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Abstract:

This Article serves as a critical introduction to the ethics and law of non-voluntary euthanasia (NVE). It begins by describing the current state of the law and potential arguments to render non-competent patients eligible for NVE. It then surveys the main ethical arguments in favor of and against NVE along four clusters of considerations: suffering, life, vulnerability and justice. This Article also addresses issues that have received less attention within mainstream debates on the topic, namely, policy considerations related to the social dimensions of vulnerability, challenges to moral personhood, and practical barriers to determining the competence of certain patients.

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INTRODUCTION

This Article explores the ethical and legal issues raised by non-voluntary euthanasia (NVE). NVE refers to the practice of clinically administering a substance that intentionally causes the death of a legally incompetent patient—that is, a person who is unable to voluntarily request euthanasia or to give (or withhold) informed consent in the end-of-life context.[1]

Depending on the jurisdiction, assisted dying with a clinical component is also called "physician-assisted suicide" (PAS) or "medical assistance in dying" (MAiD). The notion of "assisted suicide" emphasizes the agency of the patient in choosing to end her own life with the aid of a third party.[2] "Euthanasia," meanwhile, refers to the third party act of deliberately ending a patient's life to relieve her suffering.[3] "Medical assistance in dying" seeks to encompass both medically assisted suicide and euthanasia.[4] We have opted for NVE as the term that most accurately describes the patients considered in this article. However, we still use the more general term of MAiD when referring to arguments, scholarship, or laws that apply to assisted dying more generally. Paradigmatic examples of people lacking the capacity to consent to euthanasia because they do not understand the consequence of this choice would be infants, severely intellectually disabled adults, or adults with advanced dementia. The scope of this paper is limited to patients who were never competent, as well as formerly competent patients who left no clear indications of their own end-of-life medical choices.[5]

Outside of Belgium and the Netherlands,[6] NVE has been largely excluded

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1 JEFF MCMAHAN, THE ETHICS OF KILLING: PROBLEMS AT THE MARGINS OF LIFE 457 (2002) (distinguishing NVE from involuntary euthanasia, as the latter refers to situations "when an individual who is competent to give or withhold consent is killed or allowed to die either contrary to his expressed will or when his consent has not been sought"); PETER SINGER, PRACTICAL ETHICS 179 (2d ed. 1993).

2 *Final Report of the Expert Panel on MAiD and Mental Illness*, HEALTH CAN. 3 (2022), https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness.pdf.

3 *See* Richard J. McMurray et al., *Decisions Near the End of Life*, 267 JAMA 2229, 2229 (1992).

4 *E.g.*, Loi du 28 mai 2002 relative à l'euthanasie [Euthanasia Act], M.B., June 22, 2002, https://etaamb.openjustice.be/fr/loi-du-28-mai-2002_n2002009590.html; Criminal Code, R.S.C. 1985, c C-241 (Can.).

5 It excludes patients who left advance directives or for whom previous values and beliefs furnish clear guidance for end-of-life decisions, as well as patients with enough autonomy to express preferences regarding end-of-life decisions. These cases raise additional issues, such as the extent to which one can decide what will happen to one's older self, and how to balance respect for autonomy with other considerations. *See, e.g.*, Ben A. Rich, *Prospective Autonomy and Critical Interests: A Narrative Defense of the Moral Authority of Advance Directives*, 6 CAMBRIDGE Q. OF HEALTHCARE ETHICS 138, 138–139 (1997); Stavroula Tsinorema, *The Principle of Autonomy and the Ethics of Advance Directives*, 59 SYNTHESIS PHILOSOPHICA 73, 85–86 (2015).

6 *See, e.g.*, Marije Brouwer et al., *Should Pediatric Euthanasia Be Legalized?*, 141 PEDIATRICS

from national debates on the legalization of physician-assisted suicide, euthanasia, or medical aid in dying. Judgments rendered on the matter and legislation regulating the practice reflect a belief that the person needs to retain the capacity to autonomously choose to live or die for MAiD to be justifiable. In other words, only competent adults, capable of autonomously requesting physician-assisted suicide and giving free and informed consent to receive it, are eligible.[7]

Although NVE has so far been mostly absent from public policy debates, initiating a conversation on the legalization of NVE is important in anticipation of policy debates that are likely to arise in the not-too-distant future, particularly in jurisdictions where MAiD has already been legalized. Emerging trends in the medical field suggest that substitute decision-makers (SDMs) of incompetent patients who are deemed to be suffering may eventually look to judicial and political institutions to support a right to NVE. SDMs may advocate that continued existence, as lived by their dying or profoundly disabled relatives, is not in these individuals' best interests.[8] For instance, the Canadian Paediatric Society (CPS) reported in 2018 that parents of "never-competent" severely disabled or terminally ill infants and children, "including those too young to make a reasoned decision," are increasingly approaching Canadian health care professionals to discuss MAiD-related issues.[9] Relying on SDMs to decide whether discontinuing life-sustaining treatments is in a patient's best interests creates a decisional protocol that could be transposed to the euthanizing of incompetent patients when it is deemed to be in their best interests. The United Kingdom's Royal College of Paediatric and Child Health's (RCPCH's) clinical and ethical guidelines for deciding on the withdrawing or withholding of life-sustaining care suggest that the child health team must work with parents to determine what is in the child's best interests, and that it may be in the best interests of a child to die "when life is limited in quality."[10] The American Medical Association's (AMA's) opinion on "withhold[ing] or withdraw[ing] life-sustaining interventions" also recognizes the authority of SDMs to decide, within the ethical boundaries of substituted judgement, what the best

1, 1 (2018).

7 *Id.*

8 *See, e.g.*,

9 *See id.*; *see also* R. v. Cadotte, [2019] QCCS 1987, paras. 5, 9, 13, 33–37, 64 (Can.) (Mr. Cadotte was convicted of manslaughter for suffocating his wife who suffered from advanced early-onset Alzheimers and was permanently in hospital care. Prior to the advanced progression of her disease, his wife had expressed a desire to die rather than be in care,*id.* para. 9, and Mr. Cadotte stated that all he wanted to do was protect her, *id.* para. 64. Although anecdotal and not indicative of a trend, it is reported that Mr. Cadotte had asked his demented wife's healthcare team if they could shorten her suffering by providing her with MAiD. The request was refused because she was not competent and not at a point where her natural death had become reasonably foreseeable. *Id.* paras. 33–37.).

10 Vic Larcher et al., *Making Decisions to Limit Treatment in Life-Limiting and Life-Threatening Conditions in Children: A Framework for Practice*, 100 ARCHIVES DISEASE CHILDHOOD s1, s4 (2015).

interests of patients are in end-of-life contexts.[11]

From bioethical and legal stances, arguments in favor of legalizing NVE will likely deploy the same expansionist strategy used to argue in favor of voluntary euthanasia—that is, starting from an existing practice and arguing that logical coherence and concerns of justice require expanding its scope, to treat like cases alike.[12] Once euthanasia is considered a "benefit"—that is, a treatment administered because it is in the patient's best interests—it becomes possible to argue that depriving someone of this benefit is potentially discriminatory.

Such claims could lead jurisdictions where voluntary MAiD is already legal to go beyond the autonomy-based justifications initially put forward to justify the practice. It is therefore important to foster collective reflection on the implications of legalizing NVE, particularly for vulnerable populations. This Article aims to provide a broad and critical survey of the main ethical and legal arguments in favor of and against the practice.

This Article distinguishes itself from existing literature on NVE in its focus and goals. Scholarship on the subject can be described, albeit in a very general way, as belonging to two broad categories.[13] First, there are those texts premised on the "slippery slope" argument, in which scholars debate whether the legalization of voluntary MAiD inevitably leads to the legalization of non-voluntary MAiD.[14]

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11 CODE OF MEDICAL ETHICS, Op. 5.3 (AM. MED. ASS'N 2001).

