despite nurses' letters against renewing VUMC's Magnate designation, the institution again received the credentialing last year.[90] The significance of the Magnate status is to recognize hospitals for their excellence in nursing. In conclusion, liability should not rest solely on the nurses and nursing boards. Healthcare institutions also need to be liable for their role in the rising incidence of malpractice cases.

V. NEW MODELS FOR NEGLIGENCE & MEDICAL ERRORS

Institutions abroad are implementing new models to assess negligence versus culpable homicide. Negligence implies ignorance. Thus, a negligent doctor should not be criminally liable for a lapse of concentration or error of judgment. In colloquial terms, one tries to do the right thing but actually does the wrong thing. The same cannot be said for a doctor who disregards the safety of others and is guilty of a violation.[91] New models may provide further guidance for the judicial process to evaluate whether the negligence of healthcare professionals is sufficiently gross to be adjudged criminally.

A. Deciding When Negligent Conduct Becomes Culpable

Older models examine whether death occurs and assigns blame in medical settings. Newer models consider the context in which negative events occur, assessing for both harm and culpability. For negligent conduct to be culpable, three factors must be considered: awareness, choice, and control.[92] Awareness describes when a defendant is aware of a risk and elects to omit to act or to act in a certain way. There must be an awareness of a risk of harm to others, willful blindness, or dissonance in respect of such risk. The awareness can be at the time of the event or before the incident, such as the motorist who drives at an excessive speed. Next, choice deals with when the defendant exercises a conscious choice to act or omit to act. For example, a healthcare worker makes a choice to run an unnecessary risk or has the capacity to

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[88] Craig RN, JD, *supra* note 5.
[89] Mackenzie Bean, *Vanderbilt should lose Magnet status over RaDonda Vaught's treatment, nurses say*, BECKER'S HOSPITAL REV. (Aug. 5, 2022), https://www.beckershospitalreview. com/nursing/vanderbilt-should-lose-magnet-status-over-radonda-vaught-s-treatment-nurses-say.html.
[90] *Id.*
[91] Robson et al., *Doctors Are Aggrieved - Should They Be? Gross Negligence Manslaughter and the Culpable Doctor*, THE J. OF CRIM. L. 313 (2020), https://journals.sagepub.com/doi/full/10.1177/0022018320946498.
[92] *Id.*

refuse to work. The last factor is control. Control is present when a person can alter the chain of events.[93]

In looking at culpability in the RaDonda case, the prosecutor accused Ms. Vaught of being aware when her willful blindness resulted in her pulling vecuronium, instead of versed.[94] In regard to choice, Ms. Vaught made a choice to ignore the warning messages from the medication cabinet. Lastly, the prosecutor stated that Ms. Vaught could have refused to pull the medication for her co-worker. However, the element of control was missing because she had no control over the lack of staff coverage. Hence, Ms. Vaught's actions were negligible, and not culpable. To conclude, the justification of criminal liability should not depend on if the patient dies but on whether the conduct should be judged.[95]

B. The Sliding Scale of Negligence

In New Zealand, criminal prosecution for medical manslaughter has been abandoned.[96] Criminal law is only applied to healthcare settings in cases of deliberate harm or recklessness. To summarize, the grossness of the negligence per se should be the necessary mens rea, instead of the defendant's state of mind. Their "sliding scale of negligence" test focuses on the defendant's conduct. The point of the "sliding scale of negligence" test is to evaluate how far below an endpoint of the scale is reached. If the defendant's behavior is illogical, the negligence should be adjudged as gross and culpable.[97]

The first point on the scale is the Bolam test, which defines the standard of care for a professional, meaning "the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill…it is sufficient if he exercises the 'ordinary skill of an ordinary competent man' exercising that particular art." [98]The next point is whether the defendant's actions are illogical or grossly unreasonable, "[w]here a judge can be satisfied that the body of expert opinion 'cannot be logically supported at all' that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed." A grossly negligent doctor is considered to have behaved "illogically" where there has been a blatant disregard for accepted practice or adherence to an outdated practice. Essentially, they have failed to recognize the risks in their approach which could cause the death of a patient.[99] Once the illogical marker is met, culpability is considered.

The "sliding scale of negligence" test has four categories of culpability and one level of harm. At the most serious end, the offender shows a blatant disregard for a very high risk of death resulting from the negligent conduct, whereas the lower end includes

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[93] Robson et al., *Doctors Are Aggrieved - Should They Be? Gross Negligence Manslaughter and the Culpable Doctor*, THE J. OF CRIM. L. 326-29 (2020), https://journals.sagepub.com/doi/full/10.1177/0022018320946498.
[94] WKRN News 2, *supra* note 15.
[95] Robson, *supra* note 93.
[96] Robson, *supra* note 93.
[97] Robson, *supra* note 93.
[98] Robson, *supra* note 93.
[99] Robson, *supra* note 93.

the offender's actions as a 'lapse' in an otherwise satisfactory standard of care.[100] In addition, the approach reduces the seriousness of the offense with mitigating circumstances, such as the offender lacking the necessary expertise which contributed to the negligent conduct, the offender being subject to stress or pressure, the negligent conduct occurring in circumstances where there was reduced scope for exercising usual care and competence, and the negligent conduct was compounded by the actions or omissions of others.[101] In deciding Ms. Vaught's judgment, the judge looked at mitigating factors under TCA 40-35-113, in which the defendant committed the offense under such unusual circumstances that it is unlikely that a sustained intent to violate the law motivated the criminal conduct.[102] To reiterate, the "sliding scale of negligence" model focuses on the conduct itself to determine culpability, instead of trying to determine the mens rea.

C. Unified Approach to Tackling Medical Errors

In looking at both Ukrainian and participating countries of the European Court of Human Rights (ECHR) practice, the lack of a unified approach to understanding and tackling medical errors were believed to be a factor in the failure to establish leading legal practices of national courts.[103] The Convention for the Protection of Human Rights and Fundamental Freedoms established Article 2, which is the right to life, which implies both negative and positive obligations of the state. In an attempt to comply with Art. 2, ECHR's suggested three approaches in understanding medical error. First, a medical error is seen objectively, as an unlawful action with negative social consequences. Second, a medical error is understood as a result of good faith deceit and a result of the committed negligence. Third, any departure from medical standards, including protocols, is a medical error.[104]

The ECHR's position on medical error and carelessness of healthcare workers is as follows: 1) errors of judgment of a healthcare worker, meaning the negligence in coordinating the actions of such workers during the treatment of a patient, are not sufficient to hold the state liable for the fulfillment of positive obligations under Art. 2 of the Convention, 2) the national system of law, to prevent medical negligence, should provide for remedies for victims in criminal courts and/or in civil courts, 3) medical errors should be evaluated in disciplinary bodies.[105] Medical error is defined as the innocent action (act or omission) of a healthcare professional that has caused or could cause potential harm to a patient's health and which results from a deliberate deception.[106] Medical negligence is the failure to perform or improper performance of professional duties by a healthcare professional as a result of a negligent or dishonest

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[100] Robson et al., *Doctors Are Aggrieved - Should They Be? Gross Negligence Manslaughter and the Culpable Doctor*, THE J. OF CRIM. L. 337 (2020), https://journals.sagepub.com/doi/full/10.1177/0022018320946498.
[101] *Id.*
[102] Tennessean, *supra* note 54. *See also* TENN. CODE *§ 40-35-113* (JUSTIA 2019), 2019 *Tennessee Code Title 40 - Criminal Procedure Chapter 35 - Tennessee Criminal sentencing Reform Act of 1989 Part.*
[103] Liudmyla Dobroboh et al., *Medical Illegality and Errors in the Leading Legal Practice*, ADVANCES IN SOC. SCI., EDUC., AND HUMAN. RSCH. 55-58 (2020), http://creative commons.org/licenses/by-nc/4.0/.
[104] *Id.*
[105] *Id.*
[106] *Id.*

attitude that has caused or could cause harm to a patient's health.[107] Due to the difference in medical error and medical negligence, events involving either that result in an injury to a patient's health should be recognized differently and dealt with differently.[108] In establishing a unified approach, national courts can have a consistent standard for evaluating medical errors.

VI. NEED FOR HEALTHCARE REFORM

Reform is needed to aid the current nurses in the healthcare system before more nurses leave the profession. Over two years of fighting the pandemic have resulted in an all-time high of burnout and a mass exodus of nurses.[109] According to the U.S. Bureau of Labor Statistics, in just 2022, 1.7 million people quit healthcare. In a recent survey of 1,000 healthcare professionals, the reason cited for quitting was burnout.[110] Nurses are either quitting to take higher paying traveling positions or choosing to retire early.[111] As mentioned before, patient outcomes and medical errors are affected by a shortage in staffing.[112] The effect of nursing shortages on the future of healthcare will be discussed. The interventions on how to improve the current situation for nurses will be listed. In regard to healthcare institutions, oversight needs to be provided with clear policies and protocols. Lastly, recent changes in legislation will predict where the profession of nursing and nursing reform is headed.

A. Nursing Shortages After the Pandemic

A perfect example of the nursing shortage after the pandemic occurred in the Northeast Hospital Corporation (NHC), a health system in Massachusetts.[113] Starting in 2020, their nurses were quitting in the masses. Unsafe staffing due to high patient acuity and low wages were issues long before the pandemic. However, with NHC prioritizing its profit margins over nurse and patient safety, even during the pandemic, the existing situation became worse. Nurses were placed in danger of providing compromised patient care during the public health crisis of COVID-19. Hospital administrators understaffed the hospitals to generate greater operating margins. In 2020, NHC had a profit margin of 12.8%, five times more than the state average. As a result,

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[107] *Id.*
[108] Dobroboh et al., *supra* note 103.
[109] Deb Gordon, *Amid Healthcare's Great Resignation, Burned Out Workers Are Pursuing Flexibility and Passion*, FORBES (May 2022), https://www.forbes.com/sites/debgordon/ 2022/05/17/amid-healthcares-great-resignation-burned-out-workers-are-pursuing-flexibility-and-passion/?sh=5339afd57fda.
[110] *Id.*
[111] Hailey Mensik, *Third of nurses plan to quit their jobs by end of 2022, survey shows,* HEALTHCAREDIVE (Mar. 2022), https://www.healthcaredive.com/news/nurse-burnout-covid-quit-travel-incredible-health/620488/; *See* MacPhee *supra* note 30.
[112] *Id.*
[113] David Schildmeier, *MNA: Years of Understaffing Exacerbated by Pandemic Drives 40% Loss of Nursing Staff at Northeast Hospital Corporation (Beverly Hospital & Addison Gilbert Hospital in Goucester) in the Last Three Years: Mass Resignation of North Shore nurses is the Latest Manifestation of a Statewide Crisis in Nursing Care as Hospital Corporations Like Northeast Hospital Corp Sacrifice Nursing and Patient Safety to Boost Profit Margins,* PR NEWSWIRE ASSOC. LLC., 2022.

the organization experienced an unprecedented loss of 322 nurses in 2022, 40% of the hospital's nursing staff.[114]

Commenting on the nursing profession as a whole, the American Nurses Association (AMA) notes that nursing shortages were already a problem before the pandemic. Factors included retiring nurses outpacing new entrants, an increase in demand for healthcare from aging and chronic disease populations, and an inadequate workforce.[115] These existing factors, combined with a surge in demand for nurses during the pandemic, worsened the nursing shortage and exposed the challenges nurses face in the workplace. As a result, the U.S. Bureau of Labor Statistics projects over 200,000 openings for registered nurses over the decade.[116] Also, high turnover of nursing staff translates to higher costs for training new nurses or using temporary staff.[117] With the aging population, healthcare cannot afford to have a shortage of nurses.

B. Interventions by Healthcare Organizations to Assist Nurses

Referring back to the findings by the Nurses Service Organization (NSO), research indicates that nurses who take continuing education and risk management courses have a lower incidence of malpractice lawsuits.[118] Thus, healthcare organizations clearly need to invest in training for both new and experienced nurses. Not only should risk managers encourage nurses to keep up with trends in healthcare, but they also should implement a peer review process for all the nurses to ensure continued compliance with policies and procedures, as well as best practices and clinical standards.[119]

Also, burnout in nurses decreases with interventions that improve work organization. Improvements in work organization consist of work pace and work shifts based on staff preferences.[120] The organization can influence job satisfaction by increasing support with greater teamwork and improving relationships with managers. With a decrease in workload, nurses can focus on recording medical history, which facilitates the transmission of information without errors and omissions.[121] In addition, another staff member can handle the responsibility to admit, discharge, and transfer patients. Lastly, organizations can employ teams to handle the transport of patients, initiate intravenous therapy, and transport laboratory specimens. Thus, the nurses can spend more time on tasks which require skilled nursing knowledge and assessment.[122]

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[114] *Id.*
[115] ANA, *Nurses in the Workforce*, AM. NURSES ASS'N., https://www. nursingworld.org/practice-policy/workforce/ (last visited Apr. 3, 2023).
[116] Occupational Outlook Handbook, *Registered Nurses*, U.S. BUREAU OF LAB. STAT. (last visited Apr. 4, 2023), https://www.bls.gov/ooh /healthcare/registered-nurses.htm.
[117] WFJM van den Oetelaar, et al., *supra* note 13.
[118] PROQUEST, *supra* note 66.
[119] PROQUEST, *supra* note 66.
[120] Perez-Francisco et al., *Influence of Workload on Primary Care Nurses' Health and Burnout, Patients' Safety, and Quality of Care: Integrative Review*, HEALTHCARE 8-10 (2020), https://pubmed. ncbi.nlm.nih.gov/31947761/.
[121] *Id.*
[122] Swiger, *supra* note 28.

Speaking of alternatives, telenursing through telephone calls or video conferencing is a viable option.[123] Benefits of telecare for the healthcare system include fewer readmissions, better therapeutic control, improvements in diseases, and fewer in-person consultations. By having virtual nursing programs, the burden on bedside nurses is eased with virtual nurses performing tasks that do not require physical proximity, such as handling admissions interviews, discharge instructions, and medication instructions. The virtual nurses can be assigned a group of patients for whom they provide care for their shift duration.[124] With more nursing staff to monitor each patient, detection of rapid changes in patient condition is improved because staff will know early to respond before a patient's condition worsens. In addition, nurse managers can better optimize nurse-to-patient ratio and patient acuity due to added support of the telecare nurses.[125]

Finally, good workload management helps to keep employees healthy as a high workload is a predictor for burnout and absenteeism.[126] In developing a nursing workload management method, it needs to be easy to interpret, be applicable to different types of hospital wards, and cover all activities of nurses, both direct and indirect patient care. Direct patient care may include activities from assisting patients with bathing or eating, handing out medication, changing bed linen, or helping with wound care. Indirect patient care may include activities that facilitate patient turnover, mandatory registrations, communication with family, etc.[127] A well-developed nursing workload management method will provide both guidance and consistency in patient care. Overall, the various interventions discussed creates a collective responsibility between nursing leadership and direct care nurses in better managing nurse workload, which in turn ensures delivery of nurse satisfaction and high-quality patient care.

C. Credentialing & Oversight Programs at Healthcare Institutions

External organizations exist whose function is to audit healthcare institutions, such as The Joint Commission (TJC).[128] TJC is an independent, not-for-profit organization that accredits more than 20,000 US healthcare programs and organizations. TJC provides unbiased assessments of the organization's achievement in patient care and safety. TJC looks at factors such as multitasking, interruptions, worker fatigue, etc., with the aim of avoiding medical errors and identify non-compliance. With successful certification, hospitals are awarded accreditation. Accreditation assists hospitals in obtaining liability insurance and receiving support from the state and federal government for Medicare and Medicaid. However, TJC only reviews each hospital every two to three years to reevaluate patient care and safety.[129]

Hence, healthcare institutions need to develop their own oversight programs to regularly evaluate patient care and safety. To illustrate, in developing a plan to optimize

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[123] Perez-Francisco, *supra* note 120.
[124] AHA, "5 Imperatives to Scale a Virtual Nursing Program, AM. HOSP. ASS'N. (last visited Apr. 4, 2023), https://www.aha.org/aha-center-health-innovation-market-scan/2023-02-28-5-imperatives-scale-virtual-nursing-program.
[125] *Id.*
[126] WFJM van den Oetelaar, et al., *supra* note 13.
[127] Swiger, *supra* note 28.
[128] Roopma Wadhwa & Annie P. Boehning, *The Joint Commission*, STATSPEARLS PUBLISHING LLC. (Mar. 16, 2023).
[129] *Id.*

in-hospital stroke care, an in-hospital stroke quality oversight program is recommended to provide data-driven performance feedback and drive targeted quality improvement efforts.[130] The board would consist of various healthcare professionals who set clear and measurable goals for improvement.[131] Participating disciplines for stroke quality could include neurology, internal medicine, neurocritical care, neurosurgery, neuro-interventional radiology, and nursing. Also, an oversight board would aid in translating complex therapies, often dictated by current treatment guidelines, to treating patients in an easy-to-understand process and in standardizing protocols. Without standardized protocols and quality benchmarks, diagnosis and management may be delayed.[132]

Effective protocols for in-patient stroke treatment include staff education, a simplified assessment method, a defined in-hospital alert activation system, and a dedicated team to respond to code stroke alerts.[133] Education may include pocket cards, posters, in-service lectures, grand rounds, and case simulations. Feedback should be provided after each code and reviewed at least semiannually in a nonpunitive and constructive manner. Written protocols should be used to expedite treatment and to ensure consistency. Developing written checklists to use on the floors would solve the issue of lack of familiarity with the protocol or inconsistent adherence. The last task is for the board to review and track their performance through the collection and analysis of internally generated data, which in turn gives feedback on how to reach national benchmarks. In the end, high-performing hospitals, with accreditation and oversight, tend to have better outcomes in regard to quality than hospitals that do not.[134]

D. Legislation by Congress for Nursing Reform

Safe nursing staff legislation is necessary and has caught the attention of Congress. In May of 2021, Congress introduced S.1567: Nurse Staffing Standards for Hospital Patient Safety and Quality Act.[135] The bill was referred to the United States Senate Committee on Health, Education, Labor, and Pensions. The committee is currently made up of twenty-one members. Public health falls under the jurisdiction of the Committee. The makeup of the committee varies from past and present politicians from various parties, i.e., Bernie Sanders of the Independent Party as majority leader to minority members such as Mitt Romney of the Republican Party.[136] The Nurse Staffing Standards for Hospital Patient Safety and Quality Act aims to amend the Public Health Service Act and create a federal standard for safe nursing staffing ratios. The impotence of the bill was the decrease in healthcare employment seen in 2020. The bill hopes to reduce the negative impact low staffing can have on the health of nurses and their patients. The Committee recognizes that improper staffing can lead to more mistakes and less patient satisfaction, as well as burnout for nurses and the impotence to leave

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[130] Nouh, et al., *Identifying Best Practices to Improve Evaluation and Management of In-Hospital Stroke: A Scientific Statement from the American Heart Association*, STROKE 165-72 (Apr. 2022).
[131] *Id.*
[132] *Id.*
[133] *Id.*
[134] Ross Millar, et al., *Hospital Board Oversight of Quality and Patient Safety: A Narrative Review and Synthesis of Recent Empirical Research*, THE MILBANK QUARTERLY 738 (2013).
[135] Whitney Sandoval, *Updates on Safe Staffing Legislation in the U.S.*, BC BEST COLLEGES (Aug. 2022), https://www.bestcolleges.com/nursing/safe-staffing-legislation/.
[136] U.S. Senate Committee on Health, Education, Labor, and Pensions, https://www. help.senate.gov (last visited Apr. 3, 2023).

the profession.[137] As of March 2022, sixteen states have laws or regulations to address nurse staffing in hospitals.[138] At present, there is no federal standard.

Instead of assigning nurses to a general number of patients, the bill categorizes the number per department.[139] The ratio is broken down to account for various departments within a hospital. The ratio factors in the demand nurses will most likely encounter with patients in each unit, i.e., one nurse for one patient in a trauma emergency unit, one nurse for two patients in critical care, etc.[140] In addition, a nurse will have federal protection against employer retaliation if staffing ratios are not followed. Also, the legislation accounts for the demonstration of unit-specific competence, meaning the direct care registered nurse must demonstrate current competence. Employers will be mandated to have a staffing plan for the nurse staffing ratios that must be posted ahead of time, and must be updated annually.[141] Once the bill passes, hospitals will have two years to comply. By being mindful of safe staff-to-patient ratios, healthcare facilities can increase positive patient outcomes and decrease mistakes, which will decrease nursing burnout.[142] With federal legislation, consistent application of nurse-to-patient ratio will have a consistent application across all the states and have the federal government's power behind it.

CONCLUSION

RaDonda Vaught's case was not the first time a healthcare professional has been charged in criminal court and may not be the less. However, her case was unique because the media publicly brought a nurse's negligence to light and sensationalized her. Healthcare workers from across the nation rallied outside her trial because RaDonda Vaught's criminalization as a healthcare worker was considered cruel and unusual. As discussed in length, all the factors which possibly led to her medication error have long been building up in the nursing profession. The prosecutor focused on Ms. Vaught's individual conduct while her defense lawyer emphasized how the healthcare system has failed his client. The healthcare system made Ms. Vaught the "scapegoat" for all the problems that had escalated at the healthcare institution to which she was employed at, as if only one person is responsible for the care of a patient.

Before society is quick to criminalize healthcare professionals, the legal profession must consider the difficulty nurses have in carrying out their duty of care with the "five rights." Nurses administer medications in unsafe settings exacerbated by the healthcare institutions that employ them. Healthcare institutions should strive to improve systems to combat medication errors. In addition, hospitals need to encourage a safety culture to report errors, which will provide lessons on how to avoid the same mistake in the future. Otherwise, medication errors will continue to be made and be underreported.

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[137] Library of Congress, *S.1567 - Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2021,* CONGRESS.GOV, https://www.congress.gov/bill/117th-congress/ senate-bill/1567/text.
[138] Sandoval, *supra* note 135.
[139] Library of Congress, *supra* note 137.
[140] Library of Congress, *supra* note 137.
[141] Library of Congress, *supra* note 137.
[142] Library of Congress, *supra* note 137.