12 This strategy has been used to argue in favor of voluntary euthanasia, by drawing an analogy between this practice and the already accepted practice of withdrawing life-sustaining treatments upon request by the patient. The latter practice was conceptualized as "passive euthanasia" and analogized with "active euthanasia" by arguing that the distinctions between them were not legally or morally relevant. *E.g.*, Michael Tooley, *In Defense of Voluntary Active Euthanasia and Assisted Suicide*, *in* CONTEMPORARY DEBATES IN APPLIED ETHICS 65, 66, 71–80, (Andrew Cohen & Christopher Heath Wellman eds., 2005).

13 We do not claim to cover the entire literature with this categorization. Rather, the proposed categories reflect general trends identifiable in the literature. However, there are some texts that do not fit in any of the proposed categories.

14 *See* Michael Stingl, *Voluntary and Non-Voluntary Euthanasia: Is There Really a Slippery Slope?*, *in* THE PRICE OF COMPASSION: ASSISTED SUICIDE AND EUTHANASIA 157 (Michael Stingl ed., 2010) (arguing that the concept of the unbearable suffering of competent patients is a logically clear line that can distinguish voluntary and non-voluntary euthanasia). *See generally* Penney Lewis, *The Empirical Slippery Slope from Voluntary to Non-Voluntary Euthanasia*, 35 J. L. MED. & ETHICS 197 (2007) (discussing the lack of empirical evidence that NVE rates are higher in jurisdictions that legalized VE than those with prohibitions on euthanasia and criticizing slippery-slope arguments as unhelpful to the debate on the legalization of euthanasia generally); Kumar Amarasekara & Mirko Bagaric, *Moving from Voluntary Euthanasia to Non-Voluntary Euthanasia: Equality and Compassion*, 17 RATIO JURIS 398 (2004) (arguing that the legalization of VE is likely to lead to the legalization of NVE and advancing several reasons why NVE is morally impermissible); David Albert Jones, *Is There a Logical Slippery Slope from Voluntary to Non-Voluntary Euthanasia?*, 21 KENNEDY INST. ETHICS J. 379 (2011) (exploring the validity of logical slippery-slope arguments generally before concluding that a refined formulation of a slippery-slope argument that accepting VE implies accepting NVE is logically valid); Robert M. Walker, *Physician-Assisted Suicide: The*

This Article does not intervene in that debate. Instead, we justify our examination of NVE on the basis of the aforementioned possibility that denying euthanasia to people unable to consent to it may be construed as discriminatory, and on evidence from the medical field that SDMs may eventually advocate for the legalization of this practice in jurisdictions where MAiD has already been legalized. The Article does not take a position on whether the SDMs' concerns are the result of a slippery slope related to the legalization of voluntary MAiD. Second, there are texts on the ethics of non-voluntary MAiD that tend to focus on "quality of life" arguments centered on the individual. Some texts address this issue in relation to specific populations, like infants,[15] non-mature children,[16] or mentally ill individuals,[17] while others discuss the subject more broadly.[18] In either case, these articles generally neglect important policy considerations related to vulnerable groups in a society characterized by various forms of oppression. This Article responds to this important omission in the literature on NVE. Finally, we survey a broad array of ethical arguments both for and against legalizing NVE.

Unlike essays that focus on one particular dimension of the goodness/rightness or badness/wrongness of NVE, this Article provides readers with a critical introduction to the ethical landscape that policymakers will have to consider. By targeting an audience of jurists familiar with rights-based claims, we wish to problematize the assumptions that underlie these claims, drawing on philosophical insights.

Legal Slippery Slope, 8 CANCER CONTROL 25 (2001) (surveying pivotal court cases in the US that have defined issues and distinctions in "right-to-die" cases and concluding that the legalization of VE in case law would likely lead to the extension of access to euthanasia to incompetent patients, and therefore NVE).

15 *See, e.g.*, B.A. Manninen, *A Case for Justified Non-Voluntary Active Euthanasia: Exploring the Ethics of the Groningen Protocol*, 32 J. MED. ETHICS 643, 643–44 (2006); Alexander A. Kon, *Neonatal Euthanasia Is Unsupportable: The Groningen Protocol Should Be Abandoned*, 28 THEORETICAL MED. & BIOETHICS 453, 456–59 (2007).

16 *See generally* Harprit Kaur Singh, Medical Assistance in Dying (MAID) for Minors in Canada: Considering Children's Voices (Mar. 2018) (M.A. Thesis, McGill University) (ProQuest) (suggesting that the child's voice is a useful tool for assessing unbearable suffering in the context of eligibility for MAiD).

17 *See generally* Jukka Varelius, *Mental Illness, Lack of Autonomy, and Physician-Assisted Death*, *in* NEW DIRECTIONS IN THE ETHICS OF ASSISTED SUICIDE AND EUTHANASIA 49 (Michael Cholbi & Jukka Varelius eds., 2d ed. 2015) [hereinafter Varelius, *Lack of Autonomy*] (suggesting that the main arguments for physician-assisted death also support physician-assisted death for incompetent psychiatric patients whose illness is incurable and who persistently express the notion that their existence is unbearable); Jukka Varelius, *On the Moral Acceptability of Physician-Assisted Dying for Non-Autonomous Psychiatric Patients*, 30 BIOETHICS 227 (2016) [hereinafter Varelius, *Moral Acceptability*] (arguing restricting physician assisted-suicide to autonomous psychiatric patients on moral grounds is not compatible with the acceptance of end-of-life practices commonly referred to as passive euthanasia for non-autonomous patients).

18 *See, e.g.*, SINGER, *supra* note 1, at 175–218; MCMAHAN, *supra* note 1, at 424; L.W. SUMNER, PHYSICIAN-ASSISTED DEATH: WHAT EVERYONE NEEDS TO KNOW 157–95 (2017).

We will begin by providing some background on the ethical parameters that structure academic and political discussions of NVE, most notably the principle of respect for autonomy, and the important tensions with this principle raised in the context of NVE. Part 3 examines existing exceptions to the general requirement of autonomy in relation to MAiD. Finally, Parts 4 through 7 move beyond the principle of respect for autonomy in order to grapple with tensions raised in Parts 2 and 3 by examining four clusters of ethically and legally relevant considerations in favor of and against legalizing NVE: suffering, life, vulnerability and justice. Having examined these clusters of ethically and legally relevant considerations, we ultimately conclude that the most persuasive arguments for NVE, those based on beneficence, are insufficient when viewed within a broader liberal conception of commitment to equality and human rights.

While there are different ways of categorizing arguments that justify legalizing MAiD for non-autonomous patients to different extents (or not at all), we suggest that these four concepts encompass all the salient arguments in scholarship on the matter. We prefer to divide arguments thematically instead of by theories of normative ethics (e.g., consequentialism or deontology) or ethical principles (e.g., beneficence or justice) because this approach is more relevant to legal and policy discussions. While this Article provides a comprehensive literature review and takes a critical stand toward the limitations of some mainstream arguments about NVE, it does not flesh out a theory of the permissibility of NVE in ideal or non-ideal circumstances. However, the arguments we present can contribute to the future elaboration of such theoretical proposals. Our critical literature review may notably inform a "principlist" approach, insofar as it holds that the same problem can be looked at through the lens of different ethical principles.[19] It may also inform policymaking considerations, such as the compatibility of legal frameworks with principles found in legal texts, such as human rights conventions.