Traditionally, liability in a criminal case has relied on the defendant's mens rea. Except for extreme cases of culpable and reckless practitioners, medical errors by healthcare professionals lack the intent to harm. New models account for the context in which healthcare professionals must make decisions before determining if the level of negligence is culpable. With new models and a unified approach to tackling medical errors, courts will have guidance on deciding the appropriate judgment, instead of using the current model and convicting healthcare professionals as we would criminals who have the intent to break the law.

Instead of putting all our resources into criminalizing healthcare workers in the future for medication errors, let's focus instead on providing the support the nurses need to carry out their duties, including sharing liability amongst healthcare managers and healthcare organizations. Healthcare organizations need to be held accountable for how they proceed in disciplining negligent or reckless healthcare staff. In addition, the management of these healthcare institutions needs to work on improving workload management. Lastly, healthcare institutions need to be regulated, not only by external organizations but also by internal oversight boards to regularly ensure patient safety and care improvement. As seen, the healthcare system has not supported its nurses, especially during the pandemic, resulting in massive numbers of nurses either retiring early or resigning when we need them the most. Essentially, Ms. Vaught's case was a wake-up call to Congress that reform is necessary in the form of federal legislation consistent amongst all the states. Otherwise, our country will face an uncertain future with insufficient nursing staff to handle the increasing, aging population.

WOMB FOR RENT: A SURROGATE'S PERSPECTIVE ON SURROGACY AND ITS REGULATION

Julia Mahoney*

Abstract: As a three-time gesational surrogate and a current law student, I have a unique view on surrogacy laws and regulations. The accessibility of commercial surrogacy is surrounded by uncertainty and controversy, which has a great impact on hopeful intended parents and where they choose to begin their surrogacy journey. Additionally, laws regarding using a surrogate for assisted reproductive technology (ART) are rapidly changing, making the decision more complex and confusing. This paper starts with my own experiences with surrogacy in different states to provide a backdrop and some context for why surrogacy regulations matter. I continue with a brief overview of surrogacy in the United States and a couple of the most influential cases. Next, I consider the arguments presented for federal vs. state legislation. I end the paper with suggested legislation for surrogacy contracts at the state level, providing reasoning to overcome many of the common anti-surrogacy arguments. I look to the state of Minnesota to provide background and context. However, the proposed legislation is relevant to many states in a similar position as Minnesota, having no current surrogacy legislation.

Keywords: Surrogate; Surrogacy; Assisted Reproductive Technology; ART; Fertility; Legislation; Minnesota

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INTRODUCTION

Currently, each state regulates surrogacy contracts its own way, leading to a variety amongst states regarding laws, and often leading to uncertainty regarding legal parentage and the enforceability of surrogacy contracts. While federal statutes regarding surrogacy would be ideal, states should enact regulations at the state level governing surrogacy contracts and requirements which would make surrogacy safer for all parties involved. This paper focuses on how a state can legislate surrogacy locally and why it should do so in today's shifting political landscape.

In this paper I will first give a brief introduction to surrogacy, explaining the different types of surrogacies, and why it is still needed and desirable when adoption is an option. Next, I will provide a brief history of surrogacy in the United States and review two of the most influential cases that have shaped American surrogacy laws, followed by an overview of current state of laws within the U.S. I will then provide an overview of arguments for legislating surrogacy at the federal or state level. Finally, I propose legislation and offer reasoning that acknowledges many of the anti-surrogacy arguments. To do this, I will focus on the state of Minnesota, providing reasons why Minnesota should choose to pass legislation on surrogacy, and a brief history of the attempts Minnesota has made to legislate surrogacy in the past. Focusing on Minnesota allows me to provide context and case history. However, many states are in the same position as Minnesota, having no current surrogacy legislation. The proposed legislation in the final section is relevant and applicable to many states in a similar situation.

I. MY PERSONAL SURROGACY EXPERIENCE

I decided to become a surrogate after having my first, and only, child. I felt extremely lucky to have been able to have a child after my husband was diagnosed with cancer at the age of twenty-five. Because of the uncertainties involved, he had to stop his medication for a few months before we could conceive. A couple years later, I knew I wanted to help people that had no other way to have families of their own.

My first two surrogacies occurred while I lived in California. I used a surrogacy agency whose main purpose was to match willing women to couples looking for a surrogate and help them navigate the complicated process of creating a family through surrogacy.[1] My first surrogacy was for a traditional couple, husband and wife, from Florida. She had a medical condition and knew from a young age she could never carry a child. Using a donor egg and the father's sperm, they had a little girl. When they held their baby for the first time and I saw the look on their faces, it was such a fulfilling feeling that I knew I wanted to help another couple become a family. I was quickly matched up with a gay couple from Texas. They used one intended father's sperm and chose an egg donor that resembled the other intended father. They had twin girls.

My third surrogacy was a couple years later when I was living in Minnesota. I was signed up with the agency as an available surrogate but because of the lack of legislation in Minnesota, it took many months before some intended parents were willing to work with me. Due to the Minnesota process requiring a post birth order of parentage, the parents were nervous that I would want to keep the baby and would

[1] A PERFECT MATCH, https://www.aperfectmatch.com (last visited Nov. 18, 2025).

refuse to give up my parental rights as the birth mother after the child was born. We had a successful surrogacy experience, and they had twins, a boy and a girl. However, after they were born, only the father's name could go on the birth certificate. I still had to go through the process of surrendering my rights as a parent so their mother's name could be included on the birth certificates. It felt very strange going through the process of giving up parental rights to children that were never mine to begin with. That experience is ultimately what inspired me to address the topic of surrogacy legislation in Minnesota.

II. BACKGROUND

In general, a surrogate mother ("surrogate") is "a woman who becomes pregnant… for the purpose of carrying the fetus to term for another person or persons."[2] There are two types of surrogacies within the world of assisted reproductive technology ("ART"). A traditional surrogacy is when the surrogate uses her own egg and is impregnated by artificial insemination.[3] This can also be referred to as "genetic surrogacy."[4] Since the child that results from this kind of surrogacy is genetically related to the surrogate mother, a surrogacy contract with a traditional surrogate agreeing to give up her parental rights after the child is born is usually held to be unenforceable in courts in cases where the surrogate mother changes her mind and no longer wants to surrender the child.[5]

A gestational surrogacy is when the surrogate carries a child created from an egg that is not hers and if she is married, sperm not from her husband.[6] The egg and sperm are used to create an embryo in a lab through in vitro fertilization ("IVF").[7] The gestational surrogate, or gestational carrier ("GC"), prepares her body in advance to receive the embryo by taking medications.[8] The embryo is then implanted into her uterus and she carries the fetus to term.[9]

The people entering into contract with a surrogate are referred to as Intended Parents ("IPs"). The couple may be an Intended Mother ("IM") and Intended Father ("IF"), just one IP, two IFs, or two IMs if neither can carry a pregnancy.[10] The resulting embryos can range from being one hundred percent genetically related to the IPs using the IM's egg and IF's sperm, using a donor egg and the IF's sperm, using the IM's egg and donor sperm, or using both donor egg and donor sperm.[11] From a legal perspective, gestational surrogacy is generally considered the safer alternative to traditional

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[2] *Surrogate Mother*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/surrogate%20mother (last visited Mar. 12, 2025).
[3] MAUREEN MCBRIEN & BRUCE HALE, ASSISTED REPRODUCTIVE TECHNOLOGY: A LAWYER'S GUIDE TO EMERGING LAW AND SCIENCE 137 (3d ed. 2018).
[4] *Id.*
[5] *Id.* at 139.
[6] *Id*.
[7] *Gestational Surrogacy,* CLEVELAND CLINIC (June 7, 2022), https://my.clevelandclinic.org/health/articles/23186-gestational-surrogacy.
[8] *Id*.
[9] *Id*.
[10] *Id*.
[11] MCBRIEN & HALE, *supra* note 3, at 140.

surrogacy, with fewer legal complications because of the lack of genetic connection between the surrogate and baby.[12]

IPs seek out surrogates for many reasons. An IM may be infertile due to a medical issue with her uterus, she may not be able to get pregnant without putting herself or the fetus at risk, or she may have had a hysterectomy.[13] Some IPs may be biologically incapable of bearing a child, such as a single man or a gay couple.[14]

III. SURROGACY OR ADOPTION

The choice to adopt or use a surrogate to grow a family is subjective to the needs and desires of each couple.[15] Adoption is less expensive than surrogacy.[16] However, with a surrogacy, IPs have more control over who is carrying the child and the genetics of the child, whether they are biologically related to either IP or come from a similar gene pool as the IPs.[17]

Many barriers to adoption also make surrogacy a more viable option. With infertility rates rising, the interest in adoption is also rising.[18] According to American Adoptions, one of the largest adoption agencies in the US, there are currently over two million families waiting to adopt a baby.[19] Additionally, the birth mother often chooses who will adopt her baby.[20] Some adoption agencies also place restrictions based on age, geography, and marital status.[21] Simply put, adoption is not always an option for couples to have a baby.

IV. HISTORY OF SURROGACY IN THE US

Two of the most influential surrogacy cases in the US, *In Re Baby M* and *Johnson v. Calvert*, seem to be at opposite ends of the spectrum.[22] *In Re Baby M* from 1988 dealt with a surrogacy contract involving a traditional surrogate.[23] *Johnson v. Calvert* from 1993 considered a surrogacy contract involving a gestational surrogate and contained a vastly different ruling.[24]

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[12] *Id*. at 141.
[13] *Gestational Surrogacy, supra* note 7.
[14] *Id.*
[15] *Surrogacy vs. Adoption*, MODERN FAM. FORMATION L. OFFS., https://www.modernfamilyformation.com/surrogacy-vs-adoption (last visited Nov. 18, 2025).
[16] *Id.*
[17] *Id.*
[18] W. Marshall Prettyman, *The Next Baby M Case: The Need for a Surrogacy Statute*, 18 SETON HALL L. REV. 896, 897 (1988).
[19] *How Many Couples are Waiting to Adopt a Baby?*, *AM. ADOPTIONS*, https://www.americanadoptions.com/pregnant/waiting_adoptive_families (last visited Nov. 18, 2025).
[20] *Id.*
[21] As an example, Catholic Charities of Southern Minnesota requires the adoptive couple live in a certain region, be married at least two years, be under the age of 45, and have experienced infertility and no longer seeking fertility treatments. *See Domestic Infant Adoption*, *CATH. CHARITIES OF S. MINN.*, https://www.ccsomn.org/adoption-program-page/domestic-infant-adoption/ (last visited Nov. 18, 2025).
[22] *See* Susan L. Crockin, Meagan A. Edmonds & Amy Altman, *Legal Principles and Essential Surrogacy Cases Every Practitioner Should Know*, 113 FERTILITY & STERILITY 908, 909, 913 (2020), https://doi.org/10.1016/j.fertnstert.2020.08.030.
[23] *In re* Baby M, 537 A.2d 1227 (N.J. 1988).
[24] *Johnson v. Calvert,* 851 P.2d 776 (Cal. 1993).

In the *Baby M* case, IPs Mr. and Mrs. Stern contracted with Mrs. Whitehead in New Jersey to be a surrogate and have a baby via artificial insemination using Mr. Stern's sperm. Upon delivery of the child, Whitehead would receive $10,000 and all medical bills paid.[25] However, when the surrogate delivered the child, she had second thoughts and wanted to keep the baby girl.[26] She brought her home from the hospital and did not turn her over to the Sterns for three days.[27] The day after she surrendered the child, Whitehead told the Sterns how distraught she was without the baby and could not live without her.[28] Fearing for Whitehead's life, the Sterns turned the baby back over to her upon the promise that she would be returned to them in one week.[29] Instead, Whitehead fled to Florida.[30] Mr. Stern then filed suit for the enforcement of the surrogacy contract.[31] The New Jersey trial court held that the contract was valid and Whitehead's parental rights should be terminated.[32] However on appeal, the New Jersey Supreme Court held that the surrogacy contract was void and unenforceable because it violated New Jersey statutes which prohibited payment in exchange for the adoption of a child, and because surrendering parental rights could only be done after a child is born, not beforehand.[33] As Mrs. Whitehead was the genetic mother and Mr. Sterns the genetic father, the Court determined custody of the child would go to Mr. Sterns using the best interests of the child parameters.[34] As a result of this outcome, Baby M has "has long been held up as a cautionary tale for surrogacy and has had a significant impact in restricting both traditional, genetic surrogacy in many states and compensated surrogacy of any type in a few states."[35]

Johnson v. Calvert is at the other end of the spectrum, with a gestational surrogate instead of a traditional surrogate, and a ruling that favored the IPs and upheld the contract, looking at the intentionality of the parties involved as a key deciding factor in the case.[36] The Calverts contracted with Johnson to be their surrogate using IVF.[37] The embryo was created using Mrs. Calvert's egg and Mr. Calvert's sperm.[38] In return for carrying the child to term for the Calverts, Johnson would receive $10,000 paid in installments.[39] In February 1990, Johnson found out that the embryo transfer was successful and she was pregnant.[40] However, the relationship between the parties deteriorated, and in July 1990, Johnson demanded the balance of the payment, threatening to refuse giving up parental rights to the child.[41] The Calverts then initiated a lawsuit to be declared the legal parents and Johnson responded with her own suit to be declared the legal mother.[42] The trial court upheld the surrogacy contract and

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[25] *Baby M,* 537 A.2d at 1235.
[26] *Id.* at 1236.
[27] *Id.*
[28] *Id.*
[29] *Id.* at 1237.
[30] *Id.*
[31] *Baby M,* 537 A.2d at 1237.
[32] *Id.*
[33] *Id.* at 1240.
[34] *Id.* at 1261.
[35] Crockin, *supra* note 22, at 909.
[36] *Johnson v. Calvert,* 851 P.2d at 782.
[37] *Id.* at 778.
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Johnson v. Calvert,* 851 P.2d at 778.

declared the Calverts the legal parents of the baby who had been born that September.[43] Upon review by the Supreme Court of California, the decision was upheld.[44] The Court emphasized regarding the Calverts that "[b]ut for their acted-on intention, the child would not exist," and further emphasized that the Calverts had not intended to donate an embryo to Johnson.[45] Regarding the payments made to Johnson, the Court held that the payments were compensation "for her services in gestating the fetus and undergoing labor, rather than for giving up 'parental' rights."[46]

As the earliest reported surrogacy dispute, the decision in *Baby M* is touted as a cautionary tale and warning against surrogacy, and was instrumental in many states banning traditional surrogacy or prohibiting the compensation of surrogates.[47] For example, after *Baby M*, New Jersey common law prohibited traditional surrogacy agreements, and New York refused to hold any surrogacy agreements as enforceable, whether a traditional or gestational surrogate was used.[48] In an article for the *American Journal of Law & Medicine* urging for legal unity and federal legislation of surrogacy, Eric A. Feldman, JD, PhD; Professor of Law and Professor of Health Policy and Medical Ethics at the University of Pennsylvania Law School, wrote, "For the past three decades, the Baby M case has cast a shadow over the regulation of surrogate motherhood in the United States, despite fundamental changes in both science and society."[49]

Since *Johnson v. Calvert,* "[s]everal states by statute or case law have determined that legal parentage can be established for intended parents either prior to the birth of the child... or at, or shortly after, the birth of the child."[50] The case is also still being used as legal precedent in surrogacy disputes, arguing that the intent to have a child should be the deciding factor regarding parenthood.[51]

V. SURROGACY IN THE UNITED STATES CURRENTLY

Surrogacy contracts are treated differently across the United States.[52] Some states have legislation favorable to surrogacy, while others have legislation prohibiting surrogacy contracts, and many states have no legislation at all regarding ART using surrogacy.[53]

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[43] *Id.*
[44] *Id.*
[45] *Id.* at 782.
[46] *Id.* at 784.
[47] Crockin, *supra* note 22, at 909.
[48] *See* Caitlin Conklin, *Simply Inconsistent: Surrogacy Laws in the United States and the Pressing Need for Regulation,* 35 WOMEN'S RTS. L. REP. 67, 74, 79 (2013).
[49] Eric A. Feldman, *Baby M Turns 30: The Law and Policy of Surrogate Motherhood*, 44 AM. J. L. & MED. 7, 8 (2018).
[50] Crockin, *supra* note 22, at 913.
[51] *See, e.g., Mamer v. Weingarten*, 328 Cal. Rptr. 3d 922, 926 (Ct. App. 2025); *Miles v. Gernstein*, 331 Cal. Rptr. 3d 492 (Ct. App. 2025).
[52] *Surrogacy Laws by State,* AM. SOC'Y FOR REPROD. MED., *https://connect.asrm.org/lpg/resources/surrogacy-by-state?ssopc=1* (last visited Nov. 19, 2025).
[53] *Id.*

Today, surrogacy is generally permitted and contracts upheld in most of the states.[54] Below is a brief overview of how each state regards surrogacy.[55] However, it is important to remember that even states that expressly permit surrogacy still vary in the restrictions required to do so.[56] Some states allow only gestational surrogacy, require the IPs to be married, or to be contributing both the egg and sperm, to name a few of the more common restrictions.[57]

Have statutes that expressly permit surrogacy by statute		Have no statute but are generally favorable	Have statutes stating surrogacy contracts are unenforceable	Have statutes that neither permit not prohibit surrogacy but are generally favorable
Alabama	Michigan	Alaska	Arizona	Nebraska
Arkansas	Nevada	Georgia	Indiana	New Mexico
California	New Hampshire	Hawaii	North Carolina	Tennessee
Colorado	New Jersey	Maryland		
Connecticut	New York	Massachusetts		
Delaware	North Dakota	Minnesota		
D.C.	Oklahoma	Missouri		
Florida	Rhode Island	Montana		
Idaho	Texas	Ohio		
Illinois	Utah	Oregon		
Iowa	Vermont	Pennsylvania		
Kansas	Virginia	South Carolina		
Kentucky	Washington	South Dakota		
Louisiana	West Virginia	Wisconsin		
Maine				

Wyoming is not included above because it is an outlier in that it has a statute that addresses surrogacy without permitting or prohibiting it, and at the time of writing this paper, there was not enough data available to know where courts stand regarding upholding surrogacy contracts.[58]

In addition to whether surrogacy contracts will be upheld is the issue of how each state views parentage after the child is born.[59] In *Surrogacy: American Style*, Richard Storrow states, "The issue at this point in the surrogacy journey is whether the law will recognize that the surrogate is *not* the legal mother, even though she gestated

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[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Surrogacy Laws by State, supra* note 52.
[59] Richard F. Storrow, *Surrogacy: American Style*, *in* SURROGACY, LAW AND HUMAN RIGHTS 193, 207 (Paula Gerber & Katie O'Byrne eds., 2015).

the child and may be its genetic progenitor."[60] Whether the IPs are able to obtain a pre-birth order of parentage, which would allow their names to go directly on the child's birth certificate when it is born, or they will have to complete the process with a post-birth order of parentage varies by state.[61] Much of the time, the distinction comes down to who is providing the genetic material or whether the IPs are a heterosexual married couple.[62] For example, in Arizona, if neither IP shares a genetic link to the child, they will need to go through the post-birth order of parentage process, but that same couple can be granted a pre-birth order of parentage if the surrogacy occurs in California.[63]

VI. ARGUMENTS FOR FEDERAL LEGISLATION

Because of the vast difference in laws between the states, many argue that federal legislation should be enacted to regulate surrogacy.[64] Moreso than varying cost, the main reason for choosing a specific state to undergo a surrogacy contract is due to its favorable laws.[65] This "forum shopping" is common with any area of law with inconsistencies across the states, such as tax law or business law, and surrogacy law is no different.[66] As an example of this forum shopping, my own three surrogacies were with IPs from different states (Florida, Texas, and New York) who chose to work with me due to the favorable laws of the state I resided in at the time (California for the first two and then Minnesota). In an article for *The New York Times Magazine*, author Alex Kuczynski wrote about her own surrogacy experience, sharing that part of their decision to use a surrogate who lived in Pennsylvania was so her and husband's names could go directly on the birth certificate as the genetic parents.[67]

Proponents of federal regulation suggest surrogacy can be regulated under the Commerce Clause[68] which states, "Congress shall have the power... to regulate commerce... among the several States."[69] IPs often use surrogates, agencies and IVF centers from multiple states.[70] Additionally, a gestational surrogacy agreement ("GSA") can include payments made to a surrogacy agency, legal fees and expenses, fertility clinic fees and expenses, medical expenses, insurance costs, and the surrogate's fees and expenses.[71] IARC Surrogacy, an agency based in Minnesota, provides a total cost estimate ranging from $124,000.00 to $176,000.00.[72] Thus, forum shopping is a main argument in favor of federal regulation with the reasoning that it "takes large sums of

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[60] *Id.* at 207.
[61] *Id.* at 211.
[62] *See, e.g.*, Crockin, *supra* note 22; Feldman, *supra* note 49; Conklin, *supra* note 48.
[63] *Surrogacy Laws by State*, *supra* note 52.
[64] Storrow, *supra* note 59, at 212.
[65] Erica Davis, *The Rise of Gestational Surrogacy and the Pressing Need for International Regulation,* 21 MINN. J. INT'L L. 120, 123 (2012).
[66] *Id.*
[67] Alex Kuczynski, *Her Body, My Baby*, N.Y. TIMES MAG. (Nov 28, 2008), https://www.nytimes.com/2008/12/14/magazine/14letters-t-HERBODYMYBAB_LETTERS.html.
[68] Conklin, *supra* note 48 at 90.
[69] U.S. CONST. art. I, § 8, cl. 3.
[70] Conklin, *supra* note 48, at 90.
[71] *Cost Estimates,* IARC SURROGACY, https://iarcsurrogacy.com/cost-estimates/ (last visited Nov. 19, 2025).
[72] *Cost Estimate - Surrogacy with Frozen Transfer (SET),* IARC SURROGACY, (last visited Nov. 19, 2025), https://iarcsurrogacy-com.s3.us-east-2.amazonaws.com/wp-content/uploads/2025/02/cost-estimate.pdf.

money out of state economies."[73] With such a substantial effect on interstate commerce, the Aggregation Principle introduced in *Wickard v. Filburn* would apply. The Court would only require Congress to have a rational basis related to a legitimate government interest for the passed regulation.[74] The World Center of Baby estimates that approximately 750 babies are born through surrogacy each year in the United States.[75] With up to $1.5 million going into the economy each year through surrogacies, under *Wickard*, Congress should only need a rational reason to pass federal legislation, such as the desire to ensure surrogacies are consistently handled safely for both IPs and surrogates, and parentage orders recognized across state lines.

The Equal Protection Clause[76] has also been cited as a possibility for Congress to regulate surrogacy.[77] The argument is that when it comes to orders of parentage, women are treated differently than men. An example of this argument appears in *in re TJS* where a New Jersey couple attempted to use the Equal Protection Clause to deem the New Jersey Parentage Act as "facially unconstitutional because they treat differently similarly-situated groups—infertile married men and women—without sufficient justification."[78] Specifically, the law automatically determined a man is the father of a child born to his wife when donor sperm is used, but the inverse was not true if a woman used a gestational surrogate to carry a child from a donated egg.[79] In a 4-3 decision, the Court decided in favor of New Jersey.[80] However, the argument and the split court show this could be a viable argument in the future regarding orders of parentage when a woman is not the carrier of her own child.

Interestingly, on March 11, 2025, a bill entitled the "Access to Family Building Act" was introduced to the US House of Representatives "[t]o prohibit the limitation of access to assisted reproductive technology, and all medical care surrounding such technology."[81] The definition of ART specific to the bill is:

> The term "assisted reproductive technology" means all treatments or procedures which include the handling of human oocytes or embryos, including in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, and such other specific technologies as the Secretary may include in this definition, after making public any proposed definition in such manner as to facilitate comment from any person (including any Federal or other public agency).[82]

It is unclear whether the definition above would cover the use of surrogacy because it is not explicit in saying so, and an embryo transfer with a gestational

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[73] Conklin, *supra* note 48, at 94.
[74] *Wickard v. Filburn*, 317 U.S. 111, 124 (1924).
[75] Ihor Lanetskyi, *How Many Surrogate Births Per Year: Statistics of Newborn Babies*, WORLD CTR. OF BABY (Apr. 27, 2025), https://worldcenterofbaby.com/blog/how-many-surrogate-births-per-year-statistics-of-newborn-babies/.
[76] U.S. CONST. amend. XIV, § 1. ("No state shall...deny to any person within its jurisdiction the equal protection of the laws.").
[77] Conklin, *supra* note 48, at 89.
[78] *In re* T.J.S., 16 A.3d 386, 390 (N.J. Super. Ct. App. Div. 2011).
[79] *Id*.
[80] *See, in re* T.J.S., 54 A.3d 263, 264 (N.J. 2012).
[81] Access to Family Building Act, H.R. 2049, 119th Cong. (1st Sess. 2025).
[82] 42 U.S.C. 263a–7(1).

surrogacy includes the transfer of an embryo into a woman's uterus rather than an intrafallopian transfer.[83] The current wording of the definition allows for additional circumstances. However, even if surrogacy was more directly addressed, the bill is a proposition to prohibit limiting ART rather than specific legislation to unify state conduct.

VII. SURROGACY LEGISLATION AT A STATE LEVEL

Having each state decide how to deal with GSAs and orders of parentage is supported by the fact that family law is traditionally dealt with at the State level. Article I Section 8 of the US Constitution lists the specific powers of the federal government, "The Congress shall have power to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States," and "[t]o make all laws which shall be necessary and proper for carrying into execution the foregoing powers, and all other powers vested by this Constitution in the government of the United States, or in any department or officer thereof."[84] As stated in the Tenth Amendment, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."[85] As a result, laws regarding family relationships such as marriage, divorce, and adoption are dealt with at the state level.[86] Surrogacy falls within the category of family law because it includes an order of parentage by the court, which can come in the form of a pre-birth or post-birth order of parentage.[87] "[E]stablishing parentage for children born from surrogacy is a critical legal component of any surrogacy arrangement."[88]

Another reason for passing surrogacy legislation at the state level is because previously held federal standards can change when cases come before the Supreme Court. This would have a broad impact on surrogacy in the United States.[89] Recent cases demonstrate that social attitudes and political agendas and the makeup of the Supreme Court can change the tide drastically. As an example, in 1973, the Supreme Court through *Roe v. Wade* determined that abortion was a fundamental right due to a person's reproductive autonomy, at least until the fetus was viable.[90] However in 2022, with *Dobbs v. Jackson Women's Health Organization,* the Supreme Court overturned this decision, stating abortion is not a fundamental right, and left the decision to individual states on whether or not to criminalize abortion at any point in the

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[83] *The 5 Step Surrogacy Medical Process*, AM. SURROGACY, https://www.americansurrogacy.com/surrogate/surrogates-medical-process (last visited Nov. 19, 2025).
[84] U.S. CONST. art. I, § 8, cl. 1.
[85] U.S. CONST. amend. X.
[86] *Is Family Laws Federal or State*?, L., (Sept. 16, 2023), https://family.laws.com/family-court/family-courts.
[87] Crockin, *supra* note 22, at 913.
[88] *Id.*
[89] It should be noted that laws can change at the state level as well, but would only affect that particular state rather than having such a broad impact on the entire industry.
[90] *See generally, Roe v. Wade*, 410 U.S. 113 (1973), *overruled* by *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022).

pregnancy.[91] All nine of the Supreme Court Justices in 1973 had been replaced by 2022.[92]

Similarly, *Fisher v. University of Texas at Austin*, a 2016 case that upheld a previous 2003 decision in *Grutter v. Bollinger* allowing colleges to consider race in admissions decisions in order to ensure a diverse student body,[93] was overturned by *Students for Fair Admissions v. Harvard* in 2023.[94] The Supreme Court in 2023 included only four new Justices that were not seated on the Court in 2016.[95] Again, these cases illustrate that while federal legislation would seem ideal in providing broad and uniform standards and practices for surrogacy, even Supreme Court decisions can seem unstable in a shifting political environment.

VIII. REASONS FOR PASSING SURROGACY LEGISLATION IN MINNESOTA

As a result of *Dobbs*, Minnesota passed the Protect Reproductive Options ("PRO") Act in 2023.[96] The PRO Act established "Every individual has a fundamental right to make autonomous decisions about the individual's own reproductive health" and includes the right to obtain an abortion as a fundamental right.[97] Upon passing the law, Governor Walz stated:

> Last November, Minnesotans spoke loud and clear: They want their reproductive rights protected – not stripped away...Here in Minnesota, your access to reproductive health care and your freedom to make your own health care decisions are preserved and protected.[98]

For this very same reason, Minnesota should enact legislation surrounding surrogacy which would allow both surrogates and IPs the security of knowing their surrogacy contracts will be upheld in courts, and IPs recognized as the rightful and legal parents of children born through surrogacy through a pre-birth order of parentage. Within its definitions, the PRO Act includes planning and fertility services as part of "reproductive health care."[99] Surrogacy is one way people use ART and fertility services for which specific legislation would give peace of mind to both IPs and surrogates, and direction to courts if an issue did arise. In a 2015 article entitled *Surrogacy: American Style*, Richard Storrow noted, "the legislative trend, if there is one, is toward legalizing surrogacy where it has been illegal, or providing a statutory

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[91] *See Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 302 (2022). ("The Constitution does not prohibit the citizens of each State from regulating or prohibiting abortion.").
[92] *Justices 1789 to Present*, SUP. CT. OF THE U.S., https://www.supremecourt.gov/about/members_text.aspx (last visited Nov. 19, 2025).
[93] *See generally, Fisher v. Univ. of Tex. at Austin*, 579 U.S. 365 (2016), *overruled by Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181 (2023).
[94] *See generally, Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181 (2023).
[95] *Justices 1789 to Present*, *supra* note 92.
[96] MINN. STAT. § 145.409 (2023).
[97] MINN. STAT. § 145.409 Subd. 3.
[98] *Governor Walz Signs Reproductive Freedom into Law*, OFF. OF GOVERNOR TIM WALZ & LT. GOVERNOR PEGGY FLANAGAN (Jan. 31, 2023), https://mn.gov/governor/newsroom/press-releases/#/detail/appId/1/id/562506.
[99] MINN. STAT. § 145.409 Subd. 2.

framework for it where it has been practiced with minimal guidance."[100] A decade later, Minnesota is still in that latter category and it is time to provide that statutory framework. As such, the possibility remains that different courts can produce different outcomes, even when the facts of the case are exactly the same.[101]

In addition to not having statutory regulation, Minnesota does not have any published court cases to set a precedent over how future cases involving a surrogacy contract or order of parentage as a result of surrogacy may be decided. The following two unpublished cases decided by the Minnesota Court of Appeals suggest that the courts are permissive with surrogacy contracts but cannot be relied on by surrogates or IPs should questions arise within their own surrogacy journey. These cases also illustrate why legislation on the enforceability of surrogacy contracts and parentage orders in the case of surrogacy would be beneficial.

Decided in 2010*, A.L.S. v. E.A.G*. involved a traditional surrogacy contract. The surrogate, E.A.G., used her own egg, fertilized by artificial insemination, with the intent of delivering a baby for a same-sex couple.[102] She then refused to give up her parental rights after the child was born.[103] The Court determined that she was the legal mother of the child because she did not fit the definition of an egg donor under the Minnesota Parentage Act, and therefore the prohibition of an egg donor being a parent did not apply.[104] However, the Court then determined that the father of the child, A.L.S, would have sole custody of the child based on the best interests of the child standard under Minn. Stat. § 518.17.[105] In this case, the Court specifically declined to address the enforceability of surrogacy contracts in general, or the question as to whether or not they violate public policy.[106] This case was highly fact- and circumstance-based. Had the facts been different and with no legislation on surrogacy contracts, the Court may easily have found in favor of sole or joint custody with the birth mother in a traditional surrogacy.

P.G.M. v. J.M.A is also an unpublished decision but gives a slightly better insight into how Minnesota courts view GSAs. In *P.G.M.*, the niece of an HIV-positive gay man from New York offered to act as his gestational surrogate.[107] He at first declined the offer, but later accepted, and drafted a contract based on others he had found online.[108] The contract specified that it would be governed by Illinois rule of law where the "sperm-washing" process and embryo transfer would occur, and included provisions regarding the reimbursement of expenses to the surrogate, J.M.A.[109] In an oral modification P.G.M. agreed to pay J.M.A. $20,000 and did so in December

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[100] Storrow, *supra* note 59, at 198.
[101] Conklin, *supra* note 48, at 85 (providing an example in Raftopol v. Ramey, 12 A.3d 783 (Conn. 2011), where a same-sex couple was initially denied birth certificates listing both parents after the birth of twins via surrogacy, despite having used the same surrogate in a prior pregnancy and having been able to put both of their names on the birth certificate).
[102] A.L.S. v. E.A.G., No A10-443, 2010 Minn. Ct. App. LEXIS 1091, at *2 (Oct. 26, 2010).
[103] *Id.*
[104] *Id.*
[105] *Id.*
[106] *Id.* at *15-16.
[107] *P.G.M. v. J.M.A. (In re Baby Boy A.*), No. A07-452, 2007 Minn. App. LEXIS 1189, at *2-3 (Dec. 11, 2007) [hereinafter P.G.M. v. J.M.A.].
[108] *Id.* at *3.
[109] *Id.* at *3-4.

2004.[110] Over the summer of 2005 while J.M.A. was pregnant, the parties had a falling out and J.M.A. demanded additional payment in the amount of $120,000 and threatened to abort the fetus if her demand was not met.[111] J.M.A. delivered the child in Minnesota in December 2005 without telling P.G.A.[112] P.G.A. filed a paternity action once he learned of the child's birth.[113] The Court of Appeals of Minnesota upheld the choice of law provision to use Illinois law as stipulated in the contract.[114] The Court also deemed that the contract did not violate public policy because there was "no Minnesota statute or case law that prohibits GSAs and the legislature has expressly protected the rights of individuals who use assisted-reproduction technologies." [115] As the biological father of the child, P.G.A. was granted parental rights and sole custody of the child.[116] This case illustrates how the guidance of Illinois legislation was helpful to the Court in having a structure to determine whether the GSA should be upheld but leaves room for doubt regarding a parentage order in cases where donor eggs or sperm, or both, are used.

The uncertainty created by the lack of legislation leaves IPs unsure of the outcome in many aspects of their GSAs[117], even in Minnesota, which is generally considered friendly toward surrogacy contracts. I had the opportunity to interview reproductive law attorney Taylor Rolf, who is Owner and Managing Partner of Steven H. Snyder & Associates, one of Minnesota's largest reproductive law firms.[118] 99 percent of the work Rolf does is related to surrogacy or other forms of ART.[119] Having been part of over 1,000 GSAs, the firm has a one hundred percent success rate which she credited as being due to all parties being fully informed of the process, and having comprehensive contracts with each party represented by individual counsel.[120] Even so, one of the largest concerns of IPs is due to the post-birth order of parentage required by Minnesota[121] under the Uniform Parentage Act, which requires that any parental order must be stayed until after the birth of the child.[122] Rolf noted that if IPs have the option to choose a surrogacy in Minnesota with a post-birth order of parentage, or California with a pre-birth order of parentage, many will prefer and choose the California process.[123] Currently, Minnesota makes use of a process by which the IPs can take the baby home from the hospital through a temporary designation of guardianship/parental power of attorney which is set up in advance of the birth.[124]

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[110] *Id.* at *4.
[111] *Id.* at *5.
[112] *Id.*
[113] P.G.M. v. J.M.A. at *5.
[114] *Id.* at *7 ("The record contains no evidence that, by selecting Illinois law, the parties acted in bad faith or with intent to evade Minnesota law. First, Minnesota law does not address—mush less prohibit—GSAs...Illinois law, unlike Minnesota law, provides a clear statutory structure for interpretting GSAs.").
[115] *Id.* at *16.
[116] *Id.* at *22.
[117] Conklin, *supra* note 48, at 93.
[118] Zoom Interview with Taylor Rolf, Owner & Managing Partner, Steven H. Snyder & Assocs. (Mar. 14, 2025).
[119] *Id*.
[120] *Id.*
[121] *Id.*
[122] MINN. STAT. § 257.57 Subd. 5 (2024).
[123] Rolf, *supra* note 118.
[124] MINN. STAT. § 257.57 Subd. 5.

IX. PREVIOUS ATTEMPTS TO LEGISLATE SURROGACY IN MINNESOTA

Proponents of surrogacy in Minnesota have been attempting to have surrogacy officially legalized and legislated. In 2008, S.F. 2965 passed both the House and Senate and would have granted legislation for gestational surrogacy contracts. However, then Governor Pawlenty vetoed the bill, stating it was controversial and there were bipartisan objections.[125] The Minnesota Star Tribune reported that among his reasons for vetoing the bill were the "lack of protections for women who contract to carry and deliver children for others, including failure to establish the surrogate mother's right to make her own medical decisions while she's pregnant."[126]

Attempts to pass legislation regarding GSAs were made again in 2010, 2013, 2014, 2015 and 2016, but none made it past the Senate, and some not making it past the House.[127]

In 2024, the Minnesota Parentage Act was updated to include orders of Parentage when ART is used.[128] Minn Stat. 257E.15(a) states, "If the court determines that an individual is a parent under this chapter, either because the individual gave birth to the child or the individual is a consenting intended parent under section 257E.23, the court shall adjudicate the individual to be a parent of the child." At first glance, this section seems to imply that pre-birth orders can now be granted in Minnesota so that IPs using surrogates can have their names on their child's birth certificate without having to go through the post-birth order of parentage process. However, in the Definitions section, "Assisted Reproduction" includes an extra note that makes it clear that surrogacy contracts are not included:

> Assisted reproduction does not include a pregnancy under a surrogacy agreement, the pregnancy of a surrogate, the transfer of an embryo to a surrogate, or when a child is conceived pursuant to a surrogacy agreement. For purposes of this subdivision, "surrogate" means an individual who agrees to become pregnant but who does not intend to be legally bound as a parent of the child.[129]

Additionally in 2024, another bill was introduced to legislate surrogacy with H.F. 5453, but got stuck in the Judicial Financial and Civil Law Committee and did not go anywhere.[130] The proposed bill was comprehensive and long, consisting of eleven pages and nine subsections.[131] While some of the proposed legislation was good, much of it would have been disadvantageous to surrogates, intended parents, and the agencies that help them arrange the complicated process. The bill was a proposal for gestational

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[125] Journal of the Senate 10378-79 (85th Minn. Leg. May 16, 2008).
[126] Kevin Duchschere, *Pawlenty Vetoes Bills on Sick-leave Use, Surrogacy Contracts,* STAR TRIB. (May 17, 2008, 12:09 AM), https://www.startribune.com/pawlenty-vetoes-bills-on-sick-leave-use-surrogacy-contracts/19013079.
[127] Legislative Commission on Surrogacy, *Overview of Cases and Legislative Activity in Minnesota; Key Policy Issues,* 2-3 (June 28, 2016).
[128] MINN STAT. 257E.
[129] MINN. STAT. 257E.10, Subd 2.
[130] H.F. 5453, 93rd Leg., 2024 Reg. Sess. (Minn. 2024).
[131] *Id.*

surrogacy agreements and specified that traditional surrogacy agreements would be invalid.[132]

Some of the beneficial proposals include eligibility requirements for a surrogate that mirror those used by agencies, a requirement that the parties are each represented by independent counsel, and provisions detailing that parental rights would be vested in the IPs upon birth of the child.[133]

Among the disadvantageous specifications was a requirement that a GSA could only contain a single-embryo transfer.[134] This is disadvantageous because the age of the provider of the egg and whether fresh or frozen embryos are used affects the quality of the embryo and success rate of a live birth after an embryo transfer.[135] For example, an intended mother aged forty-two using her own eggs, could have a lower embryo quality with only a thirteen percent chance of a successful live birth.[136] H.F. 5453 also would have prohibited IPs from being eligible to participate in a GSA in Minnesota unless at least one of them contributes a gamete, they have been married at least two years, have completed a mental health evaluation, and have a proven medical necessity to use a surrogate.[137] These restrictions would seem to violate a person's fundamental right to reproduce as declared by the Supreme Court in *Skinner v. Oklahoma* which declared, "We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race."[138] Admittedly, *Skinner* was not addressing the use of ART for reproduction. But if the right to reproduce is acknowledged as a fundamental right, why should the method of reproduction be restricted based on marital status or any other qualification? Prettyman pointed out that

> While the exact scope and nature of [the rights of familial privacy and reproduction] has been neither clearly nor consistently elucidated by the [United States Supreme] Court, its opinions have consistently found a "right of the individual to be free from unwarranted governmental intrusion into the decision whether to bear or beget a child." The decision to engage in surrogate parenting, thus, would appear to fall within the ambit of constitutional protection.[139]

Additionally, Attorney Rolf mentioned that the medical necessity aspect of surrogacy is often a touchy subject for the IM because she has often already been through so much herself.[140] Forcing a person to prove medical necessity for surrogacy,

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[132] *Id.*
[133] *Id.*
[134] *Id.*
[135] Zhao Li, et al., *Comparison of Embryo Quality and Pregnancy Outcomes Using a New Grading System for Embryo Morphology in an In Vitro Fertilization (IVF) Program*, 1 *Fertility & Sterility Reps.* 264, 267 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC8244281/.
[136] *Id.*
[137] H.F. 5453, 93rd Leg., 2024 Reg. Sess. (Minn. 2024).
[138] *Skinner v. State of Okl. ex rel. Williamson*, 316 U.S. 535, 541 (1942).
[139] Prettyman, *supra* note 18, at 901 (quoting *Carey v. Population Servs. Int'l*, 431 U.S. 678, 687 (1977)).
[140] Rolf, *supra* note 118.

as proposed in the bill[141], is not only hurtful and degrading, but could be used as a way to exclude same-sex couples from entering surrogacy agreements in Minnesota.

H.F. 5453 also proposed that surrogacy agencies be non-profit agencies only.[142]

Having so many restrictions on GSAs could ultimately result in less surrogacies taking place in Minnesota due to the forum shopping already common by IPs seeking a surrogate.

X. GSAS IN CALIFORNIA

In Comparison, California is the most surrogate friendly of any state, with the most liberal laws.[143] The following is a brief overview of California's statutes regarding assisted reproduction and surrogacy contracts. There are few restrictions or barriers IPs must overcome when seeking to start a family through ART in California. Cal. Fam. Code § 7962 governs GSAs, orders of parentage, confidentiality, and presumption of validity all within the same statute which includes the following:

- "Intended parent" means an individual, married or unmarried, who manifests the intent to be legally bound as the parent of a child resulting from assisted reproduction.[144] Notice there are no restrictions on who can be an IP based on marital status, sexual orientation, or any other stipulations.

- GSAs must include the date the agreement is executed, the persons from whom the gametes originate (unless a donor is being use), the identity of the IPs, and how the IPs intend to cover medical costs of the surrogate and newborn(s).[145]

- The surrogate and IPs must each be represented by independent counsel.[146]

- The GSA must be notified or witnessed.[147]

- The medical process must not begin until the contract is fully executed.[148]

- An action to establish the parent/child relationship may be filed before birth.[149]

- The GSA shall rebut any presumptions that the surrogate or spouse is a legal parent.[150]

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[141] H.F. 5453, 93rd Leg., 2024 Reg. Sess. (Minn. 2024).
[142] *Id.*
[143] Karine Bogoraz, *Student Project: Surrogacy Research Guide: California,* PACE UNIV. L. LIBR. RSCH. GUIDES (March 29, 2023), https://libraryguides.law.pace.edu/c.php?g=452971&p=3156883.
[144] CAL. FAM. CODE § 7960(c) (West 2025).
[145] CAL. FAM. CODE § 7962(a) (West 2025).
[146] CAL. FAM. CODE § 7962(b).
[147] CAL. FAM. CODE § 7962(c).
[148] CAL. FAM. CODE § 7962(d).
[149] CAL. FAM. CODE § 7962(e).
[150] CAL. FAM. CODE § 7962(f).