I. THE ETHICAL PARAMETERS OF NVE

The least controversial reason an individual may choose suicide or euthanasia is that they prefer non-existence over a life of unremitting and severe suffering. Even then, however, individuals will understand and weigh suffering differently in light of not just their immediate pain, but also the values, meanings and roles they ascribe to pain that may annihilate or belittle,[20] all of which requires intensely personal axiological judgments.

19 *See e.g.*, TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (8th ed. 2019).

20 *See generally* ERIC J. CASSELL, THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE (2d ed. 2004) (detailing Cassell's seminal conceptualization of suffering).

It is unsurprising, therefore, that judges and legislators in the West have mostly avoided taking a position on the irreducibly controversial question of what makes a life (not) worth living or proposing criteria that the state may use to determine which of its citizens have a life worth living.

Facing unsolvable axiological disagreements, those Western states that have legalized MAiD have largely circumvented such questions by relying on theories of authority instead—that is, by asking *who* should make the decision.[21] Honoring individual autonomy (or dignity, when understood as a state of affairs conditional to autonomy) does not require solving the grave question of when a life is no longer worth living; instead, MAiD legislation carves out a space where individuals may decide this for themselves. From this perspective, the only required procedural protection is to establish that the individuals in question have a sufficient degree of autonomy to make competent decisions. Proponents of this view claim that:

> [a] state may not deny the liberty claimed by the patient-plaintiffs in these cases without providing them an opportunity to demonstrate, in whatever way the state might reasonably think wise and necessary, that the conviction they expressed for an early death is competent, rational, informed, stable and uncoerced.[22]

Several Western legislators have endorsed this view by replacing bans on voluntary MAiD with safeguards meant to ensure that only people able to give free and informed consent to MAiD will access it.[23]

This is not to deny that medical entities have long been in the business of evaluating unavoidably value-laden concepts, like health and quality of life, and of providing guidelines to assess whose life ought to be saved in extreme situations where rationing resources or withholding care becomes necessary.[24] Nonetheless, legislative and judicial bodies that have legalized forms of assisted dying have almost exclusively done so to respect personal autonomy rather than taking a position on the value-laden question of what makes a life worth living.

There are many ways in which policy debates about NVE could go astray. For instance, popular discourses about NVE could pay attention to human suffering,

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21 In the words of John Arras: "When it comes to matters of life and death, our society prefers procedure to substance. Instead of asking, 'What is the right thing to do?' we ask, 'Who should decide?' Sometimes this preference derives from the sober acknowledgement of a problem's intractability." John D. Arras, *Toward an Ethic of Ambiguity*, 14 HASTINGS CTR. REP. 25, 25 (1984).

22 Ronald Dworkin et al., *Assisted Suicide: The Philosophers' Brief*, 27 N.Y. REV. BOOKS, Mar. 27, 1997, at 41, 47.

23 *See, e.g.*, *Canada's Medical Assistance in Dying (MAID) Law*, GOV'T OF CAN. (Mar. 1, 2024), https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html#s2; End of Life Choice Act, 2019 §§ 11–15 (Act No. 67/2019) (N.Z.).

24 Larcher et al., *supra* note 10, at s4–s5.

but notably through the sentimentalist rhetoric debunked by critiques of the "tragedy model" of disability.[25] This introduction only highlights that a debate on whether the state should legalize NVE cannot proceed by way of simple expansion. It must confront anew all the substantive questions that bioethicists and lawyers have managed to bracket by relying on autonomy (the liberal, proceduralist route). These questions are unfortunately more daunting in the case of incompetent patients because of (i) the epistemic obstacles to knowing how certain people with cognitive impairments experience life and suffering, (ii) their belonging to a historically stigmatized category of people, and (iii) the susceptibility of SDMs to consider factors that are not strictly for the benefit of the persons they represent.

II. EXCEPTIONS TO THE GENERAL REQUIREMENT OF AUTONOMY IN THE CURRENT LAW

A common feature of PAS/MAiD in all jurisdictions where it has been legalized is a requirement for autonomous decision-making. Individuals must retain the capacity to express a voluntary request for MAiD and to consent to it in an informed way.[26] However, although the requirement for autonomous decision-making is the norm, some jurisdictions do permit NVE in specific circumstances. For example, the Netherlands accepts NVE for never-competent severely ill or disabled infants according to the standards set out in the Groningen Protocol.[27] Indeed, some scholars have expressed the concern that NVE may be happening in the Netherlands and in Belgium for patients with psychiatric disorders.[28] This part provides an overview of these instances of NVE[29] both as a experiential foundation

25 *See* Jonas-Sébastien Beaudry, *Death as "Benefit" in the Context of Non-Voluntary Euthanasia*, 43 THEORETICAL MED. & BIOETHICS 329, 334, 352 (2022).

26 *See* Sarah Mroz et al., *Assisted Dying Around the World: A Status Quaestionis*, 10 ANNALS PALLIATIVE MED. 3540, 3540–47 (2021); Trudo Lemmens, *Charter Scrutiny of Canada's Medical Assistance in Dying Law and the Shifting Landscape of Belgian and Dutch Euthanasia Practice*, 85 SUP. CT. L. REV. 459, 512 (2018) [hereinafter *Charter Scrutiny*]. Note that, with regard to the requirement for capacity in MAiD legislation, Belgium and the Netherlands differ from American states and Canada in that they accept some form of advance request for MAiD.

27 *See* Eduard Verhagen & Pieter J.J. Sauer, *The Groningen Protocol—Euthanasia in Severely Ill Newborns*, 352 NEW ENG. J. MED. 959, 961 (2005) (describing the Protocol).

28 *See, e.g.*, Louis Charland, Trudo Lemmens & Kyoko Wada, *Decision-Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders*, J. ETHICS MENTAL HEALTH 1, 9 (2016) (citing Scott Y.H. Kim, Raymond G. De Vries & John R. Peteet*, Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014*, 73 JAMA PSYCHIATRY 362, 362–67 (2016)); Lieve Thienpont et al., *Euthanasia Requests, Procedures and Outcomes for 100 Belgian Patients Suffering From Psychiatric Disorders: A Retrospective, Descriptive Study*, 5 BRIT. MED. J. OPEN 1, 2 (2015); Stephan Claes et al., *Euthanasia for Psychiatric Patients: Ethical and Legal Concerns About the Belgian Practice*, 5 BRIT. MED. J. OPEN 1, 1–2 (2015).

29 Our analysis is focused on systems of Benelux countries for two reasons. First, concerns for nonvoluntary MAiD recently arose from there. Second, Benelux systems are similar to the Canadian

to introduce the ethical and legal concerns implicated by NVE and to ground the practical relevance of our broader consideration of these concerns in the following parts.

A. NVE for Infants in the Netherlands

In 2004, the Groningen Protocol was drafted at the University Hospital of Groningen in collaboration with the district attorney and was published nationwide in 2005.[30] The Dutch Association for Paediatric Care subsequently ratified it. It has been used since as a national guideline for the ethical termination of the lives of severely ill or disabled newborns and for the reporting of physicians' decisions in that regard to authorities.[31] The Protocol is not entrenched in the Dutch legal framework regulating MAiD.[32] As a result, the Protocol does not fully protect physicians from prosecution.[33]

The Protocol provides guidelines for the withholding or withdrawing of life-sustaining treatment and for non-voluntary MAiD. It identifies three groups of newborns: (i) those with no chance of survival, for whom treatment can be withheld or withdrawn;[34] (ii) those "who potentially can survive but whose

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one (although, up to now, Canada has limited MAiD to the end-of-life context). *See* Lemmens, *supra* note 26, at 469.