- Confidentiality of the agreement.[151]
- The GSA is presumed valid.[152]
- All funds must go through an escrow account, or a trust account maintained by an attorney if they are not being paid directly to a medical facility.[153]

In a discussion with one of the fathers of the twin girls I had for a gay couple from Texas, he stated, "[w]ere if not for the favorable practice of law in San Diego, we wouldn't have had such a great experience."[154]

XI. PROPOSED LEGISLATION FOR MINNESOTA

The following addresses how Minnesota may pass legislation to regulate GSAs, yet not outright ban traditional surrogacies. I propose that Minnesota adopt regulation similar to that of California as I will outline below. Legislation should be protective of both surrogates and IPs but should not dictate how a surrogacy is done.[155]

Surrogate Eligibility:

Although California code does not specify eligibility requirements for surrogates,[156] Minnesota could benefit from codifying specific requirements even though most surrogacy agencies already have requirements a surrogate must meet before she is eligible to act as a surrogate.[157]

The following proposed minimum requirements for surrogates reflect the eligibility requirements already in place at most surrogacy agencies. Not every surrogacy arrangement originates with an agency, as often a close friend or family member will act as a surrogate for a loved one.[158] However, including these requirements in legislation could help alleviate fears and misconceptions surrounding surrogacy and allow for the bill to be passed rather than stuck in a committee due to the opinions of outspoken opponents. "Well-designed regulation can greatly mitigate most of the potential tangible harms of surrogacy, and this would seem to be the appropriate function of law in a liberal society in response to an issue on which no societal consensus exists."[159]

1. Minimum age of 21

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[151] CAL. FAM. CODE § 7962(g)-(h).
[152] CAL. FAM. CODE § 7962(i).
[153] CAL. FAM. CODE § 7961 (West 2025).
[154] Telephone interview with David [last name withheld] (Mar. 25, 2025).
[155] Rolf, *supra* note 118.
[156] *See generally,* CAL. FAM. CODE § 7962 (West).
[157] *See, e.g., Surrogate Requirements & Qualifications*, IARC SURROGACY, https://iarcsurrogacy.com/surrogacy/surrogate-requirements/ (last visited Apr. 15, 2025); *Gestational Carrier (GC) Requirements*, SURROGACY CTR. OF AM., https://surrogacycenter.com/carriers/ (last visited Apr. 15, 2025); *Surrogate Requirements*, CIRCLE SURROGACY, https://www.circlesurrogacy.com/surrogates (last visited Apr. 15, 2025).
[158] Rolf, *supra* note 118.
[159] Feldman, *supra* note 49, at 12 (quoting Elizabeth Scott, *Surrogacy and the Politics of Commodification*, 72 L. & CONTEMP. PROBS. 109, 146 (2009)).

2. Have at least one child of her own
3. Pass a medical screening[160]
4. Healthy BMI
5. No significant history of depression or mental health illness
6. No tobacco or recreational drug use
7. Pass a psychological test
8. Not on government aid

Common arguments against surrogacy are that surrogacy treats unborn children as commodities that are bought, sold, and discarded.[161] Surrogacy opponents also claim that surrogacy agencies prey upon vulnerable women who end up in coercive situations with short- and long-term emotional trauma.[162] Contrary to that belief, studies have not found that surrogates in the U.S. are being exploited or being coerced into signing surrogacy contracts.[163] Though the surrogate will likely not be as well off financially as the IPs, "[f]inancial inequality...does not necessarily lead to financial exploitation."[164] The proposed legislation for surrogate qualification is aimed at combatting some of these arguments by adding safeguards that would make exploitation much more difficult.

Requirements one through seven address the concerns of the physical and mental health of the surrogate. It is important to know in advance if a woman can safely deliver a child with no medical complications.[165] A person's weight and drug, alcohol, or tobacco use can bring additional complications to a pregnancy.[166]

Requirement eight addresses the concern of economic stability of the surrogate. One of the major arguments against surrogacy is that it is baby selling.[167] One of the ways to combat the presumption that a surrogate is "only in it for the money" is ensure that the surrogate is not under financial hardship. Agencies will also disqualify a woman from being a surrogate if she is on government aid for two reasons. First, it is of utmost importance to ensure that the surrogate is in a stable living environment and can "fully

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[160] *Medical Screening for Surrogacy: Understanding the Process*, EXTRAORDINARY CONCEPTIONS (Oct. 3, 2023), https://www.extraconceptions.com/surrogate-medical-screening-process-in-2022/. Medical screenings include a medical history, physical exam, pap smear, urine test, and blood tests to check for infectious diseases, drug use and certain hormones. Blood type and RH factor are also checked to ensure the surrogate will be compatible with the genetics of the fetus she will carry.
[161] *Surrogacy*, MINN. CATHOLIC CONF., https://www.mncatholic.org/surrogacy (last visited Apr. 15, 2025).
[162] *Id.*
[163] Feldman, *supra* note 49, at 13.
[164] *Id*.
[165] *Medical Screening for Surrogacy: Understanding the Process, supra* note 160.
[166] *Id.*
[167] Feldman, *supra* note 49, at 14.

focus on her pregnancy without financial stress."[168] Additionally, a compensated surrogacy would likely negatively affect the surrogate's eligibility to receive benefits such as cash assistance, housing, or welfare.[169]

Intended Parent Eligibility:

I propose that there not be any minimum requirements for IPs. Minnesota should instead adopt a definition for "Intended Parent" similar to California's, focusing on the intent of a person to become a parent.[170] "There is no reason why marital status or sexual orientation should be disqualifying for surrogacy, just as they are not disqualifying for same-sex couples seeking to adopt, or unmarried couples choosing to conceive."[171] Including any sort of medical necessity requirement would also be superfluous. Attorney Rolf mentioned that in her years as a lawyer, she has never encountered an IP that simply did not want to go through pregnancy.[172]

Gestational Surrogacy Agreement Provisions:

1. Parties must have independent legal representation.

2. Compensated surrogacy permissible.

3. Surrogate compensation to be paid in installments.

4. Any funds to the surrogate must go through a third-party escrow account.

5. An action to establish the IPs as the parents may be filed before the birth of the child.

6. Follow the guidelines provided by the American Society for Reproductive Medicine ("ASRM") regarding the number of embryos to transfer.

7. GSAs must include the date of execution, identify the source of the gametes (unless a donor is being used), and include how the IPs intend to cover costs.

8. The GSA must be notified or witnessed.

9. The medical process may not begin until the contract is fully executed.

10. The GSA shall rebut any presumption that the surrogate or spouse is a legal parent.

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[168] *Why Can't I Become a Surrogate if I'm on Public Assistance?*, FAM. SOURCE CONSULTANTS, https://www.familysourceconsultants.com/faq-items/cant-become-surrogate-im-public-assistance/#:~:text=Gestational%20Surrogates%20are%20required%20to,Section%208%20housing (last visited Apr. 16, 2025).
[169] *Id.*
[170] *See,* CAL. FAM. CODE § 7960(c) (West 2025).
[171] Feldman, *supra* note 49, at 15-16.
[172] Rolf, *supra* note 118.

11. Include a confidentiality provision.

12. The GSA shall be presumed valid.

Provision one stating that each party be represented by independent legal counsel is the most important aspect that needs to be addressed, regardless of other requirements.[173] In reference to separate legal counsel, Feldman states:

> Such representation can be paid for by agencies offering services, with the cost passed through to intended parents. By guaranteeing that surrogates are able to consult with attorneys who can help them to understand the terms of their surrogacy contracts, advocate for adequate compensation, and help to protect their individual rights, opportunities for the exploitation of surrogates will be greatly reduced.[174]

Having independent legal counsel also nullifies the argument that a surrogate is being coerced into a contract. It is the duty of legal counsel to fully inform their client, whether the surrogate or the IPs, of the risks of surrogacy, both medical and legal.[175] The Model Rules of Professional Conduct for lawyers, requires that a lawyer be competent in the area of law they are practicing[176] give candid advice,[177] and "explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation."[178]

Provisions two through four address compensation for surrogates. In written testimony provided to the Legislative Commission on Surrogacy in 2016, a previous surrogate provided the following statement:

> These women are being paid a reasonable amount for their time, obligations, expenses, and services during the process of becoming pregnant and carrying the intended parents' pregnancy for them. This is no different than legislators like you, being paid above and beyond your primary employment for your time and services in performing the duties for the people of Minnesota. Just as you are performing a civic duty by serving in the legislature (for which you should be paid despite the primarily altruistic nature of your motivation), I performed a service from the heart for my intended parents (and women like me should be paid despite the primarily altruistic nature of our motivation).[179]

The comparison of being paid for service even when it is altruistic in nature, similar to the civic duty of legislators was a theme that appeared in many of the letters.[180] Feldman responds to the worry that compensation of surrogates is equal to

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[173] Rolf, *supra* note 118.
[174] Feldman, *supra* note 49, at 14.
[175] Rolf, *supra* note 118.
[176] MODEL RULES OF PRO. CONDUCT r. 1.1 (AM. BAR ASS'N 2020).
[177] *Id.,* r. 2.1.
[178] *Id.*, r. 1.4(b).
[179] Letter from Ann Estes, gestational carrier, to Rep. Anna Wills & Sen. Greg Clausen, Minn. Legislative Comm'n on Surrogacy (July 15, 2016), in SURROGATE TESTIMONIALS, at 29, https://www.lcc.mn.gov/inactive/lcs/meetings/07192016/surrogate_testimonials.pdf.
[180] *Id.*, at 32, 41, 44, 49,64, 68, 78, 106, and 113.

baby selling by pointing out that "those who support surrogacy most decidedly do not support baby selling."[181] Furthermore, baby selling is putting a price on the child as a good for sale, whereas "[s]urrogacy arrangements...focus on paying surrogate mothers for their medical care, lost wages, health insurance, and more."[182] Attorney Steven H. Snyder emphatically responded to an editorial that likened surrogacy to baby selling by stating:

> Surrogacy is not "baby-selling." The actual genetic or intended parents of the child create their own embryo with their genetic material before it is ever entrusted to the surrogate for her temporary care and gestation. It is not the surrogate's child when the embryo is first created; it is not the surrogate's child while she receives and expressly agrees to gestate it solely for the intended parents' benefit; it is not the surrogate's child when she gives birth and returns the child to the child's actual parents. You cannot sell something that never belonged to you in the first place.[183]

Prohibiting payments to surrogates would also likely result in fewer women willing to go through the long and arduous surrogacy process.[184]

Funds provided to the surrogate should go through a third-party escrow account and paid in installments. This allows the IPs and the surrogate to have a relationship free from stressful discussions about money. For this reason, Attorney Rolf mentioned that she encourages her clients not to talk about money at all and let any needed discussions regarding compensation or reimbursement be addressed by the parties' lawyers.[185] Making payments in installments also combats the argument that surrogacy is baby selling. The surrogate is not handed a lump sum when she hands over the baby but is paid throughout the pregnancy as compensation for her service. This also harkens back to the *Johnson v. Calvert* case in which Judge Panelli distinguished a compensated surrogate paid in installments as different from being paid to give up parental rights.[186]

Provision five addresses the parental rights of the IPs. Storrow points out that IPs do not want to go through a process similar to that of adoption to be recognized as their child's parents, and want "the assurance that they will be legally recognized as the child's sole parents immediately upon its birth."[187] This can also be accomplished by amending the Minnesota Parentage Act to include the use of surrogates in ART by removing the additional language from Minn. Stat. 257E 10, Subd. 2 which specifically excludes surrogacy in the definition of ART.

Provision six regarding the number of embryos to transfer is in response to the most recent surrogacy bill introduced in 2024 trying to limit all surrogacy contracts to a single-embryo transfer.[188] The goal should be to have one healthy child. However, a

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[181] Feldman, *supra* note 49, at 15.
[182] *Id.*
[183] *Alternative Facts and Surrogacy*, STEVEN H. SNYDER & ASSOCS. (Feb. 13, 2017), https://www.snyderlawfirm.com/blog/2017/02/alternative-facts-and-surrogacy/.
[184] MCBRIEN & HALE, *supra* note 3, at 142.
[185] Rolf, *supra* note 118.
[186] *Johnson v. Calvert*, 851 P.2d at 784.
[187] Storrow, *supra* note 59, at 200.
[188] H.F. 5453, 93rd Leg., 2024 Reg. Sess. (Minn. 2024).

single-embryo transfer is not the medically correct call for every situation.[189] Following the guidelines provided by ASRM regarding the number of embryos to transfer would allow for circumstances where the embryo quality is not as high to still have a good chance of a successful pregnancy and birth.

Provisions seven through twelve address typical contract situations such as the execution date and confidentiality.

CONCLUSION

Even though Minnesota and many other states are known to be "surrogacy friendly," legislation should still be enacted which would safeguard both GCs and IPs, limiting the statutes to regulate gestational surrogacies. Feldman points out that "the legal system is well-equipped to manage surrogacy. A more permissive legal stance toward surrogacy requires that contracts between surrogate mothers and intended parents be encouraged and enforced."[190] For this reason, legislation should include minimum requirements for surrogates and contracts. The minimum requirements would provide confidence to the parties, guidance for courts, and help to alleviate some fears or misconceptions of surrogacy by showing that the state has thought through these various circumstances.

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[189] *See generally*, Practice Comm. of the Am. Soc'y for Reprod. Med. & Practice Comm. of the Soc'y for Assisted Reprod. Techs., *Guidance on the Limits to the Number of Embryos to Transfer: A Committee Opinion*, 116 FERTILITY & STERILITY 651 (2021), https://www.asrm.org/globalassets/_asrm/practice-guidance/practice-guidelines/pdf/guidance_on_the_limits_to_the_number_of_embryos_to_transfer.pdf.

[190] Feldman, *supra* note 49, at 12.

BEYOND LEGISLATION: THE CASE FOR CONSTITUTIONAL DISABILITY RIGHTS

John E. Seay*

Abstract: Disability protections in the United States are relatively few. Most specifically, this research asks, "Should states implement and expand disability protections in their constitutions?" To support this claim, this research analyzes the U.S. Constitution, state constitutions, U.S. territory constitutions, and relevant disability rights legislation, particularly in the context of demographic trends drawn from the U.S. Census. Federal protections like the ADA can be repealed, and constitutional amendments are difficult to pass; therefore, states should incorporate explicit disability protections into their constitutions. This research clarifies the current status of disability protections and guides future efforts to expand them.

Keywords: Constitutions; Disability; State; Federal; Territory

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Disability protections in the U.S. are heavily reliant on legislation, however in the event of a bad actor legislation can be repealed. Due to this and the process by which the U.S. Constitution is amended, it would be far easier for states to amend their won constitutions. With disability cases on the rise, more individuals are relying on faulty legislation. As someone with a disability witnessing how individuals with disabilities in the U.S. are exposed to discrimination even in the present day, I realized the need for an increase in protections is of utmost importance.

INTRODUCTION

Disability protections in the United States are relatively few. Most specifically, this research asks, "Should states implement and expand disability protections in their constitutions?" To support this claim, this research analyzes the U.S. Constitution, state constitutions, U.S. territory constitutions, and relevant disability rights legislation, particularly in the context of demographic trends drawn from the U.S. Census. Federal protections like the ADA can be repealed, and constitutional amendments are difficult to pass; therefore, states should incorporate explicit disability protections into their constitutions. This research clarifies the current status of disability protections and guides future efforts to expand them.

Imagine living in a world where tasks such as opening a door, eating, or talking on the phone are impossible. What would this look like? How would this feel? For many with disabilities, this is not a matter of imagining, but instead a reality they face every day.

Disabilities are increasingly prevalent in American society. Could this be due to increasing cases of individuals who have disabilities, expanding social and health programs, or a decrease in social stigma around those with disabilities?

When looking at disabilities it is important to consider Veteran Affairs (V A) disability protections, as people who fall into this category are entitled to further benefits and protections. There are several ways to analyze protections to which people with disabilities are entitled; some of these protections can be observed through a constitutional analysis of both the U.S. Constitution as well as individual state and territory constitutions. Although some states do explicitly state their protections and acknowledge those with disabilities, some do not, and with this absence of clearly defined protections, a level of moral interpretation is required to elucidate these protections. When protections are not stated in such constitutions, there must be legislation to make up for this undeniable gap, the most notable legislation being the Americans with Disabilities Act (ADA), Individuals with Disabilities Education Act (IDEA), and The Fair Housing Act. A culmination of these different forms of protection is meant to embody the protections that seek to keep people with disabilities safe every day; however, do they actually protect those with disabilities?

I. LITERATURE REVIEW

Disability protections can be a complicated subject; some protections can be inferred, while others are explicitly written, and many are designed to be undiscovered. According to Harris, there are three distinct time periods associated with disability: the pre-industrial era, when people with disabilities were integrated into society but culturally excluded; the industrial era, which led to widespread institutionalization; and

a post-industrial period marked by a gradual shift toward social and cultural integration.[1] Despite having undergone a lowering of industrialization ideas since the end of the Cold War, the United States has witnessed social and cultural integration return through a relatively slow process. Oakes also observes that legislation concerning disability rights has historically lagged behind social and cultural developments.[2] Until the 1990 passing of the American Disabilities Act (ADA), certain disability protections were reliant on the Rehabilitation Act of 1973.[3] Raj considers the Individuals with Disabilities Education Act (IDEA) in conjunction with the ADA to note that these pieces of legislation do not protect individuals at different times, and instead argues that people with disabilities are simultaneously protected by both.[4]

This is an important viewpoint to acknowledge in regard to disability protections that people are entitled to, as all of the benefits that they fall under actively protect them at the same time demonstrating that these laws function together, not in a sequential or exclusive manner. Oakes also looks at the constitutional interpretation of disabilities and acknowledges that although the United States Constitution does not explicitly cover disability protections or discrimination, it could be implied under the equal protection and due process clauses.[5] Noting the different policies that were passed with disability protections in mind, other legislation seems to have fallen through the cracks as Oakes declines to discuss the Individuals with Disabilities Act or Fair Housing Acts. Oakes does talk about the United States Constitution; however, a gap can be noted with regards to state constitutions. Across the spectrum of research that scholars and researchers have access to, there seems to be a common gap with reference to state constitutions and their disability protections, as a whole. Green discusses the various types of discourse behind disabilities and draws attention to categories in which people with disabilities can fall into, which in itself could be seen as somewhat of a discriminatory practice as it compares one's disabilities and pain to others.[6] This is not an adequate system that seeks to cover an entire spectrum of people and should not be set into categories.

II. JUSTIFICATION OF IMPORTANCE OF RESEARCH QUESTION

While legislation provides many protections for individuals with disabilities, research has also shown that constitutional protections are limited—and even among the state constitutions that include them, the language is often insufficient or inconsistent. These constitutions lack the proper wording to be considered all-encompassing for individuals with disabilities. Conversely, states that do not include disability protections often include offensive wording which is counterintuitive to furthering protections for individuals with disabilities. The documented rise in

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[1] Harris, Jennifer L., and Roulstone, Alan. *Disability, Policy and Professional Practice*. London: SAGE Publications, Limited, 2010. Accessed March 12, 2025. ProQuest Ebook Central, 15.
[2] Oakes, Wayne Thomas. *Perspectives on Disability, Discrimination, Accommodations, and Law: A Comparison of the Canadian and American Experience*. New York: LFB Scholarly Publishing LLC, 2004. Accessed March 12, 2025. ProQuest Ebook Central, 47.
[3] Wayne Thomas Oakes, *Perspectives on Disability, Discrimination, Accommodations, and Law,* 48.
[4] Raj, Claire. "THE LOST PROMISE OF DISABILITY RIGHTS." *Michigan Law Review* 119, no. 5 (2021): 933–85. http://www.jstor.org/stable/45386463, 933.
[5] Wayne Thomas Oakes, *Perspectives on Disability, Discrimination, Accommodations, and Law,* 48.
[6]Green, Sara E., and Loseke, Donileen R., eds. *New Narratives of Disability: Constructions, Clashes, and Controversies*. Bingley: Emerald Publishing Limited, 2019. Accessed March 12, 2025. ProQuest Ebook Central.

disability cases, combined with the fact that legislation can be easily repealed, underscores the need for widespread constitutional protections.

III. METHODOLOGY

Research for this paper takes into account a multi-method approach that takes a qualitative, quantitative, and historical approach to the issue of disability protections. This study used an analysis of United States (U.S.) Census and Social Security Administration (SSA) data to track disabilities as a whole, while looking to see if there were any groups that were disproportionately affected, either by race, gender, or location. The research was also guided by qualitative research through analysis of the United States, state, and United States territory constitutions, as well as relative U.S. Supreme Court cases. The qualitative methodology in this research also spanned to include federal legislation and policies set to protect those with disabilities. With regards to the historical approach, this research is further guided by historical legislation that has protected those with disabilities such as the Americans with Disabilities Act (1990) and the All Handicap Children Act (1975). Through these three different methodologies, this paper examines why so many individuals rely heavily on the ADA, despite the presence of some protections in federal, state, and territorial constitutions. This research further investigates whether these constitutional provisions are sufficient to adequately protect individuals with disabilities.

IV. BACKGROUND ON DISABILITIES

Individuals with disabilities represent one of the most marginalized groups in the United States. Individuals with disabilities have been subject to abuse, abandonment, institutionalization, and ignominy; a group that has faced public defamation by some of the most powerful people in the world. The United States (U.S.) government defines disability under the Americans with Disabilities Act (ADA) 1990 as:

> The term "disability" means, with respect to an individual—
>
> (A) a physical or mental impairment that substantially limits one or more major life activities of such individual;
>
> (B) a record of such an impairment; or
>
> (C) being regarded as having such an impairment[7]

Building on this definition, the historical treatment of individuals with disabilities reveals significant shifts in policy and perception over time. Starting with the turn of the seventeenth century, the United States saw an increase of facilities known as almshouses; other names for these facilities were poorhouses and asylums.[8] These

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[7] ADA.gov. "Americans with Disabilities Act of 1990, As Amended." Accessed March 25, 2025. https://www.ada.gov/law-and-regs/ada/.

[8] U.S. National Park Service, "Disability History: Early and Shifting Attitudes of Treatment (U.S. National Park Service)." Accessed March 24, 2025. https://www.nps.gov/articles/disabilityhistoryearlytreatment.htm.

facilities were used to house individuals who required extra attention, including the poor, criminals, and those with disabilities.

Almshouses were used for centuries in the United States and across Europe, only being completely phased out around the 1960s in the U.S. Throughout the mid twentieth century they faced harsh criticism from the public due to ongoing reports of poor conditions and treatment which resulted in the closure of most of the remaining almshouses by the 1960s. These institutions—though known by different names—are often what people refer to when speaking about the historical institutionalization of individuals with disabilities. After the 1960s, there were strong pushes by the public for healthcare and disability policy reform. The monumental passing of The Individuals with Disabilities Education Act (IDEA) in 1975 represents a time period where disability protections would become far more prevalent than any other time in United States history. Following the passage of the IDEA, disability policy quickly gained traction, leading to a twenty-year stretch where the most influential disability policies were adopted, many of which those with disabilities still rely on today. As previously noted, Harris described the disability timeline as a pre-industrial period, followed by a strict institutional industrialization period, followed by a period of reform where institutions were slowly phased out.[9] Looking on to the late twentieth century, some of the most important legislation such as the Americans with Disabilities Act (1990) and multiple voting rights bills for those with disabilities were passed. Since the turn of the millennium, there have been no large disability bills passed; however, there have been expansions to existing policies.

V. VETERAN DISABILITIES

Although few major disability bills have been passed since the turn of the millennium, significant progress has continued—particularly in the area of veteran disability protections, which were implemented well before those for non-veterans. These protections were implemented as a result of the American Revolutionary War and provided pensions to disabled veterans who were no longer able to work due to disabilities, they had sustained due during their military service.[10] Pensions were widely expanded during the early nineteenth century. Following this time period, the most influential policies to be implemented came about in the early to mid 1900s. The events sparking these policies were World War I and World War II, with the focus of these bills being on aiding disabled veterans' families, rehabilitation, and establishing the United States Department of Veteran Affairs (VA). The establishment of this department is particularly important as this would go on to be the office that handles all things related to veteran benefits such as payment disbursements, medical treatments, and all other benefits that disabled veterans are entitled to. This department continues to prove its importance to this day, as will be covered later on when looking into disability trends over time in the United States. Unlike most non-veteran policies, there has been substantial veteran-based legislation passed after 2000; these bills were called the Veterans Claims Assistance Act of 2000 and the VA MISSION Act of 2018. The purpose of the Veterans Claims Assistance Act of 2000 was to push the Department of

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[9] Jennifer L. Harris, and Alan Roulstone, *Disability, Policy and Professional Practice,* 15.

[10] Becker, Ann. "The Revolutionary War Pension Act of 1818." Historical Journal of Massachusetts. Institute for Massachusetts Studies, Westfield State University, 2019. https://www.westfield.ma.edu/historical-journal/wp-content/uploads/2020/06/Pension-Act-of-1818-final.pdf.

Veteran Affairs to be more transparent with the process of obtaining and appealing benefit decisions, while the VA MISSION Act of 2018 was put in place to expand healthcare and community care programs for veterans and those veterans with disabilities.[11] When compared to non-veteran disability policy, the history of veteran disability protections is notably more extensive.

A. Current Disability Statistics

After the passing of the Americans with Disabilities Act (ADA) in 1990, the United States (U.S.) Social Security Administration (SSA) started collecting data on individuals who reported having a disability. This is because in the U.S., the SSA is the primary institution that handles the disbursement of benefits for those with disabilities outside of the Department Veterans Affairs (VA), both through Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI).

On the anniversary of the passing of the ADA, a press release by the U.S. Census Bureau in 2024 confirmed that roughly 44.1 million Americans who were not institutionalized had a disability.[12] The chart below consists of SSA data with a reference range of January 1995 to December 2024 and only takes into account those who were approved for disability. Therefore, it does not represent those who were denied or who were in the process of obtaining benefits. Notably, the chart reveals significant increases in disability approvals during November, followed by a sharp decline in December. Although the drastic increases appear to have stabilized by early 2005, the data does not show consistent patterns until around 2010, when sporadic spikes became less frequent. Even though the number of case approvals appears to have taken a significant decrease per month since mid 2010, this decrease can be explained by the extensive backlog of cases that remains an ongoing issue. However, it does appear that disability approvals are on the rise again as can be seen around 2022-2023; the number of approvals has begun to rise at a fairly steady rate. Clearly, data from the SSA indicate that disability cases continue to rise in the United States.

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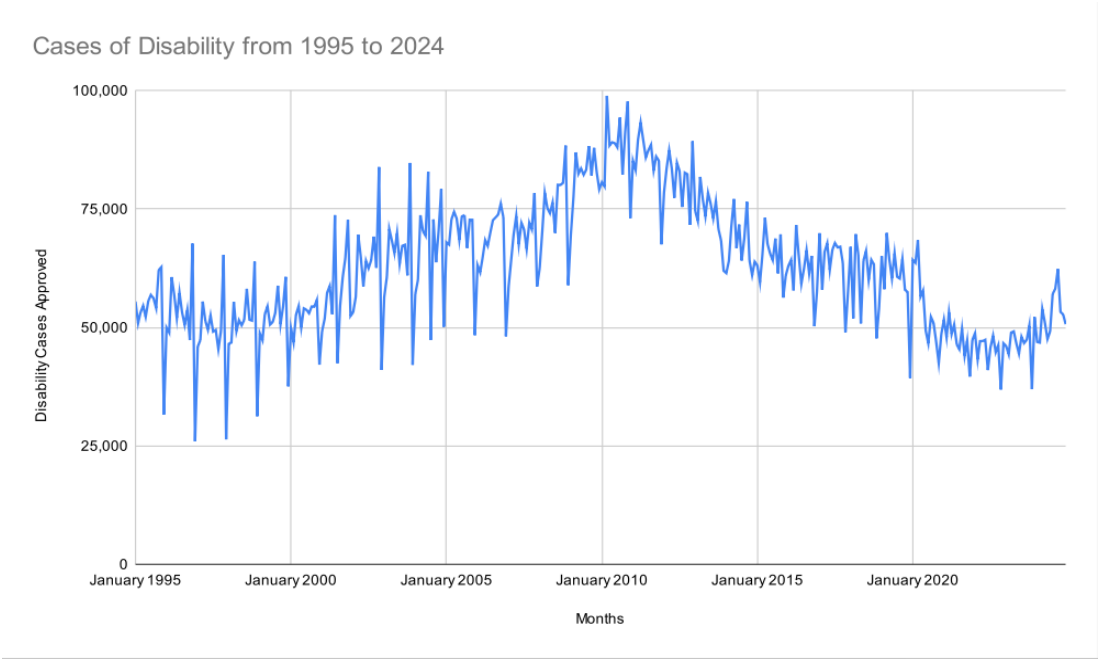
[11] Department of Veterans Affairs (jdt). "VA Launches New Health Care Options under MISSION Act." *VA News*, June 6, 2019. https://news.va.gov/press-room/va-launches-new-health-care-options-under-mission-act/.

[12] United States Census Bureau. "Anniversary of Americans with Disabilities Act: July 26, 2024." Census.gov, August 14, 2024. https://www.census.gov/newsroom/facts-for-features/2024/disabilities-act.html.

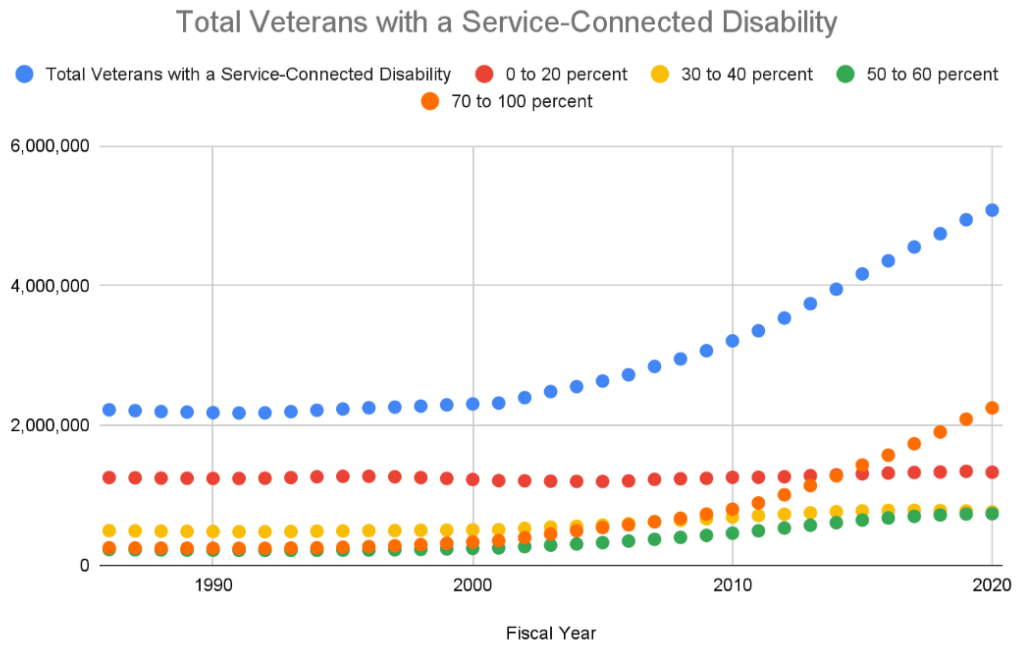


(United States Social Security Administration Data, Jan. 1995- Dec. 2024)[13]

B. Current Department of Veterans Affairs Statistics

A 2003 United States Census Bureau study found that there were an estimated 5,081,692 disabled veterans in the United States.[14] This number accounts for roughly a third of the veteran population in the United States and continues to increase. There were just over two million service-related disabilities reported in 1990, and 5,081,692 in 2023.[15]

[13] United States Social Security Administration, "Disabled-Worker Statistics." Accessed March 25, 2025. https://www.ssa.gov/OACT/STATS/dib-g1.html.
[14] United States Census Bureau. "S2102: Veteran Status." United States Census Bureau, 2023. https://data.census.gov/table/ACSST1Y2023.S2101?q=disabled+veterans.
[15] Department of Veterans Affairs Open Data Portal. "Service Connected Disability (SCD) Veterans by Disability Rating Group: FY1986 to FY2020," November 3, 2020. https://www.data.va.gov/dataset/Service-Connected-Disability-SCD-Veterans-by-Disab/vne6-2zez/about_data.



(U.S. Department of Veterans Affairs Statistics 1986-2020)[16]

The Department of Veterans Affairs (VA) reported that almost 46% of the outstanding claims as of 22 March, 2025 were individuals who took part in conflicts following the September 11 terrorist attacks in the United States.[17] The conflicts classified in this statistic were the U.S. invasion of Iraq in 2003 and the U.S. invasion of Afghanistan in 2001, while the Gulf War of 1991 and the Vietnam War of 1954 made up another ~41% of the outstanding claims.[18] These statistics suggest that despite these conflicts having come to an end, the veterans who served in these wars continue to feel the effects to this day, and many share a need for disability protections. Drawing upon the fact that almost 40% of claims are as a result of service prior to 2000, it is reasonable to infer that disabilities and disability claims are likely to continue to increase as a result of post 2000 conflicts and this inference is supported by the significant increase after 2010.

VI. DISPROPORTIONATELY AFFECTED GROUPS

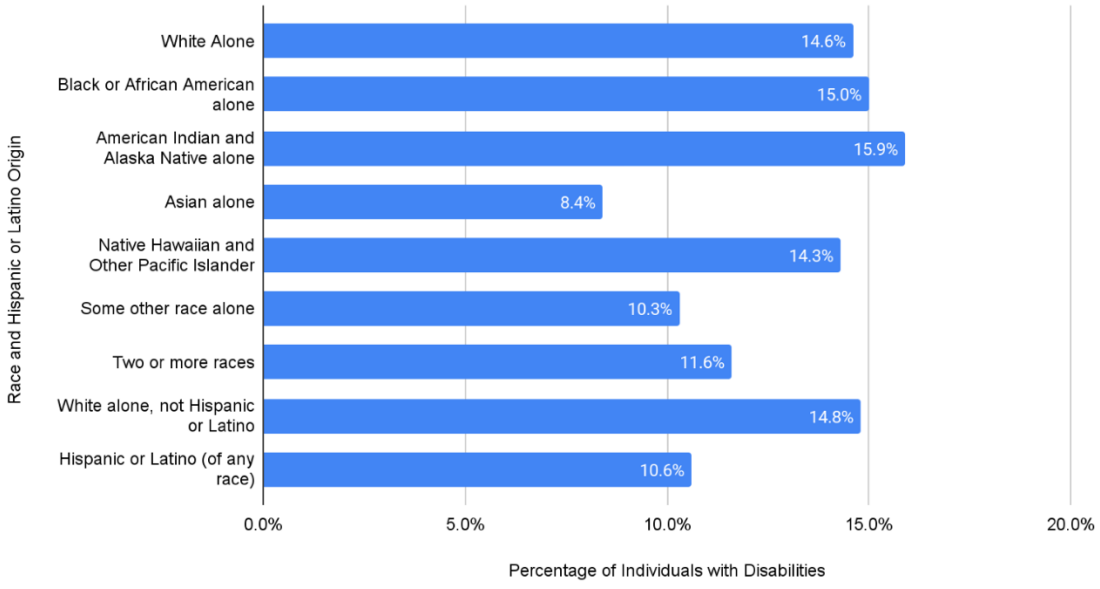
Building on the analysis of veteran and civilian disability cases, it is important to examine which demographic groups are disproportionately affected. Looking at United States Census data, individuals between the ages of eighteen and sixty-four were found to have the most disabilities in comparison to those under eighteen years of age

[16] Department of Veterans Affairs Open Data Portal. "Service Connected Disability (SCD) Veterans by Disability Rating Group: FY1986 to FY2020," November 3, 2020. https://www.data.va.gov/dataset/Service-Connected-Disability-SCD-Veterans-by-Disab/vne6-2zez/about

[17] Veterans Benefits Administration Reports. "VA.Gov," March 22, 2025. https://www.va.gov/vetdata/docs/QuickFacts/SCD_trends_FINAL_2018.PDF.

[18] Veterans Benefits Administration Reports, VA.Gov.https://www.benefits.va.gov/REPORTS/characteristics_of_claims.asp.

and those over the age of sixty-four.[19] It's worth noting that although only one-sixth of census respondents were over the age of sixty-four, this age group accounted for nearly half of all reported disability cases. The leading question with respect to disability statistics is "What group of people are disproportionately affected by disabilities?" As is evident from an analysis of the chart below, American Indians and Alaskan Natives have higher levels of disabilities than any other group with 15.9%, and Black or African Americans with the second most reported cases of disabilities relative to its population size at 15.0%.[20] In contrast, the Asian population in the United States reported that only 8.4% had a disability making it the lowest disability affected population, and "some other race" being second lowest at 10.3%.[21] While not directly tied to disability protections, these statistics will help determine whether a lack of protections disproportionately affects certain groups.



(United States Census Bureau Data Set S1810)[22]

VII. DEFINITION OF MORALITY

As previously stated, many of the constitutions that this study will seek to draw upon do not explicitly outline or mention any sort of disability protections; however, by applying a certain level of morality, these protections can start to be observed and applied. This research will utilize he philosophical teachings of John Rawls to define morality that can be followed throughout the different levels of constitutional analysis. Rawls outlines, in *Justice as Fairness,* a principle that will be used to define morality throughout the rest of this paper. This principle states, "Each person participating in a practice, or affected by it, has an equal right to the most extensive liberty compatible

[19] United States Census Bureau. "DP02." Census Bureau Tables. Accessed April 12, 2025.https://data.census.gov/table?q=DP02.
[20] United States Census Bureau. "S1810: Disability Characteristics." Census Bureau Table. Accessed April 14, 2025. https://data.census.gov/table/ACSST1Y2023.S1810?q=disability.
[21] United States Census Bureau, S1810: Disability Characteristics.
[22] United States Census Bureau, S1810: Disability Characteristics.

with a liberty for all."[23] Given the context of this principle that Rawls establishes, this paper will further seek to acknowledge constitutional protections that refer to equal rights or equal protections as can be implied by this way of thinking.

VIII. FEDERAL CONSTITUTION

The United States (U.S.) Constitution, written in 1787, was intended to be the building block for which the entire U.S. society would be built upon. In addition to establishing the Executive, Legislative, and Judicial branches, the Constitution outlines a basic set of rights guaranteed to individuals in the United States. Of the most notable protections that are commonly referred to, there are freedom of speech, freedom of religion, the right to a speedy and fair trial, and the right to bear arms. Nevertheless, there are still protections that are not explicitly defined, and instead have to be inferred. Specifically, this paper seeks to draw upon the Fourteenth Amendment, and in particular, Article One, the Equal Protections Clause of the Fourteenth Amendment. This Clause states:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.[24]

In order to superlatively outline the disability protections implied by the Equal Protections Clause, this research will dissect and emphasize the different parts. The initial part that is notable is, "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States."[25] By applying John Rawls's principle to this segment of the Equal Protections Clause, it can be deduced that individuals with disabilities are entitled to the same "privileges or immunities" as all United States citizens. The subsequent section reads, "Nor shall any State deprive any person of life, liberty, or property, without due process of law."[26] Considering the wording in this section, emphasis should be placed on the words "any person," and through the proper moral interpretation, it should be understood that this also implies the same protections for individuals with disabilities. Observing the Clause as a whole there are numerous ways that people with disabilities could observe protections and rights. By implying that states are barred from infringing on individuals' rights for all, and applying the sense of morality that Rawls outlines in his first principle; it should be understood that when the word *all* appears, those with disabilities are also included in that definition. This principle includes constitutions as well.

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[23] Rawls, John. "Justice as Fairness." *The Philosophical Review* 67, no. 2 (April 1958): 164.https://doi.org/10.2307/2182612.
[24] National Archives. "14th Amendment to the U.S. Constitution: Civil Rights (1868)," September 7, 2021. https://www.archives.gov/milestone-documents/14th-amendment.
[25] National Archives, *14th Amendment to the U.S. Constitution: Civil Rights (1868)*.
[26] National Archives, *14th Amendment to the U.S. Constitution: Civil Rights (1868)*.

IX. PROCESSES OF PASSING AN AMENDMENT

Acknowledging that the most relevant constitutional disability protections can be inferred through the Equal Protections Clause of the Fourteenth Amendment, it poses the question, "Could the United States Constitution be amended to explicitly add disability protections?". Fundamentally, the first thing that needs to be in place when exploring a U.S. Constitutional Amendment is public support. In order for a constitutional amendment to have a chance of passing, it must garner widespread public support. The legislative process for passing a constitutional amendment is relatively straightforward: it can be introduced in either the U.S. Senate or the House of Representatives. Once introduced, the proposed amendment would require a two-thirds majority to pass before proceeding to the next chamber, where it would also require a two-thirds majority.[27] If passed in both chambers, the amendment would then go to the states where a three-fourths majority, or thirty eight states, would be required for the amendment to officially be ratified.[28] It is important to note that the President of the United States does not participate in any part of the amendment process as compared to the implementation of standard legislation.

X. RELEVANT SUPREME COURT CASES

Exploring relevant United States (U.S.) Supreme Court cases, this research seeks to recognize four of the most influential disability-related cases. In the instance of O'Connor v. Donaldson (1975), the petitioner, Donaldson, argued that the respondent, O'Connor, had violated his constitutional rights under the Fourteenth Amendment by forcing Donaldson to remain institutionalized even though he was deemed not to be a threat to himself or others. Donaldson "alleg[ed] that they had intentionally and maliciously deprived him of his constitutional right to liberty."[29] Decided by a unanimous decision, the U.S. Supreme Court found that individuals with mental illnesses who are not a threat to themselves or others cannot be institutionalized involuntary.[30] The following case this research looks to pursue is Ford v. Wainwright (1986). Ford (the petitioner) was convicted of a murder and ultimately sentenced to death. At the time the murder occurred, there was no evidence that Ford was mentally hindered; however, over time Ford's mental condition continued to decline to the point where Ford was considered mentally impaired.[31] Following a mental evaluation, Ford was found to not be in a lawful state to be executed.[32] With this information, the case was appealed to the U.S. Supreme Court where it was decided in a five to four decision that the execution of an individual with a mental disability was cruel and unusual punishment as outlined under the Eighth Amendment and labeled in the dissent as "savage and inhuman."[33]

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[27] Harry S. Truman. "The Amendment Process." Accessed March 30, 2025. https://www.trumanlibrary.gov/education/three-branches/amendment-process.
[28] Harry S. Truman, The Amendment Process.
[29] Justia Law. "O'Connor v. Donaldson, 422 U.S. 563 (1975)." Accessed March 30, 2025. https://supreme.justia.com/cases/federal/us/422/563/#annotation.
[30] Wold, Shawn M. "O'Connor v. Donaldson: Due Process and the Involuntarily Civilly Committed Mental Patient." *Tulsa Law Review* 11, no. 4 (1976).
[31] Justia Law."Ford v. Wainwright, 477 U.S. 399 (1986)." Accessed March 30, 2025.
[32] Justia Law, Ford v. Wainwright, 477 U.S. 399 (1986).
[33] Justia Law, Ford v. Wainwright, 477 U.S. 399 (1986).

Looking to one of the more current disability United States (U.S.) Supreme Court cases, PGA Tour, Inc. v. Martin (2001) was a key case in recent history shedding light on protections of the Americans with Disabilities Act (ADA). Martin, who has a degenerative circulatory disease, inquired with PGA Tour, Inc. to determine if he could obtain a golf cart which could take him from hole to hole due to his condition.[34] PGA Tour, Inc. declined Martin's query stating that all other players have to walk. "The court found that the purpose of the PGA's walking rule was to insert fatigue into the skill of shot-making, and that Martin suffered significant fatigue due to his disability, even with the use of a cart."[35] Following its seven to two decision for Martin, the U.S. Supreme Court concluded in its dissent that, "Despite petitioner's walking requirement, it is not a modification that would "fundamentally alter the nature" of petitioner's tours or the third stage of the Q-School."[36]

XI. STATE CONSTITUTIONAL ANALYSIS

While the U.S. Constitution does not explicitly outline protections for individuals with disabilities; several Supreme Court cases have interpreted its provisions in ways that support disability rights. However, a number of state constitutions do explicitly provide disability protections, though their scope and language vary. This section examines how selected state constitutions address disability rights, highlighting opportunities for expansion and offering models for other states to follow. Recognizing the states whose constitutions do outline disability protections, this study sets to start by analyzing the Florida State Constitution. Florida's State Constitution declares:

> **SECTION 2. Basic rights. —** All natural persons, female and male alike, are equal before the law and have inalienable rights, among which are the right to enjoy and defend life and liberty, to pursue happiness, to be rewarded for industry, and to acquire, possess and protect property. No person shall be deprived of any right because of race, religion, national origin, or physical disability. (1998)[37]

In the conclusion of this section, it is evident that individuals with "physical disabilities" are protected in Florida's Constitution; however, even though physical disabilities are stated, the constitution lacks reciprocal mental disabilities protections. Despite the fact that the Florida Constitution lacks a clause related to mental disabilities, such a fix could unambiguously be removing the word "physical" altogether as so the remaining segment would be perceived as an all-encompassing statement for all individuals with disabilities.