30 BRUNO DEBOIS & JACQUES ZEEGERS, EUTHANASIA OF NEWBORNS AND THE GRONINGEN PROTOCOL 3 (European Institute of Bioethics trans., 2015) (2014); Verhagen & Sauer, *supra* note 27, at 961.

31 DEBOIS & ZEEGERS, *supra* note 30, at 3.

32 *Id.* However, in 2007, "the Dutch government set up a legal provision that makes it possible for a physician to deliberately end the life of a severely ill newborn without being prosecuted if certain criteria of due care are met. This legal provision has come about in close collaboration with the field of paediatricians and stems from the so-called Groningen protocol." Katja ten Cate et al., *End-of-Life Decisions for Children Under 1 Year of Age in the Netherlands: Decreased Frequency of Administration of Drugs to Deliberately Hasten Death*, 41 J. MED. ETHICS 795, 795 (2015).

33 *See* DEBOIS & ZEEGERS, *supra* note 30, at 3; SUMNER, *supra* note 18, at 192 ("Following the protocol does not guarantee that the physician will not be prosecuted; however, it was developed on the basis of a survey of twenty-two cases reported to prosecutors over the preceding seven years, in none of which was a prosecution initiated. Needless to say, Dutch criminal law governing non-voluntary euthanasia has not been changed; the protocol relies entirely on the by now familiar device of guidelines for prosecutorial discretion.").

34 A.A.E. Verhagen & P.J.J. Sauer, *End-of-Life Decisions in Newborns: An Approach from the Netherlands*, 116 PEDIATRICS 736, 736 (2005) ("They are infants with an underlying disease in whom death is inevitable, although in some cases they can be kept alive for a short period of time. Children born with severe lung hypoplasia may serve as an example. In most cases, when the futility of the treatment is apparent, the ventilatory support is removed so that the child can die in the arms of the mother or father"); *see also* Verhagen & Sauer, *supra* note 27, at 959 ("First, there are infants with no chance of survival. This group consists of infants who will die soon after birth, despite optimal care with the most current methods available locally. These infants have severe underlying disease, such as lung and kidney hypoplasia.").

expected quality of life after the intensive care period is very grim,"[35] for whom treatment can also be withheld or withdrawn if "treatment is not in the best interest of the child";[36] and (iii) those with a "hopeless prognosis"[37] who do not "depend on technology for physiologic stability and whose suffering is severe, sustained, and cannot be alleviated."[38] Infants in this last category can be euthanized when inducing death is deemed more humane than continued existence.[39] According to the two Dutch physicians who developed the Protocol, such end-of-life measures are ethically sound when the following criteria are met: "the parents must agree fully, on the basis of a thorough explanation of the condition and prognosis; a team of physicians, including at least one who is not directly involved in the care of the patient, must agree; and the condition and prognosis must be very well defined."[40] Moreover, after the infant's death, an outside legal body must determine "whether the decision was justified and all necessary procedures have been followed."[41]

Since the Groningen Protocol's publication, the rate of non-voluntary MAiD for infants has been decreasing.[42] This drop in the number of cases is likely related to "both the introduction of legal criteria governing the practice, as well as earlier and improved pre-natal screening."[43]

We introduce the practices of withholding or withdrawing life-sustaining care in this Section because the Groningen Protocol involves such practices alongside

35 Verhagen & Sauer, *supra* note 34, at 736 ("Different groups of patients may fall into this category: for instance, infants with severe congenital intracranial abnormalities (eg, holoprosencephaly) or severe acquired neurologic injury (eg, asphyxia or severe intracranial hemorrhages). Children in this category are expected to die when intensive treatment is withdrawn."); *see also* Verhagen & Sauer, *supra* note 27, at 959 ("Infants in the second group have a very poor prognosis and are dependent on intensive care. These patients may survive after a period of intensive treatment, but expectations regarding their future condition are very grim.").

36 Verhagen & Sauer, *supra* note 34, at 737.

37 *Id.*

38 *Id.* at 736–37 ("An example are children who have survived thanks to advanced technology but for whom it becomes clear after completion of intensive treatment that life will be full of suffering without any hope of improvement. In retrospect, one might not have wanted to start treatment for these children if the outcome had been known. Another example are children with serious congenital malformations or diseases that cannot be treated, and as a result of (complications of) this condition, the child will lead a life of sustained suffering that cannot be alleviated (eg, epidermolysis bullosa, type Hallopeau-Siemens). Also in this group are children from group 2 that were expected to die after the intensive care treatment was withdrawn but remained alive with severe suffering.").

39 Verhagen & Sauer, *supra* note 27, at 960.

40 *Id.*

41 *Id.*

42 ten Cate et al., *supra* note 32, at 796.

43 *The State of Knowledge on Medical Assistance in Dying for Mature Minors: The Expert Panel Working Group on MAID for Mature Minors*, COUNCIL OF CANADIAN ACADS. 112 (2018) [hereinafter *The State of Knowledge on Medical Assistance in Dying for Mature Minors*] (citing ten Cate et al., *supra* note 32, at 796), https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf.

the practice of active euthanasia. Withholding or withdrawing treatments in a way that passively terminates an infant's life are legal practices in Europe and the United States for children with very poor prognostics falling within Group 1 or 2.[44] However, infants may not die immediately, especially those belonging to Groups 2 or 3. Only in the Netherlands could doctors legally hasten their death through euthanasia.[45] The Groningen Protocol illustrates the conceptual and circumstantial proximity between so-called "passive" and "active" euthanasia. Some of the arguments we consider could apply equally in favor of or against both "passive" and "active" terminations of life, but the two practices are factually and legally different, and the question of whether and to what extent they are morally different is a controversial topic in bioethics. Given the focus of this Article on NVE, which is active euthanasia, we will not discuss of the similarities and differences between active and passive euthanasia.

B. (Non)Voluntary Euthanasia for Mental Health Patients in the Netherlands and in Belgium

Trudo Lemmens suggests that NVE for mental health patients may already be happening in the Netherlands and Belgium under the guise of voluntary euthanasia.[46] His concerns are based on a detailed analysis of two recent Belgian[47] and Dutch[48] studies, which raise concerns regarding diligent respect of the capacity assessment requirement.[49] While the Belgian study barely discusses the issue of

44 Hilde Lindemann & Marian Verkerk, *Ending the Life of a Newborn: The Groningen Protocol,* 38 HASTINGS CTR. REP. 42, 43–44 (2008); Verhagen & Sauer, *supra* note 27, at 960.

45 *See The State of Knowledge on Medical Assistance in Dying for Mature Minors*, *supra* note 43, at 111–13. "The Netherlands and Belgium are currently the only two jurisdictions where euthanasia and assisted suicide (EAS) is permitted for minors." *Id. at* 111. In Belgium, "[r]epeated requests must come directly from the patient who must exhibit the capacity to fully understand their request and its consequences," *id.* at 113, meaning infants, who necessarily lack capacity, are excluded from eligibility.

46 Trudo Lemmens, *The Conflict Between Open-Ended Access to Physician-Assisted Dying and the Protection of the Vulnerable: Lessons from Belgium's Euthanasia Regime for the Canadian Post-*Carter *Era*, *in* LES GRANDS CONFLITS EN DROIT DE LA SANTÉ 261, 299–302 (Catherine Régis, Lara Khoury & Robert P. Kouri eds., 2016). Lemmens raises concerns about the Belgian study's classification of all patients who received MAiD as competent, "without further discussion of the inherent challenges in determining competency to request aid in dying" in mental health patients. *Id.* at 300. Lemmens also notes that the Dutch study by Kim, De Vries & Peteet confirms the concerns relating to competency assessments of psychiatry patients. *Id.* at 299 n.97.. If competency cannot be or was not correctly assessed and established, there is a serious risk that NVE has necessarily occurred.