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[34] Justia Law. "PGA Tour, Inc. v. Martin, 532 U.S. 661 (2001)." Accessed March 30, 2025. https://supreme.justia.com/cases/federal/us/532/661/#tab-opinion-1960917.

[35] "PGA TOUR, Inc. v. Martin." Oyez. Accessed March 30, 2025. https://www.oyez.org/cases/2000/00-24.

[36] Justia Law, PGA Tour, Inc. v. Martin, 532 U.S. 661 (2001).

[37] The Florida Senate. "The Florida Constitution." Accessed April 8, 2025.https://www.flsenate.gov/laws/constitution#A1S02.

In contrast to Florida's more limited language, Connecticut's Constitution offers more comprehensive protections by explicitly safeguarding individuals with both physical and mental disabilities in its Equal Protection Clause. This Amendment states:

> ARTICLE XXI.
>
> Article fifth of the amendments to the constitution is amended to read as follows: No person shall be denied the equal protection of the law nor be subjected to segregation or discrimination in the exercise or enjoyment of his or her civil or political rights because of religion, race, color, ancestry, national origin, sex or physical or mental disability. Adopted November 28, 1984.[38]

Interpreting Article Twenty One of the Connecticut Constitution above, it is important torecognize that individuals with both physical and/or mental disabilities are protected. As Connecticut's version of an Equal Protection Clause, this is one of the most comprehensive disability rights provisions in any state or territorial constitution.

Unlike Florida and Connecticut, Hawaii's constitution emphasizes public health and rehabilitation but falls short of clearly defining civil rights protections for individuals with disabilities. Hawaii's Constitution mentions in multiple places helping those with disabilities as well as the promotion of public healthcare. Looking at Article Nine, Sections One and TwoHawaii's Constitution says:

> PUBLIC HEALTH
>
> **Section 1.** The State shall provide for the protection and promotion of public health. [Ren Const Con 1978 and election Nov 7, 1978]
>
> CARE OF HANDICAPPED PERSONS
>
> **Section 2.** The State shall have the power to provide for the treatment and rehabilitation of handicapped persons. [Ren and am Const Con 1978 and election Nov 7, 1978][39]

Observing the sections above, it should be highlighted that Hawaii's Constitution does look to better the lives and help rehabilitate those with disabilities. However, the constitution should also be criticized for not recognizing specific protections for individuals with disabilities, such as the right to protections from discrimination, as seen in other state constitutions. Comparing Hawaii's constitutional wording with others such as Florida's Constitution, Hawaii's does not mention anything about equal protections, rights, or discrimination, whereas Florida's states that people with physical disabilities are granted equal protections.

Illinois's Constitution provides stronger civil protections, explicitly prohibiting discrimination in housing and employment on the basis of physical or mental handicap. The most significant section to draw upon for anti-discrimination articles is Article One,

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[38] CT.gov - Connecticut's Official State Website. "Constitution of the State of Connecticut." Accessed April 8, 2025. https://portal.ct.gov/sots/register-manual/section-i/constitution-of-the-state-of-connecticut.

[39] LRB- Legislative Reference Bureau. "State Constitution." Accessed April 8, 2025.https://lrb.hawaii.gov/constitution/#articleix.

Section Nineteen of the Illinois State Constitution which states, "SECTION 19. NO DISCRIMINATION AGAINST THE HANDICAPPED All persons with a physical or mental handicap shall be free from discrimination in the sale or rental of property and shall be free from discrimination unrelated to ability in the hiring and promotion practices of any employer."[40] Such a section seeks to protect individuals with disabilities from being discriminated against while in the process of finding employment and searching for housing. This section, unfortunately, is the extent of the of explicitly listed disability protections; anything further would only be inferred protections. This provision offers more protection than many other state constitutions, though it could still be amended to further broaden its scope and include additional disability categories.

Louisiana's Constitution contains multiple disability-related provisions within its Bill of Rights, offering protections in both general equal protection language and in access to public accommodations. These sections say:

> §3. Right to Individual Dignity
>
> Section 3. No person shall be denied the equal protection of the laws. No law shall discriminate against a person because of race or religious ideas, beliefs, or affiliations. No law shall arbitrarily, capriciously, or unreasonably discriminate against a person because of birth, age, sex, culture, physical condition, or political ideas or affiliations. Slavery and involuntary servitude are prohibited, except in the latter case as punishment for crime.
>
> §12. Freedom from Discrimination
>
> Section 12. In access to public areas, accommodations, and facilities, every person shall be free from discrimination based on race, religion, or national ancestry and from arbitrary, capricious, or unreasonable discrimination based on age, sex, or physical condition.[41]

The protections seen in the Louisiana State Constitution sections above are extensive, with Section Three being regarded as the Equal Protections Clause of their constitution and highlighting that no person shall be discriminated against due to physical condition. Along with Section Twelve, which addresses public accommodations and denounces discrimination against those with disabilities, a comprehensive set of disability protections are observed. Although the protections outlined above are extensive, the treatment of mental disabilities remains vague and would benefit from clearer, more explicit inclusion.

The Massachusetts Constitution, which notably served as a model for the United States Constitution, includes a non-discrimination clause for individuals with disabilities; however, its reliance on ambiguous qualifiers like "otherwise qualified" limits the provision's effectiveness.[42] The most notable segment of the Massachusetts

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[40] Article I. "Illinois Constitution." Accessed April 8, 2025. https://www.ilga.gov/commission/lrb/con1.htm.

[41] Louisiana State Senate. "Louisiana Constitution of 1974," January 8, 2024.https://senate.la.gov/Documents/LAConstitution.pdf.

[42] Commonwealth of Massachusetts. "John Adams & the Massachusetts Constitution." Accessed April 10, 2025. https://www.mass.gov/guides/john-adams-the-massachusetts-constitution.

Constitution is, "ART. CXIV. No otherwise qualified handicapped individual shall, solely by reason of his handicap, be excluded from the participation in, denied the benefits of, or be subject to discrimination under any program or activity within the commonwealth."[43] Structurally acceptable, this clause should be amended for clarity as it seeks to call upon "qualified handicapped individuals."[44] Without properly defining who meets the qualifications mentioned, this section could be seen as somewhat fragmentary, especially in the eyes of those the section intends to protect.

In contrast to Massachusetts's limited clause, the Michigan Constitution offers broad and inclusive language that affirms the state's commitment to the care, education, and rehabilitation of individuals with all types of disabilities. Through observations made of this constitution it is of utmost importance to note how unequivocally displayed disability protections are in the Michigan Constitution. Article VIII, Section 8 of the Michigan Constitution states: "Institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported."[45] Though not explicitly granting equal protections or encouraging anti-discrimination practices across the board, the constitution does address all with disabilities and encourages education as well as healthcare and rehabilitation. These protections are important and lacking in other state constitutions that do have equal protections; however, in addition there are ways that could make these protections more inclusive and impactful for those with disabilities.

In contrast to Massachusetts's limited clause, the Michigan Constitution offers broad and inclusive language that affirms the state's commitment to the care, education, and rehabilitation of individuals with all types of disabilities. Taking note of Article Two, Section Four of the Montana Constitution, it says: "Individual dignity. The dignity of the human being is inviolable. No person shall be denied the equal protection of the laws. Neither the state nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, color, sex, culture, social origin or condition, or political or religious ideas."[46] The terminology referred to in this section of the Montana Constitution does not explicitly state individuals with disabilities; however, it does refer to those with conditions, which can be implied as disabilities. The use of the word conditions does fit the adequacy and all encompassing feeling that the word disability does on its own; however, to individuals whose focal point is on disabilities explicitly laid out, this could be overlooked as an inferred protection.

In contrast to Montana's implied protections, the Nevada Constitution explicitly affirms equality under the law for individuals with disabilities through clear and inclusive language in its Equal Protections Clause. The most noteworthy component of the Nevada Constitution can be found in Article One, Section Twenty Four when it

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[43] FindLaw. "Massachusetts Constitution Amendments Art. CXIV." Accessed April 10, 2025. https://codes.findlaw.com/ma/massachusetts-constitution/ma-const-amend-art-cxiv.html.
[44] FindLaw, Massachusetts Constitution Amendments Art. CXIV.
[45] Michigan Legislature. "MCL - Article VIII § 8." Accessed April 10, 2025. https://legislature.mi.gov/Laws/MCL?objectName=MCL-ARTICLE-VIII-8&highlight=disabled.
[46] Montana Code Annotated 2023. "Section 4. Individual Dignity, MCA." Accessed April 10, 2025. https://archive.legmt.gov/bills/mca/title_0000/article_0020/part_0010/section_0040/0000-0020-0010-0040.html.

states, "**Equality of rights**. Equality of rights under the law shall not be denied or abridged by this State or any of its political subdivisions on account of race, color, creed, sex, sexual orientation, gender identity or expression, age, disability, ancestry or national origin."[47] Reflected above, the Nevada State Constitution makes use of its Equal Protections Clause to draw upon disability protections, stating that people with disabilities are afforded the same rights as all other individuals in Nevada. Notably, the statute does not specify types of disabilities, which suggests that its language is intentionally inclusive of all individuals with disabilities—not just those with physical or mental conditions.

An analysis of all nine state constitutions reveals the need for consistent, inclusive language across all state constitutions regarding disability protections. Clauses such as Equal Protection Clauses, anti-discrimination clauses, and others such as that of housing and healthcare should include the word disabilities or disabled as a single word in an attempt to be as inclusive as possible without noting physical or mental disabilities. The notion of physical or mental disabilities, or the word disabled, could be seen as exclusionary of other disabilities, as noted in the Florida and Louisiana Constitutions.

Recognizing that only nine of fifty state constitutions were drawn upon for their implementation of explicit disability protections, the other forty one states either have no explicit disability protections and require some degree of moral analysis, have nothing that could be looked upon in an attempt to identify disability protections, or have offensive wording aimed at individuals with disabilities. Among the states whose constitutions contain outdated or offensive language, the Ohio Constitution serves as a notable example. Article Seven, Section One of the Ohio Constitution states, "Institutions for the benefit of the insane, blind, and deaf and dumb, shall always be fostered and supported by the state; and be subject to such regulations as may be prescribed by the General Assembly."[48] Given this Amendment was not implemented until 1851, improper wording of note in this section being "dumb" and "insane" could be chalked up to simply being conventional for its time; however, it should be argued that such wording is far outdated and offensive in contemporary terms. Therefore, beyond constitutions being amended to include disability protections, constitutions with such offensive and outdated wording should be updated and amended for accuracy and the inclusion of modern and less offensive terminology.

Considering that many states lack modern disability protections in a world of declining institutionalizations and what Oakes considers "a lowering of industrialization ideas and more social and cultural integration," this research must also examine the process at which states amend their own constitutions.[49] The process of amending state constitutions is slightly different across the United States; however, the main premises remain the same. The most common process is called a Legislative Referred Constitutional Amendment, where members of the state legislature propose amendments which will be voted on by both chambers of the state legislature. This is where things can differ as some states require a different number of sessions and/or votes to pass through the different chambers. Past this, once an amendment has passed

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[47] "The Constitution of the State of Nevada." Accessed April 10, 2025. https://www.leg.state.nv.us/Const/NVConst.html#Art1.

[48] States, Ohio, United. "The Second Constitution of the State of Ohio, " March 10, 1851.

[49] Wayne Thomas Oakes, *Perspectives on Disability, Discrimination, Accommodations, and Law,* 48.

the state legislature, it would be placed on a ballot for citizens of the state to vote on before it could be enshrined in the state constitution. Other processes of amendment implementation include constitutional conventions, constitutional commission, and citizen-initiated constitutional amendments, though not as widespread.

XII. TERRITORY CONSTITUTIONS

Though United States Territories are oftentimes not referenced with respect to their constitutions or US policy in the first place, it is of utmost importance to address all U.S. Constitutions in order to draw upon their protections or lack thereof. The only Territory to address disability protections would be that of Puerto Rico which states in PR Const art II § 1, "Section 1. The dignity of the human being is inviolable. All men are equal before the law. No discrimination shall be made on account of race, color, sex, birth, social origin or condition, or political or religious ideas. Both the laws and the system of public education shall embody these principles of essential human equality."[50] This portion of the Puerto Rico Constitution is both an Equal Protections and Anti-Discrimination Clause for those with conditions. This section also uses more encompassing terminology noting all with conditions opposed to listing only individuals with a mental and/or physical disability. Apart from Puerto Rico, both the Northern Mariana Islands and American Samoa do not have constitutional disability protections, while both Guam and the United States Virgin Islands do not have written constitutions.

XIII. LEGISLATION ADDRESSING VETERANS DISABILITY

While probing through the various constitutions outlined earlier in this research, the gaps that were noted were undeniable; however, the United States Congress has passed an abundance of legislation in an effort to address the gaps. In an effort to adequately draw upon the legislation that seeks to fill these spaces, this research will take a chronological approach to this legislative analysis. Beginning with the Pension Act of 1818, this Act was put into effect just after the start of the American Revolutionary War which took place between the Kingdom of Great Britain and the thirteen British Colonies which is now known as the United States of America. The Pension Act of 1818 was established to aid veterans who served in the Continental Army for at least nine months and for widows of veterans who had died during the Revolutionary War.[51] Benefits of this act were to ensure that veterans and widows receive a fixed pension that would last for the rest of their lives.[52] The significance of the Pension Act of 1818 is that it would unknowingly end up being the origination of veteran disability legislation in the United States.

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[50] Justia Law. "Puerto Rico Constitution :: Article II - Bill of Rights :: Section 1." Accessed April 11, 2025

[51] Becker, Ann. "The Revolutionary War Pension Act of 1818." Historical Journal of Massachusetts, 2019. https://www.westfield.ma.edu/historical-journal/wp-content/uploads/2020/06/Pension-Act-of-1818-final.pdf.

[52] National Parks Service. "Revolutionary War Veteran and Widow Pensions (U.S. National Park Service)." Accessed April 12, 2025. https://www.nps.gov/articles/000/revolutionary-war-veteran-and-widow-pensions.htm.

Although not a piece of legislation, Executive Order 5398, signed by then President Herbert Hoover in 1930, completely transformed the way veterans received benefits in the United States. By consolidating hospitals, administrative bureaus, and offices, Executive Order 5398 marked the establishment for what is today known as the United States Department of Veterans Affairs.[53] The significance of this Executive Order not only established the Department of Veterans Affairs, but is also the enforcement agency for veteran legislation and protections in addition to the dispersion of monetary benefits.

Following Executive Order 5398, another significant measure impacting disabled veterans is the Veterans Claims Assistance Act of 2000. Recognizing the treacherous process of applying for and proving one's disabilities, this act was implemented to assist disabled veterans, one way of doing this is by aiding veterans in obtaining relevant documentation that is required as part of the application process.[54] Though this bill was not intended to walk all claimants through the entire process, it is still important to note as many veterans are prevented by their disability from being able to obtain the relevant documentation on their own.

The final piece of veteran disability-related legislation examined in this study is the Promise to Address Comprehensive Toxics (PACT) Act of 2022. Being one of the newest pieces of legislation to address veteran disabilities, this act pursues the issue of veterans who were exposed to toxins while in service. With this in mind the PACT Act expanded healthcare access to all veterans, and with a focus on veterans with disabilities related to toxin exposure, it:

Expands and extends eligibility for VA health care for Veterans with toxic exposures and Veterans of the Vietnam, Gulf War, and post-9/11 eras, Adds 20+ more presumptive conditions for burn pits, Agent Orange, and other toxic exposures, adds more presumptive-exposure locations for Agent Orange and radiation, Requires VA to provide a toxic exposure screening to every Veteran enrolled in VA health care, [and] Helps us improve research, staff education, and treatment related to toxic exposures.[55]

Not only did this improve and expand access to healthcare for millions of veterans, but it also made the goal for many to obtain their benefits more accessible and more possible as it expanded previously existing statutes to encompass more individuals who received toxin exposure and suffered injuries.

XIV. CIVILIAN DISABILITY LEGISLATION

Although disability legislation that applies to disabled veterans does not apply to civilians, civilian disability legislation does also apply to disabled veterans. As seen in a multitude of veteran disability legislation, the topics are often concentrated on the expansion of veteran specific healthcare, veteran monetary benefits, and veteran jobs;

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[53] The American Presidency Project. "Executive Order 5398—Consolidation and Coordination of Governmental Activities Affecting Veterans." Accessed April 12, 2025.https://www.presidency.ucsb.edu/documents/executive-order-5398-consolidation-and-coordination-governmental-activities-affecting.

[54] "Veterans Claims Assistance Act of 2000." U.S. Government. Accessed April 12, 2025. https://www.congress.gov/106/plaws/publ475/PLAW-106publ475.pdf.

[55] Veterans Affairs. "The PACT Act and Your V A Benefits," March 5, 2024.https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

however, there is legislation that has to fill in the gaps that veteran legislation does not cover, and to protect individuals who are not veterans. Through a chronological analysis of legislation, this study will inspect the legislation that protects all disabled veterans and civilians. Analyzing The Individuals with Disabilities Education Act (IDEA) passed in 1975, this act aimed to ensure that individuals with disabilities had a fair chance to succeed in school. Though far more extensive, this act further pushed to give parents more of a voice in their child's education, and began the implementation of reasonable accommodations that could be used to aid students who needed extra support such as, braille, sign language interpreters, and speech therapy. This was one of the first major acts that sought to support individuals with disabilities, and the first piece of legislation that was passed in a twenty-five year stretch that witnessed the most disability legislation passed from 1975 to 2000.

When examining voting rights for individuals with disabilities, two key pieces of legislation frequently cited are the Voting Accessibility for the Elderly and Handicapped Act of 1984 and the Help America Vote Act of 2002 (HAVA). The two of these acts together both establish the need for increased accessibility in polling places and initiate basic requirements for polling places such as ramps in locations with stairs, the use of alternative voting methods, and provide funding so that states can acquire more accessible voting methods. Through a combination of these pieces of legislation voting accessibility has been greatly improved, though individuals with mental disabilities are still a largely disproportionately affected group.

The next piece of legislation is also likely the most known and widely regarded, the Americans with Disabilities Act of 1990 (ADA). The ADA should be regarded as an anti-discrimination act that seeks to protect individuals with disabilities from discrimination while also expanding rights they are entitled to. Since the ADA is such a wide-reaching piece of legislation, this research will touch upon the most influential parts in an attempt to best summarize how extensive the protections included are. The most common practice that was formally organized as a result of the ADA would be handicapped parking, although a common practice prior to the passing of the ADA there were no provisions for how handicapped parking was required to work. The ADA established business and federal building requirements for handicapped parking, spot size requirements, and requirements for the number of spots for a specific location. In addition to handicapped parking provisions, the ADA heavily addressed workplace discrimination, stating: "The American with Disabilities Act of 1990 (ADA) makes it unlawful to discriminate in employment against a qualified individual with a disability. The ADA also outlaws discrimination against individuals with disabilities in State and local government services, public accommodations, transportation and telecommunications."[56] Furthermore, the ADA aids in communication (e.g. text to speech), accessibility in public schools for children, voting accessibility, reasonable work, living, and school accommodations, and insurance discrimination. Recognizing the substantial protections provided by the ADA, it is often regarded as a comprehensive and far-reaching piece of legislation; however, the heavy reliance on the Americans with Disabilities Act (1990) raises concerns about the vulnerability of those protections to legislative change.

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[56] US EEOC. "The ADA: Your Employment Rights as an Individual With a Disability." Accessed April 12, 2025. https://www.eeoc.gov/publications/ada-your-employment-rights-individual-disability.

Turning to more recent legislation, one final measure worth highlighting is the Affordable Care Act of 2010 (ACA). The ACA, more commonly known as Obamacare, was passed in 2010 following a time period where many lacked health insurance. The continuous objective for the ACA is to expand healthcare to those who would otherwise not be able to afford it. In a study published in 2016, it was found that, "When the law was enacted in 2010, almost 50 million Americans were uninsured—about 19% of the nonelderly population—and among the uninsured, an estimated 91% had incomes below 400% FPL and thus were potentially eligible for benefits under the ACA (52% for expanded Medicaid and 39% for exchange subsidies)."[57] Following the passing of the ACA the number of uninsured has dropped by almost half to around twenty six million individuals in the United States as of 2023; this is an extraordinary statistic as many of the individuals who take advantage of the ACA are economically disadvantaged, elderly, or are individuals with disabilities.[58]

Though with all of the good that does come with this degree of sprawling legislation, there is an unfortunate truth that must always be considered as well, and that is that such legislation can be repealed, especially if one party holds both houses of congress and the presidency. The process of repealing legislation is a relatively simple process that includes the ratification of another bill that would overrule the previous one. For this to happen, the bill would have to be introduced in either chamber of the U.S. Congress before a vote is called. Once passed through one chamber, the bill would pass to the next. If the bill passes in both chambers of congress, then it would go to the president's desk for a final signature. Once this has happened and the bill has been signed into law, the bill would then become law and the preceding bill would be nullified.

XV. INTERPRETATION OF FINDINGS

Individuals with disabilities are by far one of the most discriminated against groups in the United States. From the pre-institutionalization period, through the institutionalization period, to present day, people with disabilities find themselves looking back on an appalling history of human rights violations, starvation, and abuse. Though with a lowering of social stigma and increase in legislation, a greater number of individuals are becoming more open to discussing their disability. This increase can be noted as disability cases have risen exponentially following the passing of the Americans with Disabilities Act (1990) among civilians, as well as by millions of veterans following the Vietnam War and wars that occurred as a result of the September 11 attacks. While the upward trends in disability data are important to acknowledge, progress in expanding disability protections has remained slow. Constitutional protections are relatively few at the federal level, and only the constitutional protections that can truly be distinguished are on a state and territory constitution level, and even then, those protections can only be seen in 10 of those constitutions. Apart from the few constitutional protections that do exist, there are different pieces of legislation that seek to make up this gap. While veteran-focused legislation has remained relatively

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[57] Kominski, Gerald F., Narissa J. Nonzee, and Andrea Sorensen. "The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations." *Annual Review of Public Health* 38, no. 1 (March 20, 2017): 489–505. https://doi.org/10.1146/annurev-publhealth-031816-044555.