47 *See generally* Thienpont et al., *supra* note 28 (surveying a group of 100 outpatients who requested euthanasia for reasons related to mental health).

48 *See generally* Kim, De Vries & Peteet, *supra* note 28 (surveying reports of psychiatric euthanasia and assisted suicide cases occurring between 2001 and 2014).

49 *See* Lemmens, *supra* note 46, at 299–302; Lemmens, *supra* note 26, at 488–92, 511–18;

capacity assessment and does not acknowledge its inherent complexity and variability with mental health patients,[50] the Dutch study identifies alarming features of the practice, such as "relatively frequent disagreement among evaluating physicians with respect to the capacity of patients asking for euthanasia and the irremediable nature of the condition,"[51] "lack of details in the case reports about how capacity was assessed,"[52] no independent psychiatric review of the capacity assessment,[53] and excessive deference to physicians' judgment calls on the part of authorities charged with reviewing their decisions.[54]

Such trivialization of capacity assessments for patients whose capacity to choose death is often not clear-cut prompts Lemmens to doubt the voluntariness of all euthanasia of mentally ill patients in these countries. This fear seems to be reasonably well-founded, particularly when one considers that psychiatrists—the physicians arguably best trained in capacity assessments—often have a low estimation of their own ability to conduct such assessments.[55] Although highly subjective and variable, the "current standard of care in the area is still the individual clinical judgment of the attending physician."[56] This is the case even though physicians often "lack a good grasp of the concept and often have limited appreciation of the inherent difficulties in capacity assessment."[57] This fear is all the more reasonable when one considers the extent of the subjectivity and variability of capacity assessments in the context of MAiD for mental health patients expressing a desire to die. Indeed, Linda Ganzini and her colleagues have documented how the beliefs and values of the health care professionals in charge of assessing capacity influence their findings in the context of MAiD.[58] The ones who "are firmly committed to MAiD are more likely to judge that patients have

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Charland, Lemmens & Wada, *supra* note 28, at 9.

50 *See* Thienpont et al., *supra* note 28, 2, 4–5; Charland, Lemmens & Wada, *supra* note 28, at 9. For other authors who consider these findings alarming, see Claes et al., *supra* note 28, at 1–2. For a response to Claes et al., see generally Lieve Thienpont & Monica Verhofstadt, *A Commentary on "Euthanasia for Psychiatric Patients: Ethical and Legal Concerns about the Belgian Practice" from Claes et al.*, 5 BRIT. MED. J. OPEN (2016) (responding to four points raised by Claes et al. about the number of verifications performed by a single psychiatrist, the 38 euthanasia requests that were withdrawn, the notion of mental health issues as a transient state, and the vagueness of the term "unbearable suffering").

51 Lemmens, *Charter Scrutiny*, *supra* note 26, at 491–92 (citing Kim, De Vries & Peteet, *supra* note 28).

52 *Id.*

53 Charland, Lemmens & Wada, *supra* note 28, at 9 (citing Kim, De Vries & Peteet, *supra* note 28).

54 *Id.*

55 Lemmens, *Charter Scrutiny*, *supra* note 26, at 516.

56 Charland, Lemmens & Wada, *supra* note 28, at 4.

57 Lemmens, *Charter Scrutiny*, *supra* note 26, at 516.

58 Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 AM. J. PSYCHIATRY 595, 600 (2000).

capacity to opt for MAiD, even when they suffer from depression and other mental health conditions."[59]

The concerns raised in relation to the trivialization of capacity assessments, the impact of medical provider's pre-existing beliefs, as well as the conceptual and circumstantial overlap between passive and active euthanasia demonstrated in NVE of infants are issues that will continue to arise in the context of expanded MAiD in other jurisdictions. They will also re-emerge as we move into discussing the four conceptual clusters of legal and ethical concerns in relation to NVE in the following four parts.

III. THE MORAL IMPORTANCE OF SUFFERING AS GROUNDS FOR LEGALIZING NVE

This Part examines ethical arguments in favor of and against legalizing NVE on the basis of beneficence. First, the main points of the argument from beneficence will be summarized within the context of non-voluntary MAiD. Next, two categories of objections to the argument from beneficence, principled and circumstantial, will be discussed. Finally, we conclude that while a defeasible duty of beneficence to sometimes provide NVE exists, it can never obtain in practice for several reasons, including epistemic barriers to adequately assessing unbearable suffering and the risks that operationalizing NVE will lead to its overapplication.

A. The Argument From Beneficence in Favor of Non-Voluntary MAiD

The conception of the value of life most often associated with a defense of non-voluntary MAiD holds that quality of life should be valued above quantity,[60] a position best captured by the notions of "quality of life" and "quality adjusted life years."[61] This view makes room for the possibility of a life having a negative value, i.e., being worse than death. The more negatively valued a life is, the stronger the justification for ending it.[62]

Arguments supporting the credibility of NVE on the basis of beneficence have

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59 Lemmens, *Charter Scrutiny*, *supra* note 26, at 516 (citing Ganzini et al., *supra* note 58, at 600).

60 We explore how the value of life is perceived through different ethical paradigms in the next Part. However, it is necessary to present one of these views here, since it underlies arguments about NVE based on beneficence.

61 John Harris*, QALYfying the Value of Life*, 13 J. MED. ETHICS 117, 117–18 (1987).

62 *Id.* at 117 ("The essence of a QALY is that it takes a year of healthy life expectancy to be worth one, but regards a year of unhealthy life expectancy as worth less than 1. Its precise value is lower the worse the quality of life of the unhealthy person (which is what the 'quality adjusted' bit is all about). If being dead is worth zero, it is, in principle, possible for a QALY to be negative, i.e. for the quality of someone's life to be judged worse than being dead.").

focused on the importance of pain or suffering. It could seem vicious, wrong, and unfair to deprive non-competent people of a humane end to their suffering. Some therefore argue that non-voluntary MAiD should be legalized for incompetent patients because their suffering is as deserving of compassion as the suffering of competent persons.[63] It follows from the equal moral significance of their suffering that they are equally owed support in actively hastening a death considered to be in their own best interests.

This position relies on the fact that it seems "counter-intuitive" to consider grave suffering to be of less importance simply because it is experienced by incompetent patients, like older adults with dementia, young children, or schizophrenics in the grip of delusions and hallucinations.[64] We must recognize that incompetent patients can suffer as horribly and sometimes "far more horribly than anyone who accepts voluntary euthanasia."[65] Further, the fact that incompetent patients' distress can result from an irrational understanding of reality does not alter the equal moral significance that should be given to their suffering. Indeed, it is precisely because some incompetent patients lack insight into their illness that they suffer intolerably. It is impossible for such people "to step back from the suffering and the reality filled with it."[66] Their distress is at least as significant as that of competent individuals. Just like competent individuals can have no control over their intolerable and enduring physical and/or psychological suffering, incompetent patients too have no power over their intolerable and enduring mental suffering.[67]

From this perspective, although MAiD has been traditionally justified in the name of autonomy and well-being through the relief of intolerable and enduring suffering,[68] the administration of a substance intentionally hastening death can be justified in the absence of autonomous decision-making.[69] In such circumstances,

63 *See, e.g.*, Singh, *supra* note 16, at 32; Varelius, *Lack of Autonomy*, *supra* note 17, at 63–64; Varelius, *Moral Acceptability*, *supra* note 17, at 231–32; Bryson Brown, *Robert Latimer's Choice*, *in* THE PRICE OF COMPASSION: ASSISTED SUICIDE AND EUTHANASIA 161, 161–82 (Michael Stingl ed., 2010); NORMAN CANTOR, MAKING MEDICAL DECISIONS FOR THE PROFOUNDLY MENTALLY DISABLED 106 (2005); Len Doyal, *The Futility of Opposing the Legalisation of Non-Voluntary and Voluntary Euthanasia*, *in* FIRST DO NO HARM: LAW, ETHICS, AND HEALTHCARE 461, 473–75 (Sheila McLean ed., 2006); *see also* Amarasekara & Bagaric, *supra* note 14, at 405 (predicting that certain groups will argue that NVE should be legalized for incompetent patients because their suffering is as deserving of compassion as the suffering of competent persons).

64 *See, e.g.*, Varelius, *Lack of Autonomy*, *supra* note 17, at 63; Singh, *supra* note 16, at 31–32.

65 Brown, *supra* note 63, at 182.

66 Varelius, *Moral Acceptability*, *supra* note 17, at 232 (applying *mutatis mutandis* to all incompetent patients with irrational suffering).

67 *Id.* at 231–32.

68 *See* SUMNER, *supra* note 18, at 38–42; Varelius, *Lack of Autonomy*, *supra* note 17, at 61.

69 *Contra* Cees M.P.M. Hertogh, *Unbearable Suffering and Advanced Dementia: The Moral Problems of Advance Directives for Euthanasia, in* PHYSICIAN-ASSISTED DEATH IN PERSPECTIVE: ASSESSING THE DUTCH EXPERIENCE 215, 224–25 (Stuart J. Younger & Gerrit K. Kimsma eds., 2012)

a duty of beneficence is the only justification for MAiD. Beneficence connotes "acts of mercy" and requires, in the health care context, actions done to benefit others. This means actions undertaken to "produce a positive balance of goods over inflicted harms."[70] It involves the minimization or suppression of existing harms in order to favor goods or benefits.[71] Incompetent patients who cannot "exercise autonomy have a right to beneficence from those entrusted to decide on their behalf."[72] In the context of MAiD, beneficence would therefore require health care professionals to alleviate the enduring and intolerable suffering of their incompetent patients. The assumption at work in this argument is that there are circumstances where "a person's suffering can be so severe and unremitting that it outweighs the benefits—the pleasures and satisfactions—of further existence."[73] When other reasonable means of relieving suffering are not available or successful, administering a substance causing death can be an appropriate way to alleviate a nonautonomous patient's suffering.[74]

B. Principled Objections to NVE on the Basis of Beneficence

Arguments against legalizing NVE may deny that there is a defensible duty of beneficence to actively end a life that is worse than death. For instance, one may argue that killing someone who is unable to express a desire to die can never count as a benefit to that person. We can call these kinds of objections *principled* (or radical) because they disallow the euthanasia of non-competent people in all cases for reasons that attack some fundamental premises underlying the permissibility of non-voluntary MAiD. Alternatively, arguments against legalizing NVE may concede that NVE is not inherently unjustifiable, but instead propose a number of reasons to override a duty to end life. We can call these *circumstantial* objections. In the case where X is non-autonomous, these reasons generally relate to epistemic

(arguing that beneficence and mercifulness cannot exist without responsive receptiveness of a competent individual). "Put metaphorically, the Samaritan can only be helpful if the wounded and robbed traveler to Jericho is ready to accept his assistance, not if the traveler rejects him, feels threatened by him, or does not understand him. Only the responsiveness of the other makes the Samaritan into a merciful giver, and this responsiveness cannot be replaced by a distant request on a piece of paper. What this assistance wants is consenting reciprocity at the moment it is given." *Id.*

70 Tom Beauchamp, *The Principle of Beneficence in Applied Ethics*, STAN. ENCYC. PHIL. (Feb. 11, 2019), https://plato.stanford.edu/entries/principle-beneficence.

71 *Id.*

72 Rebecca Dresser, *Dworkin on Dementia: Elegant Theory, Questionable Policy*, 25 HASTINGS CTR. REP. 32, 32–33 (1995).

73 CANTOR, *supra* note 63, at 106.

74 *See, e.g.*, Singh, *supra* note 16, at 28; Brown, *supra* note 63, at 176; Varelius *Lack of Autonomy*, *supra* note 17, at 60, 63–64; Varelius, *Moral Acceptability*, *supra* note 17, at 232–33. *Contra* Francesca Giglio & Antonio G. Spagnolo, *Pediatric Euthanasia in Belgium: Some Ethical Considerations*, 12 J. MED. & PERSON 146 (2014)(arguing that to consider death beneficial is perverse, because without life, it is impossible to enjoy any benefit).

difficulties, that is, difficulties that relate to the nature of knowledge and limits related to its acquisition. These difficulties have two main sources: 1) inherent difficulties in assessing pain and suffering in other people, amplified by cognitive differences in the case of non-autonomous persons, and 2) conscious or unconscious considerations motivated by irrelevant interests or prejudices. We assess the plausibility of such principled and circumstantial objections in the next subsections.

1. Euthanasia Does Not Eliminate Suffering

Some critics of euthanasia have pointed out that to end a person's life does not, strictly speaking, "relieve" or "diminish" their suffering: rather, it eliminates the sufferer.[75] From this perspective, the practice may still appeal to a consequentialist because there would be less "units" of suffering remaining in the world. It might, by contrast, be less appealing to other ethicists keen to act benevolently, but who conceptualize the value of an action eliminating or diminishing suffering as being dependent upon the value of the person whom the said action benefits—in this case, no one.

According to this critique, in order for the beneficence argument to make sense, it must assume that, though there will be no one to benefit post-mortem, the living individual ultimately benefits from ceasing to exist. The rationality of a beneficence-based choice to euthanize would not be based on comparing the individual in question's state of being sick and alive, on the one hand, or dead, on the other. Instead, it would be based on a comparison between the suffering individual having "a shorter life, whose duration is truncated by suicide [euthanasia], versus the longer life an individual would be most likely to have if they forego suicide [NVE does not occur]."[76]

2. Certain Incompetent Patients Cannot Suffer

Another principled objection against euthanizing incompetent patients in order to make their suffering stop is that they cannot suffer. Some critics of the Groningen Protocol made this point by referring to the nature of "quality of life" and "suffering." Regarding "quality of life," which they define as the satisfaction one gains from "engag[ing] in life tasks," they observe that incompetent patients such as infants would not have the "cognitive and physical capacity to identify and engage in life tasks and to develop values on the basis of which they can determine

75 *See* Scott Kim, *Lives Not Worth Living in Modern Euthanasia Regimes*, 16 J. POL'Y & PRAC. INTELL. DISABILITIES 134, 135 (2019); Brouwer et al., *supra* note 6, at 2.

76 Michael Cholbi, *Suicide*, STAN. ENCYC. PHIL. (Nov. 9, 2021) § 3.7, https://plato.stanford.edu/entries/suicide.

whether those life tasks are satisfying."[77] With respect to suffering, they define it as "a complex psychosocial phenomenon in which an individual experiences the loss, to different degrees, of the ability to realize intentions, desires, and hopes for the future."[78] In contrast, pain would be "a physiologic phenomenon: the awareness of reports of tissue damage or threat of tissue damage in the central nervous system."[79] It follows that some incompetent patients cannot "suffer" or experience a poor "quality of life," at least as those terms are commonly understood, even if they can literally perceive pain.