[58] CDC. "U.S. Uninsured Rate Hits Record Low in First Quarter of 2023." Accessed April 12, 2025.https://blogs.cdc.gov/nchs/2023/08/03/7434/.

consistent since the Pension Act of 1818, the same cannot be said for legislation aimed at civilians with disabilities. Legislation for civilians was relatively non-existent prior to the mid twentieth century; prior to this time, institutionalizations were at the highest point in history. Only after the mid twentieth century did legislation start to transform the way that individuals with disabilities were protected and addressed the mistreatment that had taken place. This sequence of legislation lasted from the mid twentieth century till around 2010, with the most recent piece being the Affordable Care Act which, although beneficial to those with disabilities, was not the intended target of the legislation.

CONCLUSION

Restating that constitutional disability protections are relatively few, the United States seeks to fill these constitutional gaps through the use of legislation. However, it is deeply worrying how many individuals rely on this legislation and how simple the process of repeal is under the right circumstances. In the event that a piece of legislation such as the Americans with Disabilities Act got repealed, the tens of millions that heavily rely on it for its workplace anti-discrimination and parking protections would instantly lack those protections. Another instance that would arguably be worse would be the abrogation of the Affordable Care Act of 2010, which would strip tens of millions of individuals from their affordable health insurance that they are heavily reliant on, requiring those individuals to seek out far more costly private insurance or run the risk with no insurance at all. Noting that either of these situations would be utterly devastating for the disabled community, the need for enshrined constitutional protections should only be seen as necessary. Acknowledging that some states do already have protections for those with disabilities, it portrays that other states could follow suit and implement their own protections. Though only nine states and one territory have already implemented some level of protections for individuals with disabilities, wording should be altered to be more specific than to state “qualified” individuals, and include wording to specify which types of disabilities that are protected should be removed altogether. Constitutions that include exclusionary phrases such as physical disabilities, mental disabilities, or qualified disabilities risk undermining the intent of the Equal Protection and Anti-Discrimination Clauses in which they appear. An appropriate way to address this is by adopting consistent, inclusive language—using terms like individuals with disabilities rather than limiting or specific descriptors. By leaving out physical, mental, and qualified, it makes for a far simpler inference to include all individuals with disabilities. For entire amendments there is an extensive list of language that can be done, such as that of an Equal Protections Clause, anti-discrimination language, promotion of healthcare and rehabilitation, and the abolition of previous offensive language. The implementation of such language in state constitutions would not only lessen dependency on various pieces of legislation, but enhance the lives of individuals it would seek to protect. For the foreseeable future, the United States Constitution is likely to remain unchanged; however, additions and changes can be made to improve state constitutions, though this is only possible with the help of those who have a larger voice than that of the oppressed.

BRANDED AND BARRED: AN INTERSECTIONAL ANALYSIS OF IDENTIFYING, DESTIGMATIZING, AND DECRIMINALIZING PSYCHOLOGICAL DIAGNOSES THAT PERPETUATE RACIAL DISPARITIES OF INCARCERATED BLACK & HISPANIC MEN

Faith Chukwudinma*

Abstract: This project investigates the intersection of race, mental health, and incarceration by examining how psychological diagnoses are weaponized to perpetuate racial disparities among incarcerated Black and Hispanic men. Grounded in systems theory and supported by the historical analysis of punitive practices through Foucault's penal theory, the work critiques existing carceral mental health frameworks and proposes transformative alternatives. The study emphasizes the role of social workers in disrupting these systems and introduces a structured undergraduate internship program at the Federal Correctional Institution Fort Dix. This program integrates Systemic Cognitive Behavioral Therapy (CBT) and Forensic Assertive Community Treatment (FACT) to equip future practitioners with culturally responsive, evidence-based methods for addressing the mental health needs of incarcerated individuals. Through experiential learning, advocacy, and community-based reintegration efforts, this initiative aims to reduce stigma, foster empowerment, and advocate for systemic change within both the criminal justice and mental health landscapes.

Keywords: Racial Disparities; Incarceration; Psychological diagnoses; Black and Hispanic Men; Trauma-Informed Care; Structural Racism; Public Policy; Abolitionist Framework; Cognitive Behavioral Therapy (CBT)

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I. STATEMENT OF NEED

There is a critical need to decriminalize mental illness and address the racial disparities in psychiatric diagnoses within the justice system by increasing mental health professionals in correctional facilities, which this project aims to tackle through a specialized internship program for social work students at Federal Correctional Facility Fort Dix in Burlington County, NJ.

This project aims to decriminalize mental illness and increase the number of mental health professionals within the carceral system to meet the needs of incarcerated individuals. Despite efforts to address mental health within correctional institutions, many current models have failed to produce long-term improvements in the well-being and rehabilitation of incarcerated individuals. “In the judicial system, people with mental illness (PMI) are over-represented. The reports that PMI have been imprisoned at dramatically greater percentages during the last ten years are a grave threat for psychiatric state practitioners dealing with criminals with mental disorders. Indeed, it has been observed that three times more people are imprisoned than in psychiatric clinics with significant mental illness” (Saxena & Sahai, 2024).

In contrast, evidence-based approaches integrating systems theory, cognitive behavioral therapy (CBT), and forensic assertive community treatment (FACT) demonstrate promising outcomes. Through direct engagement at the Federal Correctional Facility Fort Dix, students will gain firsthand experience with medically accurate diagnostic methods and criminal justice and medical literature while working to implement effective interventions.

As adapted from The Price of Punishment: Public Spending for Corrections in New York by Prison Research Project, 1976 a diagram from 2019, pre-pandemic, shows that Black Indigenous People of Color (BIPOC) are incarcerated at disproportionate rates, where their racial and ethnic characteristics become determining factors in their initial arrests to final sentencing. Other factors lead to systemic inequities within the carceral system, such as high cash bail, excessive wait times for a pretrial as well as the constant threat of being jailed for technical violations, and authoritative control from correctional officers. With a specialized focus on the Federal Correctional Institution in Fort Dix, New Jersey, this institution is located within Burlington County. It is a low-security federal prison for male persons who are incarcerated. FCI Fort Dix is the largest single federal prison in the United States, housing 3,175 male inmates, with the Fort Dix camp housing 244 inmates as of March 2025. The FCI Fort Dix is a part of the Northeast Region of the Bureau of Prisons (BOP) and has a Level 2 medical care level and a Level 2 mental health care level. Level 2 in healthcare terminology is a part of the Emergency Severity Index (ESI), which stratified patients into five acuity groups. Level 2 in triaging means an emergency that could become life-threatening, with patients in this category needing immediate nursing assessment and treatment. Level 2 Centers have 24-hour access to general surgeons, orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology, and critical care; however, in higher acute care, there are transfers to Level 1 centers. FDI Fort Dix holds persons incarcerated with a range of crimes, such as murder and nonnegligent manslaughter, robbery, larceny-theft, and sexual crimes. In large carceral institutions such as FCI Fort Dix, both sexes that are incarcerated are more likely to have physical ailments such as high blood pressure, Asthma, Cancer, Arthritis, and Infectious diseases such as Tuberculosis, HIV, Hepatitis C, and COVID-19.

As adapted from The Price of Punishment: Public Spending for Corrections in New York by Prison Research Project, 1976, an updated diagram of incarcerated persons from 2022, post-pandemic, with a subtle decrease in incarcerated black persons, a sharp increase in Indigenous persons, and a decrease in Hispanic persons. The decrease in incarceration populations may be due to an overall decline in crime percentages or the subtle shrinkage in crime behaviors as a result of grassroots advocacy, lobbying, and coalition community building to decriminalize offending behavior and prioritize effective rehabilitation and reintegration practices. The COVID-19 pandemic also has a role in this change, as the pandemic exacerbated social isolation in prisons, which is identified to aggravate prisoners' mental health problems and increase suicide rates. Many prisoners experience heightened symptoms of anxiety, depression, and substance use disorder during the pandemic. Consequently, negative social implications between prison staff and incarcerated persons increased as decreased communication about both SARS-CoV-2 and the COVID-19 pandemic further increased stress and anxiety symptomatology amongst incarcerated persons.

In addition, mental ailments include symptoms of psychotic disorders, substance dependence or abuse, antisocial behaviors, past physical or sexual abuse, or maladaptive behaviors such as fighting that results in injury or cognitive disorders such as dyslexia or Attention Deficit Disorders (ADD) act comorbidly with physical ailments. "About two in five people who are incarcerated have a history of mental illness (37% in state and federal prisons and 44% held in local jails). This is twice the prevalence of mental illness within the overall adult population" (National Alliance on Mental Illness, 2024).

In the mental health world, Social Workers work through crisis interventions, providing instantaneous support and intervention methods in situations ranging in severity from mental health emergencies to natural disasters or places of high tension and continuous variable change, such as schools and hospitals. They connect clients and communities to resources such as housing assistance, healthcare, financial aid, and educational programs and navigate complex systems through advocacy. The rising number of incarcerated people has led to a demand for social workers in corrections (Matejkowski et al., 2014). However, as few as 1% of social workers have indicated they work in criminal justice as their primary practice area (Young, 2015). As a result of this rising number, Social workers can create lasting impacts on their communities, including the carceral system, through individual empowerment by providing social skills that drive personal growth and self-sufficiency.

II. PROJECT DESCRIPTION

A. Theoretical Framework: Systems Theory

A foundational aspect of this initiative is Systems Theory, which asserts that individual behaviors are influenced by their broader social environment (Kelly, 2006). A social environment may include Adverse Childhood Experiences (ACEs), substance use disorder within the home or community, family dysfunction, academic difficulties, or exposure to violence. The systemic approach emphasizes that behavior is embedded within multiple ecological levels, individual, family, community, and societal. Utilizing a systems perspective allows social work students to analyze the external factors influencing incarcerated Black men's behaviors and apply interventions that account for these complex relationships ('Systems Theory,' n.d.).

B. Unsuccessful Model: Traditional Logic of Punitive Systems

Historically, carceral mental health programs have relied on punitive measures and limited, underfunded therapeutic interventions. Incarcerated individuals with serious mental illnesses often receive inadequate treatment, leading to worsening symptoms and higher rates of recidivism. Many correctional institutions lack sufficient mental health professionals, contributing to the misdiagnosis and over-medication of incarcerated individuals, mainly Black men diagnosed with Schizophrenia Spectrum disorders (Hedden et al., 2021). Research shows that screening and treatment for mental health conditions often begin within institutions, but without sustained community-based interventions, these efforts fail to produce long-term benefits (Matz, 2018).

Utilizing Michel Foucualt's historical timeline of carceral punishment that analyzes a shift from public torture and execution to more "civilized" but overall oppressive forms of carceral punishment with the modern ideology of "moral reform," Foucault's analysis is important to note of his solution of not traditional reform, but of abolition, radical rethinking, instead of the previous historical restructuring model.

"In Foucault's eyes, penality had not evolved toward greater humanity since the Enlightenment. At most the change was cosmetic, a ruse to hide a sophisticated apparatus of repression under which the lower classes were purportedly incarcerated for their good in the name of illusory rehabilitation" (Jouet 205)

Foucault's Chronology of Evolving Penal Practices and Prison Structures

1. Early 19th Century: Solitary Confinement in America

a. Carceral Method: Solitary Confinement

b. Historical Timeframe: 1829 and Onwards

c. Examples in the U.S. Prison System: Eastern State Penitentiary (Philadelphia)

d. Foucault's Conclusion: Caused mental deterioration, not moral improvement; created mental harm

2. Mid-19th Century: Prison Labor and Racialized Exploitation

a. Carceral Method: Forced Labor and Racialized Punishment

b. Historical Timeframe: 1865

c. Examples in the U.S. Prison System: Angola Prison (Louisiana State Penitentiary)

d. Foucault's Conclusion: Linked prison labor targeting Black men to systemic racial and economic exploitation.

3. Late 19th Century: Classification and Psychological Assessment

a. Carceral Method: Medicalization and Psychological

Normalization

b. Historical Timeframe: Late 1800s and 1900s

c. Examples in the U.S. Prison System: Alcatraz Federal Penitentiary (San Francisco Bay, CA)

d. Foucault's Conclusion: Prisons used psychiatric evaluations to "normalize" inmates, beginning the medicalization of mental illness.

4. **Late 18th Century Idea, Revived Mid-20th Century: The Panopticon Model:** Bentham's Panopticon is a circular prison design in which a single guard can observe all inmates without them knowing whether they're being watched. It symbolizes constant surveillance and is often used as a metaphor for modern systems of social control.

   a. Carceral Method: Surveillance and Social Discipline

   b. Historical Timeframe: 1787 design, revived mid-20th century

   c. Examples in the U.S. Prison System: Stateville Correctional Center (Crest Hill, Illinois)

   d. Foucault's Conclusion: Identified the spread of Panoptic surveillance, which created total social discipline.

5. **1970s and Onward: Mass Incarceration and Racial Disparities in the U.S.**

   a. Carceral Method: Systematic Oppression and Mass Confinement

   b. Historical Timeframe: 1970s and Onwards

   c. Examples in the U.S. Prison System: Rikers Island (NYC) and San Quentin State Prison (California)

   d. Foucault's Conclusion: Observed mass incarceration disproportionately targeting lack and Latino men; concluded prisons served to oppress minorities systematically.

III. SUCCESSFUL MODELS OF INTERVENTION

A. Model 1: Systemic Cognitive Behavioral Therapy (CBT)

Systemic Cognitive Behavioral Therapy is an evidence-based approach that addresses both the individual and environmental factors contributing to mental health conditions. Based on Strategic Family Therapy (Haley & Madanes), Strategic Group Therapy provides direct, solution-oriented interventions that change problematic interaction patterns. Paradoxical interventions, systematic desensitization, symptom prescription, and assigned directives help participants modify behaviors effectively. Group therapy models have been particularly effective for incarcerated individuals

dealing with trauma, substance use disorders, and gang affiliation (Ciftci & Budak, 2022). A study on the effects of CBT-based psychoeducation found that functional remission levels increased. In contrast, internalized stigma levels decreased in participants receiving the intervention, demonstrating its efficacy in correctional settings (Ciftci & Budak, 2022).

1. **Strengths of Model 1:**

    a. This model is crucial in decreasing repeat offenses and recidivism statistics, in addition to addressing complex mental health symptomatology.

    b. Cognitive Behavioral Therapy (CBT) is evidence-based. It has encouraged positive physical health outcomes in re-offending rates in both youth and adults by addressing maladaptive behavioral habits and environmental determinant factors.

    c. Aids in successful societal reintegration of released offenders

    d. Cognitive Behavioral Therapy (CBT) is a continued research topic that utilizes cognitive, behavioral, and trauma-processing aspects, actively integrating newer technological advancements within its therapeutic system.

    e. Certain clinical and criminal history variables were predictive of recidivism among mentally ill offenders. (Gagliardi, Lovell, Peterson, & Jemelka, 2004, p. 151)

2. **Weaknesses of Model 1:**

    a. Offenders are frequently required to participate, raising questions about the offender's willingness to engage in therapy voluntarily.

    b. There is a therapeutic belief that maladaptive thinking patterns and personality problems play a role in the development of psychiatric disorders. However, this theory may not consider social determinant factors such as environment and culturally/spiritually diverse experiences.

    c. Cognitive Behavioral Therapy (CBT) is 'problem-focused' and 'task-oriented,' however, these cognitive and behavioral approaches may not be entirely applicable to inmates with complex experiences and symptoms. These co-occurring symptoms and conditions may include comorbid disorders such as post-traumatic stress spectrum disorders (PTSD), substance use disorder, and psychosis resulting from prolonged solitary confinement, as well as persistent trauma-related behaviors or dissociative disorders caused by chronic abuse or systemic racial violence. In addition, inmates may suffer from infectious diseases linked to poor sanitation, overcrowding, and limited access to healthcare.

B. Model 2: Forensic Assertive Community Treatment (FACT)

Building on the Assertive Community Treatment (ACT) model, FACT targets high-risk individuals with prior arrests and jail detentions. FACT prioritizes treatment for individuals with antisocial personality patterns, substance use disorders, dysfunctional family environments, and histories of antisocial or violent behaviors. Through forensic intensive case management (FICM), FACT connects incarcerated individuals with community-based services, including medical care, parole and probation supervision, and ongoing mental health treatment (Lamberti & Weisman, 2021). Evidence suggests that integrating correctional mental health treatment with post-incarceration community support significantly reduces recidivism and improves long-term mental health outcomes (Matz, 2018).

1. Strengths of Model 2:

a. Forensic Assertive Community Treatment (FACT) is an evidence-based program proven to lower recidivism rates and increase community integration with physical, mental, and legal resources.

b. It addresses mental health and criminal behavior, incorporating community leaders such as court referrals and justice providers. It is essential in direct community involvement that aids in direct societal re-entry amongst justice-involved individuals. "Suicide prevention efforts should focus on people who have spent at least 1 night in jail in the past year. Two distinct methods and datasets both indicate that during the year after jail release, an individual's suicide CMR was 9 times the mean among other U.S. adults, representing 19.9% of adult suicides in 2019, with 27.2% of suicides occurring within 2 years after release." (Smith et al., 2021) Utilizing community-based resources, evidence states that better integration of suicide risk detection and prevention across health and criminal systems that includes 911 calls, police contacts, pretrial jail detention, criminal courts, jail sentences, probation, and parole are essential to reducing the increase of suicide in prison populations.

c. Evidence-based programs to prevent recidivism and enhance community integration are essential given most people convicted of a crime are either currently in the community or will ultimately return to it (DeLuca et al., 2018).

2. Weaknesses of Model 2:

a. Although this program targets individuals with prior arrests, it can create situations of discrimination or enhance implicit biases among community workers.

b. Underutilized/understudied due to the complexity of the program.

IV. METHOLOGY: UNDERGRADUATE SSOCIAL WORK INTERNSHIP

PROGRAM

Leveraging the success of systemic CBT and FACT, this project seeks to establish an undergraduate social work internship program at the Federal Correctional Facility Fort Dix. The program will immerse students in direct work with incarcerated individuals and their families within the physical prison environment and outside in clinical rehabilitation programs, including the camps and community rehabilitation centers. These diverse environments allow for a holistic experience of these systems that range from restrictive to more autonomous. "A community-based transitions clinic may be effective in improving health outcomes and engagement in care for former prisoners" (Fox, Anderson, Bartlett, Valverde, Starrels, & Cunningham, 2014, p. 1140). The overall intention is for comprehensive training of future social workers in evidence-based assessment and intervention methods. Students will apply a systems perspective to understand the environmental factors influencing behavior and implement CBT-based group therapy models tailored to incarcerated populations. Additionally, students will work with correctional staff to develop community reintegration plans using the FACT framework, ensuring continuity of care post-release.

A. Plan Implementation

January — Week 1-4: Orientation and Introduction to Mental Health in Carceral Settings & Immersion in Correctional Facility and Inmate Interaction

Weekly Objectives: Familiarize students with the correctional facility's structure and mental health programs. Introduce racial disparities in mental health diagnoses, especially schizophrenia among incarcerated Black individuals. Establish foundational knowledge of systems theory and cognitive-behavioral therapy (CBT) in carceral settings. Begin rotations at the Federal Correctional Facility Fort Dix. Gain firsthand experience with mental health diagnosis and treatment challenges. Start establishing trust-based relationships with inmates, focusing on rapport and cultural understanding.

Activities: Orientation sessions include an overview of the correctional facility, policies, and expectations. A speaker series features mental health professionals discussing mental illness impacts and cultural competence. Lectures cover systems theory, and group reflections allow students to share their thoughts and challenges about the internship. Students shadow social workers and mental health professionals on facility rounds. They conduct supervised interviews and assessments to understand inmates' mental health challenges. Workshops address implicit biases and work with diverse backgrounds. Case study discussions focus on real-life mental health diagnoses and interventions for incarcerated individuals.

February — Week 1-4: Rotation through Community-Based Transitional Clinical Centers and Community Service and Research Activities

Weekly Objectives: Expose students to community-based clinical centers and their role in reentry programs. Enhance understanding of community interventions in reducing recidivism. Encourage student participation in community service for reentry support. Begin research activities to support the program's evidence-based framework.

Activities: Students rotate through clinics that treat formerly incarcerated

individuals. Discussions focus on applying systemic CBT and Forensic Assertive Community Treatment (FACT) in community settings. Seminars cover the reintegration process, and interactions with formerly incarcerated individuals allow students to hear firsthand experiences. Students engage in community service projects to help formerly incarcerated individuals with legal aid, education, or job training. Research posters summarizing experiences and findings are prepared for a symposium. A speaker series discusses systemic racism, mental health, and the criminal justice system. Data collection and analysis for evaluation purposes begins.

March — Week 1-4: Intensive Case Management and Direct Inmate Intervention

Weekly Objectives: Deepen student involvement in providing mental health interventions and expose students to intensive case management.

Activities: This month is heavily lecture-based and addresses specific systemic issues within the carceral system. The lecture-based learning debunks myths and preconceived notions of the incarceration system and strategically plans evidence-based solutions with social work students for implementing integral change. Students participate in case management meetings and offer input on treatment plans. They assist in implementing systemic CBT and FACT with inmates. Workshops focus on accurately diagnosing mental health conditions in correctional settings and ensuring culturally competent practices. Students start implementing interventions under supervision. Completion of workshops on diagnosis and cultural competence occurs. Feedback from inmates and staff on student performance is collected.

April — Week 1-4: Evaluation and Reflection

Weekly Objectives: Evaluate the effectiveness of interventions and assess student learning. Reflect on the emotional toll of the internship and develop self-care strategies.

Activities: Students have one-on-one evaluations with supervisors to reflect on their progress and challenges. Feedback from inmates on interventions is collected. Workshops help students process emotional challenges faced during the internship, and the data collected is reviewed in preparation for the research symposium. Evaluation reports on student performance are prepared. Completion of self-care workshops takes place. Preparation for the final research symposium begins.

May — Week 1-4: Research Symposium and Closing Ceremony

Weekly Objectives: Showcase student research and reflections on the internship. Provide closure and prepare students for future social work and criminal justice reform roles.

Activities: Students present research findings at the symposium, focusing on the internship's impact on their understanding of mental health and incarceration. A speaker series invites social justice and mental health reform leaders to discuss career opportunities. A final reflection session allows students to share their overall experiences and perspectives. Finally, evaluations from students, staff, and inmates assess the program's success and areas for improvement. Successful completion of the

research symposium occurs. Final evaluations and stakeholder feedback are collected, followed by a closing ceremony and certificate awards for program completion.