While this objection may justify the conclusion that some people cannot experience certain kinds of suffering, it neither negates nor confirms the view that NVE should be legalized. Whether we qualify their experiences as ones of "pain," "physical suffering" or "suffering," incompetent patients can experience a painful, negative state of affairs that is real. To justify the denial of relief on these grounds risks not only over-intellectualizing the concept of suffering, but also misrepresenting what suffering/pain and death mean to non-competent people experientially, if not intellectually. Even if one believes, like Cassell, that young infants or profoundly demented adults lack the capacities required for personhood and suffering, one should not deny that they can be in terrible pain and that this pain calls for relief.[80] However, the fact that non-competent patients can experience a pain that ought to be alleviated does not tell us whether this relief should take the form of pain-management care or euthanasia.

3. The Extent of Incompetent Patients' Suffering is Unknowable

A similar radical objection to legalizing non-voluntary MAiD on grounds of beneficence is based on the notions of pain and suffering and their ineliminable subjectivity.

Numerous scholars highlight that assessments of another person's suffering and quality of life are deeply subjective.[81] In this regard, the Canadian Society of

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77 Frank A. Chervenak et al., *Why the Groningen Protocol Should Be Rejected,* 36 HASTINGS CTR. REP. 30, 30–31 (2006).

[80] *Id.* at 31.

79 *Id.* at 30–31.

80 ERIC J. CASSELL, THE NATURE OF HEALING: THE MODERN PRACTICE OF MEDICINE 221 (2012).

81 *See, e.g., The State of Knowledge on Advance Requests for Medical Assistance in Dying: The Expert Panel Working Group on Advance Requests for MAID*, COUNCIL OF CANADIAN ACADS. 72 (2018) [hereinafter *The State of Knowledge on Advance Requests for Medical Assistance in Dying*], https://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf; Chervenak et al., *supra* note 77, at 31; Chris Gastmans & Jan De Lepeleire, *Living to the Bitter End? A Personalist Approach to Euthanasia in Persons with Severe Dementia*, 24 BIOETHICS 78, 82 (2010); CANTOR, *supra* note 63, at 106; Singh, *supra* note 16, at 21; Julian Savulescu, *Autonomy, Interests, Justice and Active Medical Euthanasia*, *in* NEW DIRECTIONS IN THE ETHICS OF ASSISTED SUICIDE AND EUTHANASIA 31, 40–42 (Michael Cholbi & Jukka Varelius

Palliative Care Physicians declared that "we have no objective means of confirming whether an incapable person's suffering is 'intolerable' to the point that he or she would want MAiD."[82] This subjectivity is accentuated by common communication issues with incompetent patients in the end-of-life context. For example, dementia patients gradually lose the ability to communicate their suffering to their physician as their condition worsens. Once in an advanced stage of dementia, while "there will sometimes be very reliable evidence of physical pain,"[83] it is not possible to know with certainty whether the person is experiencing intolerable suffering.[84] Similar concerns have been raised with never-competent minors: there will always be some "ambiguity or uncertainty in the understanding of a child's suffering experience through their voice."[85] This objection may be buttressed by distinguishing pain from suffering, as we noted in the previous Section, since suffering can be understood as even more unavoidably subjective than pain.[86]

The point here is not that incompetent patients cannot suffer, but rather, that their pain/suffering is unknowable without the subjective input of another party. A way to go about overcoming this barrier would be to develop technologies[87] capable of detecting the kind of pain that would produce a relatively constant desire for suicide in unavoidably suffering patients. However, this option may not be viable in the short-term, and the utility of such tools may ultimately be limited. This is because such technology would not only have to indicate that a non-competent patient's brain is registering "pain" (e.g., an experience of tissue-damaging stimuli) but also be able to convey how this awareness is subjectively experienced qua pain/suffering. Since not all patients experiencing extreme suffering—even tremendous, unending suffering—want to die, the technology

eds., 2015).

82 *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, *supra* note 81, at 145.

83 Jocelyn Downie & Georgia Lloyd-Smith, *Assisted Dying for Individuals with Dementia: Challenges for Translating Ethical Positions into Law*, *in* NEW DIRECTIONS IN THE ETHICS OF ASSISTED SUICIDE AND EUTHANASIA 97, 115 (Michael Cholbi & Jukka Varelius eds., 2015).

84 *Id.* at 106, 115.

85 Singh, *supra* note 16, at 68.

86 Chervenak et al., *supra* note 77, at 31; *see also* Eric J. Cassell, *The Nature of Suffering and the Goals of Medicine*, 306 NEW ENG. J. MED. 639, 639 (1982) (defining suffering as a threat to the "intactness of the person as a complex social and psychological entity"). Some also define pain as having a subjective, existentially personal rather than objectively factual or medical quality. *See, e.g.*, ANNE CASE & ANGUS DEATON, DEATHS OF DESPAIR AND THE FUTURE OF CAPITALISM 84 (2020) ("The long-held understanding of pain as a signal to the brain to deal with an injury has been discarded and replaced by the recognition that the mind is involved in *all* pain and that social distress or empathetic distress can engender pain in the same way as the distress from a physical injury.").

87 *E.g.*, Jennifer A. Chandler et al., *Brain Computer Interfaces and Communication Disabilities: Ethical, Legal, and Social Aspects of Decoding Speech from the Brain*, 16 FRONTIERS HUM. NEUROSCIENCE 1, 2 (2022).

would have to be able to convey whether non-existence would be a preferable state of affairs for each particular patient. This level of subjective insight remains far beyond the reach of existing technologies.

The claim of complete unknowability of pain—beyond the obvious fact that we cannot know for sure, or experience exactly, what pain means to someone else––is unconvincing. It is much less controversial to say that pain is opaque, or that it is epistemically difficult to access the pain of others. Of course, we cannot (barring futuristic technologies) step into someone else's body and experience their subjective awareness of the world. Nonetheless, medicine and public affairs proceed in spite of these obvious limitations, on the basis that human beings have enough capacities to experience pain and suffering in common for assumptions and communication not to be pointless. That said, the pain and suffering of incompetent patients remains relatively less knowable. Both the projection of one's own evaluative framework onto someone else and forms of communication are much less reliable in the case of many incompetent patients. Still, as noted above, we have developed measurements to evaluate the physical pain of non-competent people.

Given the relative opacity of incompetent patients' suffering, it would be very difficult, perhaps impossible, to determine whether pain has reached a level such that death would be a net benefit.[88] This potentially leaves policymakers, families, and doctors in a situation where they truly do not know whether a life should be continued or not, such that they may do harm whichever route they choose. One may argue that this epistemic obstacle justifies a certain humility that would weigh against euthanasia. However, if the choice is strictly between death and terrible unending pain, relying on epistemic humility to justify refusing taking any action goes farther than protecting us from the risk of unduly ending a life: it also exposes us to the risk of unduly continuing it.[89]

While the radical objections do not seem particularly conclusive on their own, their premises emphasize that it will be difficult to justify non-voluntary MAiD *on the basis of a beneficent response to suffering* when any sort of palliative care can attenuate pain.

Other objections have to do with the precision of such measurements, and

88 Beaudry, *supra* note 25, at 335–37, 351.

89 *Cf.* Rebecca S. Dresser & John A. Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 L. MED. & HEALTH CARE 234, 240 (1989) ("While the predominant danger of the orthodox approach is undertreatment, it also poses a risk that unjustified overtreatment will occur whenever the courts impose a strict standard for inferring the patient's choice if competent.");David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947, 960 (1997) ("With respect to euthanasia, terminal sedation poses the same risks of abuse while serving fewer purposes of right-to-die law. Compared with assisted suicide, terminal sedation poses even greater risks of abuse and serves fewer purposes of right-to-die law.").

whether they can be carried out with sufficient objectivity by the relevant SDMs. We now turn to these circumstantial considerations.