Key Aspects of Plan Implementation Include

1. Rotations through community facilities and the larger prison to ensure safety

2. A lecture and speaker series to provide a comprehensive academic learning experience that balances practical experience

3. Reflection/journal groups for community processing

4. Emotional processing workshops

5. Community service projects for applied learning

A reduction in recidivism rates does not measure success, as high incarceration rates are a systemic issue that will not see immediate changes in visual data unless through longitudinal studies. By utilizing evidence-based practices and restructuring previous flaws within existing prison programs, success in this program is measured by the successful reintegration of offenders into their communities and the potential optimistic outcomes of community-based interventions. Additionally, surveys evaluate success after the internship to assess if there is an increase in percentages of undergraduate social work students who are more likely to localize their population in carceral communities. Hopefully, through this internship, there will be a gradual increase from the 1-2% of undergraduate students indicated in current statistical data.

B. Challenges and Solutions in Plan Implementation

1. The overall safety of social work students includes working with correctional staff and creating a steady transition of rotations that allows for constant movement to avoid remaining in one area of the facility with variable situations.

2. Building trust between inmates and social work students in the time frame allotted does not feel transactional or exploitative. However, it creates a bridge for increased trust of inmates and psychological staff within the facility.

3. Proper and comprehensive screening and lectures that address implicit biases amongst students and inmates while teaching proper social skills within interactions with inmates

4. Understanding that academic and emotional burn-out will arise. A solution is to create wellness spaces for emotional processing or allocate times within the internship to allow for rest and emotional decompression while also implementing strategies for social work students to avoid properly balancing the emotional toll of this internship and their goals within the internship.

C. Evidence-Based Criteria for Successful Therapeutic Methods

Saxena and Sahai (2024) outline six phases of Cognitive Behavioral Therapy (CBT), which are:

1. Psychological Evaluation
2. Reconceptualization
3. Acquisition of skills
4. Integration of expertise and its application
5. Maintenance and generalization
6. Follow-up post-treatment review

Success in therapeutic methods is measured by meeting at least 50% of these criteria, with particular emphasis on follow-up post-treatment review and a comprehensive psychological evaluation.

D. Evidence-Based Criteria for Non-Successful Therapeutic Methods

Saxena and Sahai (2024) also specify that the intervention is considered a failure if the crucial behavior persists above or below the baseline. They identify key appraisal measures:

1. **Critical conduct definition:** Assessing whether excesses or shortages are essential habits.
2. **Assessment for frequency, length, or severity of critical behaviors:** Establishing a baseline for these behaviors and striving to reduce their frequency and duration, especially if they are repetitive.

Non-success in CBT is characterized by repeating maladaptive behaviors, reflecting the limitations of the problem-focused and task-oriented models. Success is hindered when there is no evidence of individual growth or voluntary willingness to engage in positive habits.

V. BUDGET

The Robert Wood Johnson Foundation (RWJF) is a community-based organization whose mission statement addresses systemic racism within medical, social, and public health systems. This internship program is requesting $200,000 in funding from the Robert Wood Johnson *Systems for Action: Community-Led Systems Research to Address Systemic Racism* Grant to create a specialized internship program for undergraduate social work students from Burlington County, NJ, focusing on those from Black and other historically marginalized backgrounds. Using an Integrative Care framework, fund allocation is structured to a full numerical value of $200,000 and percentage (100%), serving as a flexible estimate that can be revisited and adjusted based on the complexities of the healthcare and carceral systems.

Central allocations include, $28,000 for intern stipends and $27,000 for a program coordinator to ensure professional guidance and oversight. Educational and

operational needs are covered through course credit fees ($13,500), training and certification ($9,000), educational materials ($4,500), and guest speakers ($4,000), all designed to equip interns with the tools necessary to engage meaningfully with incarcerated individuals. The most significant portion, $45,000 (26.2%), is allocated as Student Stipends to address accessibility challenges in education, ensuring students from diverse socioeconomic backgrounds have equal opportunities and increasing equity within the program. The smallest allocation fund, $4,500 (2.6%), is designated for advocacy and donations. However, advocacy and donations receive a smaller allocation; other budgeted components not directly labeled under advocacy and donations, such as Family Support and Inmate Legal Support, aid incarcerated individuals through financially specific programs that further aid an incarcerated person to reenter society successfully. Administrative support ($12,500), technology and software ($9,000), and facility costs ($7,500) ensure smooth implementation.

This budget follows an integrated care framework, fostering collaboration among healthcare specialists to improve outcomes for vulnerable prison populations. A study on the method of integrative care within healthcare infrastructures further states, "…in practice, however, integrated care rarely delivers on the high expectations of those who implement it. Financial factors, and specifically lack of integration of budgets across sectors, are frequently cited as a major barrier to success…" (Allen et al., 2015). This integrative-care-based allocation method bridges the complexities of the carceral and higher education systems to create healthier, more equitable opportunities for more interns. This budget also includes services accompanying the internship's advocacy component directly toward the incarcerated population.

VI. DISCUSSION

The decriminalization of mental health and oppressive prison punishment practices are a part of the larger growing prison abolition movement with fundamental roots in practical organizing tools, grassroots mobilization ranging from local to international level, and overall community coalition building. Prison abolition can be defined as,

"First, admitting that prisons can't be reformed, since the very nature of prisons requires brutality and contempt for the people imprisoned.

Second, recognizing that prisons are used mainly to punish poor and working class people, and forcing the courts to give equal justice to all citizens.

Third, replacing prisons with a variety of alternative programs. We must protect the public from the few really dangerous people who now go to prison. But more important, we must enable all convicted persons to escape the poverty which is the root cause of the crimes the average person fears most: crimes such as robbery, burglary, mugging or rape." *(Prison Research Project: The Prince of Punishment, 1976, p. 57)*

Black and Hispanic males are more likely to be disproportionately incarcerated compared to the general population. They are generally overrepresented in prisons, and prisons, historically built on medieval concepts of crime and punishment that "perpetuate and multiply crime." As a critical call to action, there is a vital need for decriminalizing the prison system and the stigmatization of complex mental health diagnosis and symptomatology, in particular, of the demographic of incarcerated Black

and Hispanic men.

A broader theory of prison abolition from which this call to action and plan is implemented at is derived from Michel Foucault's theories of disciplinary power and his specified focus on power and knowledge, which he argues that power is not a straightforward top-down entity but a pervasive, complementary dynamic that intersects social interactions, behaviors, and institutions. Publishing the book *Discipline and Punish: The Birth of the Prison*, Foucault (1977) observes that:

"Prison 'reform' is virtually contemporary with the prison itself. It constitutes, as it were, its programme. From the outset, the prison was intended to be a penitentiary apparatus and a correctional technique. The prison was expected to reform the inmates. But soon it appeared that relapses into crime occurred frequently, that prisons produced delinquents rather than reformed citizens." (Foucault, 1977, p. 234)

With Foucault's poignant conclusions about the complex, intricate linkage that power produces knowledge, he concludes, rather than knowledge shaping and reinforcing power, he also further argues: "Prison reform is the endless task of always reconstructing the prison itself" (Foucault 1977 p. 277). The complete abolition of the carceral system, combined with the successful reintegration of formerly incarcerated individuals, could catalyze a radical restructuring of other institutional systems. Often driven by punitive, disciplinary frameworks, these systems may begin to confront their reliance on punishment, especially when past reform efforts have lacked community engagement or failed to challenge deeply embedded power structures. However, it is the continued gaining of knowledge of the consequences that ensue that are deemed valid, affirming this dynamic relationship of oppression. There is a rising number of people who are incarcerated, leading to a critical demand for social workers to work within the correctional system. Within the undergraduate system, less than 1% of future social workers indicate the correctional system and overall criminal justice as their primary area of future practice. The reduction of social workers occupying this specific practice area results from the penal system's complexities. Suicide is the single leading cause of death for people in jail, as an incarcerated person is more than 3x more likely to die from suicide than someone in the general U.S. population. According to (Miller et al. 2024), nearly 20% of suicides occurred among those released from jail in the past year, and 7% were by those in their second year post-release.

Utilizing a humanistic lens, an anecdote from a previously incarcerated person and their family cites, "Solitary is just not right or built for people. You can't retake your mind from the hurt of knowing that the outside world is going on without you," said Alex Mirzaoff, who, after over three months of incarceration and time served, returned home with a broken nose, uncontrolled diabetes, and deteriorated mental health, "This is not my son," his mother stated (Kass, 2022, as cited in New York Focus).

By creating a comprehensive internship program for future social workers to engage with people who are incarcerated, this internship provides an exceptional opportunity to create a deeper physical, emotional, and evidence-based educational connection within the individuals penalized by this complex system.

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ENHANCING THE FUNCTION OF THE PROOFREADER IN COLORECTAL CANCER STEM CELLS USING CRISPR TECHNIQUES

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Abstract: Colorectal cancer (CRC) is one of the most prevalent malignancies worldwide. Colorectal cancer stem cells (CCSCs) play a significant role in the development of therapeutic resistance and recurrence of the cancer. These cells exhibit self-renewal and pluripotency, which makes them resistant to conventional treatments. The deficiencies in DNA proofreading—particularly the exonuclease activity of DNA polymerases—might lead to a higher probability of mutations and genomic instability. This conceptual paper proposes a novel prior prevention of colorectal cancer that combines CRISPR-Cas9 gene-editing technology with enhanced DNA proofreading capacity in CCSCs. By using CRISPR to either correct mutations in exonuclease domains or fuse high-fidelity polymerases with genome-editing tools, we can potentially reduce the probability of mutation and improve therapeutic outcomes. We discuss the background, proposed methodology, possible results, and implications, integrating insights from recent single-cell RNA sequencing studies and gene therapy trials.

Keywords: DNA Polymerases; CRISPR-Cas9; Cancer Stem Cells

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INTRODUCTION

A. What Are Cancer Stem Cells?

Cancer stem cells (CSCs) constitute the fraction of the tumor with stemlike properties including self-renewal, differentiation, and tumorigenicity. In colorectal cancer, these cells have been termed colorectal cancer stem cells (CCSCs) and they play critical roles in tumor initiation, progression, metastasis, and recurrence as well. The species marker of colorectal cancer stem cells has been confirmed (e.g., CD133, LGR5). [https://pubmed.ncbi.nlm.nih.gov/38156967/]. In fact, CCSCs should be targeted because conventional therapies that fail to eliminate them result in recurrences.

B. DNA Proofreading

In the course of Cell division and DNA replication, DNA proofreading normally occurs. The main utilization of DNA proofreading to sustain the fact that information regarding the sequence of nucleotides in DNA is accurate. As nucleotides are added to be copied, new strand-forming enzymes like DNA polymerases continue adding them. Occasionally, errors do take place, and the wrong nucleotides get incorporated. So proofreading works somewhat like a scanner spotting the error and taking out the wrong piece before moving on. This greatly reduces errors that could give rise to harmful mutations. When proofreading is defective, because of a mutation in the proofreading enzyme, DNA errors can accumulate.

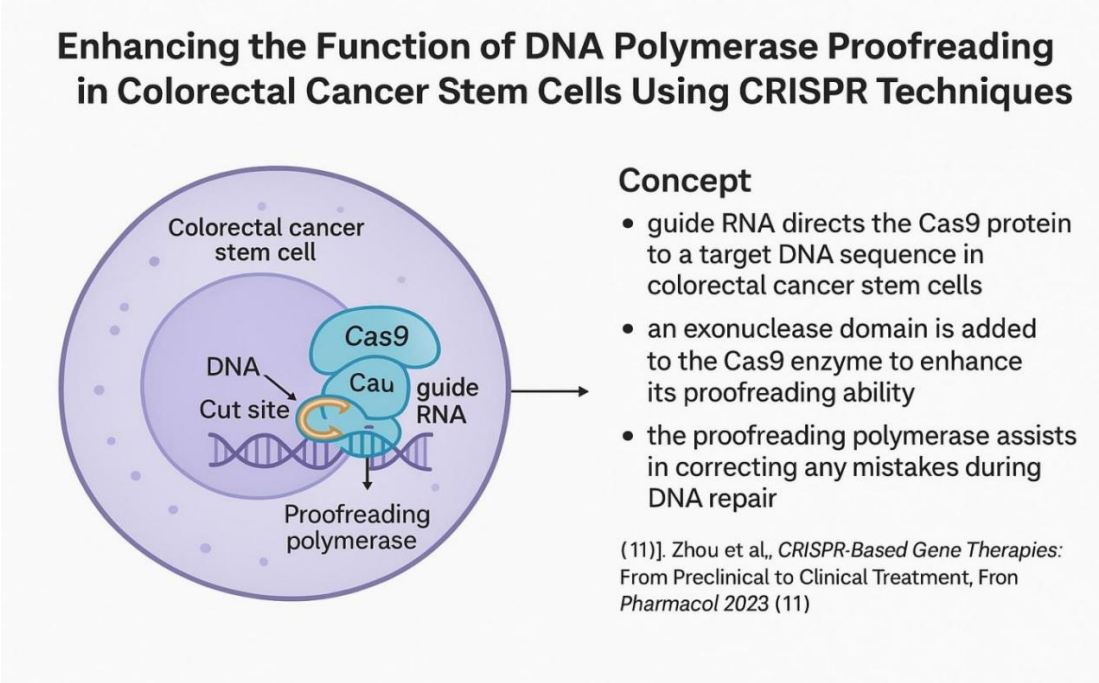
Over time, this may lead to genomic instability, cancer. Healthy proofreading systems are, therefore, absolutely critical to avoid cancer and maintain cellular stability.

C. CRISPR-Cas9

Cas9 is a kind of scissors at the molecular level that makes a cut in DNA at any specific place. It is guided by RNA to find the target gene and make a precise cut. Scientists combine this with other components to study diseases or develop therapies, such as cancer therapy by editing genomes through driving out, fixing, or adding DNA sequences. Cas9 is an accurate programming tool for genome editing. In cancer treatment, CRISPR was applied to delete oncogenes and rewire immune responses. CRISPR-based gene therapies have already made their way into clinical trials. [https://pmc.ncbi.nlm.nih.gov/articles/PMC11119143/].

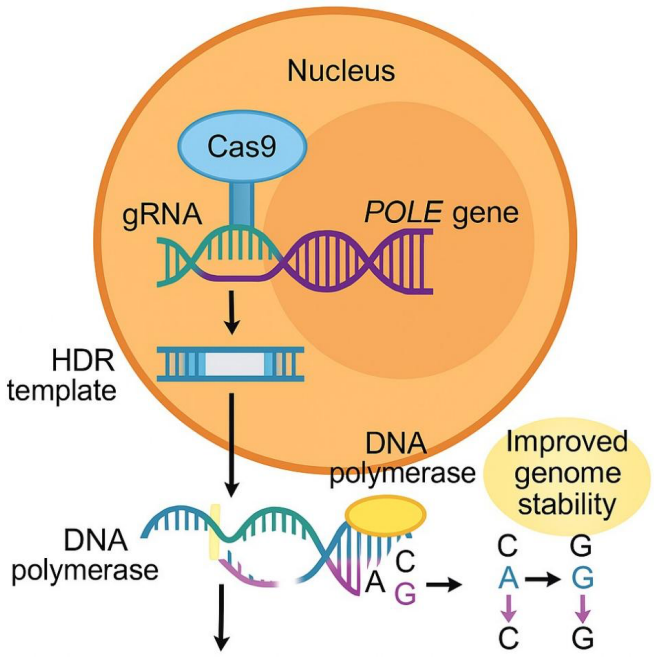
D. Enhancing Proofreader via CRISPR-Cas9

This paper suggests the application of CRISPR technology to enhance proofreading in colorectal cancer stem cells (CCSCs). These are mainly three ideas that we put forward: First, Repairing mutations in the exonuclease domain of DNA polymerases. These are enzymes responsible for correcting errors made during DNA replication. Second, Utilizing CRISPR activation (CRISPRa) to upregulate antimutator polymerases which are special polymerase variants with inherently lower error rates. Third, Engineering a Cas9 protein fused to proofreading domains so that the gene-editing tool can correct its own off-target mistakes during DNA editing. These strategies would likely increase the genomic stability of CCSCs, sensitize these cells to therapeutic interventions, and preclude them from acquiring further mutations leading to therapy resistance.



This image illustrates a proposed method to enhance DNA proofreading in colorectal cancer stem cells (CCSCs) using CRISPR-Cas9 technology. In this concept, the RNA will be directly guided to the Cas-9 protein to a specific location within the POLE gene, which is a key for proofreading DNA polymerase. Cas9 introduces a cut at the spectacular site, which allows exonuclease domain to insert or correct through homology-directed repair. To further improve the accuracy of the system, a proofreading polymerase is involved to fix any DNA mismatches during or after the editing process. This combined strategy is targeted to reduce mutation rates in CCSCs, improve genome stability, and potentially make cancer cells less resistant to treatment. The approach represents an innovative way to prove that CRISPR is not only for gene correction but also for enhancing natural DNA repair mechanisms in cancer therapy (Zhou et al., 2023).

I. Detailed Methodology and Concept Diagram



This figure illustrates the conceptual framework for enhancing DNA proofreading in colorectal cancer stem cells (CSCs) using a CRISPR-Cas9 system. The CRISPR complex is shown targeting the *POLE* gene within the nucleus of colorectal CSC. Through homology-directed repair (HDR), the exonuclease domain is engineered to enhance proofreading activity, reducing mutation rates during replication. DNA polymerase is shown actively removing mismatches. The image includes labels for Cas9, gRNA, HDR template, POLE gene, DNA polymerase, and a highlighted area showing improved genome stability post-editing.

A. Concept Overview

This study is based on a hypothesis that we will encourage DNA polymerase proofreading in colorectal cancer stem cells (CCSCs) to suppress the mutation rate and genome stability and thereby make cancer more drug-sensitive. This strategy is based on newly sophisticated CRISPR-Cas9 gene editing technology driven by recent RNA-sequence-based analysis and further develops their previous work toward adaptation of CRISPR-based gene therapy to initial testing in clinical settings (PMC11119143).

B. Strategy Summary

We propose a three-pronged strategy using CRISPR to enhance proofreading fidelity within CCSCs:

1. **Targeting the colorectal gene via repairing or enhancing the exonuclease domain** of faulty DNA polymerase genes (e.g., POLE) using CRISPR-Cas9 with homology-directed repair (HDR).

2. **Activating transcription** of antimutator DNA polymerase variants using CRISPR activation (**CRISPRa**) to suppress mutagenic replication behavior.

3. **Engineering Cas9 fusion proteins** linked to proofreading domains, providing real-time error correction during editing events.

This integrative approach seeks not only to fix existing proofreading deficits but to build a **self-correcting gene editing platform** tailored to the molecular needs of CCSCs.

II. DISCUSSION

The major issue is how to target the therapies to only the colorectal parts of the gene. Although the "marker"-LGR5, CD133- for colorectal cancer stem cells has been discovered, these are single markers, which present in normal intestinal stem cells. Thus, when the therapy is exploited, it will annihilate every cell that has the marker, making the process difficult to target only colorectal cancer stem cells. Moreover, the expression of cells can vary between tumor locations and patients, resulting in an inaccurate process.

In my opinion, to deal with the issue I have mentioned, further development should be focused on the specific marker for Colorectal Cancer Stem Cells that only CCSCs contain, so the therapy can be injected effectively.

The accuracy of DNA replication is essential for the maintenance of cellular identity and tissue function. In colorectal cancer stem cells (CCSCs), which are reportedly responsible for the reprogramming of tumors, fidelity is often relaxed through mutations in proofreading enzymes like POLE and POLD1. These defects are known to be associated with increased mutation burdens, genomic instability, and poor treatment response. Treatment strategies currently in use do not target this genetic instability in CCSCs, which also plays a role in permitting the survival and evolution of cancer cell populations that can adapt to various conditions.

To overcome this obstacle, here we develop a CRISPR-based approach to augment DNA proofreading in CCSCs. Specifically, there are three approaches we propose: (1) editing the pathogenic mutations within exonuclease domains of polymerase genes using CRISPR-Cas9 and homology-directed repair (HDR), (2) activating expression of antimutator polymerase variants via CRISPRa to reduce replication errors, and (3) engineering a Cas9–exonuclease fusion protein to facilitate error-correction gene edits. These supplements have been developed to rebalance CCSC genomes, decrease mutation-induced plasticity and increase treatment fidelity.

However, several limitations must be acknowledged. Understanding how proofreading enzymes distinguish between newly synthesized DNA strands and parental DNA strands remains a fundamental concern. Healthy cells utilize methylation and structural indicators to distinguish DNA strands which enables precise proofreading. CCSCs present extensive mutations on both DNA strands which can interrupt the recognition process. Enhanced proofreading mechanisms can inadvertently sustain faulty sequences when relying on templates that contain mutation-induced errors. This raises a significant challenge:

CRISPR-induced proofreading edits in hypermutated CCSCs may have the potential to strengthen genomic instability instead of fixing it.

The precise moment when the intervention occurs becomes essential. Maximizing correction fidelity requires administering CRISPR-enhanced proofreading systems early in tumor development before widespread mutations accumulate. The current situation indicates the need for advanced research to find early CSC populations and develop delivery mechanisms that can accurately target them.

Future investigation should address several key questions:

(1) How can we make sure the CRISPR system knows which DNA strand to fix when both strands have the same marker, but only one has cancer?

(2) Can we use lab-made DNA templates to help CRISPR fix the right parts in cells that already have a lot of mutations?

(3) Are there special genes or markers we can use to find cancer stem cells early, so we know exactly which cells to target with treatment?

(4) Does the environment around the tumor affect how well the improved proofreading system works, and could it make the system less or more effective?

The combination of single-cell RNA sequencing (scRNA-seq) improvements with new stemness signatures like SCS_sig can facilitate detailed mapping of CCSC populations throughout tumor development stages and patient groups. This method of measuring stemness as a spectrum rather than a binary trait enables the identification of patients who will gain the most advantage from CRISPR-based proofreading therapy.

The research establishes a conceptual framework that utilizes precision gene-editing techniques to stabilize the CCSC genome while minimizing the incidence of mutation-induced resistance. This approach shows promise yet requires additional experimental validation to understand DNA repair processes within highly mutated cancer genomes. The integration of computational analysis with experimental findings could produce innovative treatments that redirect colorectal cancer development towards manageable therapy outcomes.

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