C. Circumstantial Objections to NVE on the Basis of Beneficence

Whether an individual's suffering is so intolerable that it calls for actively ending life is currently assessed in a subjective manner by patients themselves in all jurisdictions where physician-assisted suicide has been legalized.[90] This subjective assessment implies that the state need not officially endorse controversial value-laden views on whether and when certain individuals are better off not existing. Should non-voluntary MAiD be legalized, third parties would have to decide whether someone's suffering calls for euthanasia. In all likelihood, for newborns and non-mature minors, that responsibility would lie with their legal guardians, who are by default their parents.[91] For adults, the SDM would be a family member, a friend, or a court-appointed guardian, depending on the circumstances and jurisdiction.[92] Medical professionals are also likely candidates to be made alternative SDMs.[93] In every case, the subjectivity inherent to third-party assessments of suffering includes a variety of risks. The SDM's response to suffering may not be properly benevolent if it is clouded by irrelevant considerations, and the SDM's evaluation of quality of life may not be beneficent if it encompasses irrelevant axiological assumptions.[94]

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90 We use physician-assisted suicide here in favour of MAiD to signify the inclusion of jurisdictions that have not legalized euthanasia as well as those which have. *See e.g.,* End of Life Choice Act, *supra* note 23, §§ 13-15; *Canada's Medical Assistance in Dying (MAID) Law*, *supra* note 23; *The State of Knowledge on Medical Assistance in Dying for Mature Minors*, *supra* note 43, at 112–13.

91 *See* Kevin W. Coughlin, *Medical Decision-Making in Paediatrics: Infancy to Adolescence*, 23 PAEDIATRICS & CHILD HEALTH 138, 139 (2018).

92 *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, *supra* note 81, at 45 (citing MICHAEL BACH & LANA KERZNER, A NEW PARADIGM FOR PROTECTING AUTONOMY AND THE RIGHT TO LEGAL CAPACITY: ADVANCING SUBSTANTIVE EQUALITY FOR PERSONS WITH DISABILITIES THROUGH LAW, POLICY AND PRACTICE 44 (2010)). The SDM may also be someone appointed in an advance directive. However, we do not consider such circumstances in the present paper.

93 *See, e.g.*, Jeff Perring, *Practical Realities of Decision-Making Relating to End of Life Care*, *in* A GOOD DEATH? LAW AND ETHICS IN PRACTICE 151, 155–56 (Lynn Hagger & Simon Woods eds., Routledge 2016) (2013).

94 Irrelevant axiological assumptions may include ableist and agist assumptions, stereotypes and prejudices, for example, the belief in a diminished societal and/or self-assessed value of the life of the elderly or persons with disabilities. For a discussion of these types of considerations, see Mary Lay Schuster et al., *Determining "Best Interests" in End-of-Life Decisions for the Developmentally Disabled: Minnesota State Guardians and Wards*, 34 DISABILITY STUD. Q. (2014) (finding that decisions made by Minnesota State Guardians as substitute decision-makers are made within a framework that includes non-problematized ableist assumptions); Laverne Jacobs & Trudo Lemmens, *The Latest Medical Assistance in Dying Decision Needs to Be Appealed: Here's Why*, THE CONVERSATION (Oct. 9, 2019), http://theconversation.com/the-latest-medical-assistance-in-

1. SDMs' Emotions, Perceptions and Values

One circumstantial objection is derived from the inherent subjectivity involved in assessing another person's suffering and overall quality of life and the related risk that SDMs' emotions, perceptions, and values might influence their assessment of whether it is in a person's best interests to end their life.[95] As explained by Gastmans and Lepeleire, for persons with dementia (but it applies *mutatis mutandis*[96] to all individuals under study in this article), "there is a real risk that their close relatives will project their personal fears and concerns onto the person suffering from dementia. If relatives impose the disvalue they attach, in terms of their own life plans, to the states they observe in the person with dementia, they may well be imposing on the person a meaning to quality of life that does not fit with the patient's current lived experiences."[97] It is often pointed out in support of such concerns that people with dementia and individuals with disabilities tend to rate their own quality of life higher than one might expect.[98]

For example, a person with dementia may adapt to her new environment and

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dying-decision-needs-to-be-appealed-heres-why-124955.

95 See Gastmans & Lepeleire, *supra* note 81, at 82; *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, *supra* note 81, at 148.

96 The Latin phrase is translated directly as "with the necessary changes" or "all necessary changes having been made." It designates that the main points of an argument are broadly applicable in a different but similar context, taking into consideration all necessary adjustments needed to move from one context to another. In this case, it indicates that Gastman's & Lapeliere's arguments about SDMs' ability to assess the quality of life of dementia patients are broadly applicable to SDMs for other types of patients, assuming distinctions between these cases have been accounted for.

97 Gastmans & Lepeleire, *supra* note 81, at 82.

98 *See, e.g.*, *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, *supra* note 81, at 148 (citing Trevor Buckley et al., *Predictors of Quality of Life Ratings for Persons with Dementia Simultaneously Reported by Patients and their Caregivers: The Cache County (Utah) Study*, 24 INT'L PSYCHOGERIATRICS 1094, 1099 (2012)); Kristiina Hongisto et al., *Self-Rated and Caregiver-Rated Quality of Life in Alzheimer Disease with a Focus on Evolving Patient Ability to Respond to Questionnaires: 5-Year Prospective ALSOVA Cohort Study*, 23 AM. J. GERIATRIC PSYCHIATRY 1280, 1286 (2015); Gina Bravo, Modou Sene & Marcel Arcand, *Surrogate Inaccuracy in Predicting Older Adults' Desire for Life-Sustaining Interventions in the Event of Decisional Incapacity: Is It Due in Part to Erroneous Quality-of-Life Assessments?*, 29 INT'L PSYCHOGERIATRICS 1061, 1066 (2017); *see also* Chervenak et al., *supra* note 77, at 31 (citing Jon E. Tyson & Saroj Saigal, *Outcomes for Extremely Low-Birth-Weight Infants: Disappointing News*, 294 JAMA 371 (2005)) (stating that "the self-reported quality of life of children with handicaps does not differ from that of children without disabilities"); Heather O. Dickinson et al., *Self-Reported Quality of Life of 8–12-Year-Old Children with Cerebral Palsy: A Cross-Sectional European Study*, 369 LANCET 2171 (2007) (finding self-reported quality of life assessments of children with cerebral palsy did not differ significantly from those of children in the control group). *But see* Govert den Hartogh, *The Authority of Advance Directives*, *in* JUSTICE, LUCK & RESPONSIBILITY IN HEALTH CARE: PHILOSOPHICAL BACKGROUND AND ETHICAL IMPLICATIONS FOR END-OF-LIFE CARE 167 (Yvonne Denier, Chris Gastmans & Antoon Vandevelde eds., 2013) (contesting the validity of such research because demented patients lose the capacity to assess their quality of life).

appear to enjoy participating in social activities at her nursing home. Her bouts of anxiety and depressive symptoms can be attenuated with comforting words by the staff and easily controlled when her antidepressant dose is adjusted. She may not show signs of recognizing her children, but she is unaware of her illness and her decline. Her children are extremely saddened that their mother no longer recognizes them and are troubled to see her caring about things as trivial as cartoons. Although she appears to be living, overall, a pleasant life that is mostly free from suffering, there is a risk that her children—because of their emotions as well as ableist and ageist values, stereotypes, and prejudices—will give disproportionate weight to the few episodes of suffering she experiences and conclude that she is better off dead than alive.

Is this risk equally alarming for never-competent patients as for formerly competent ones? For some, the answer is yes. Devaluing the quality of a human life because of ableist, ageist, or "disease-ist" values and perceptions or negative feelings and emotions is seriously reprehensible in all cases.[99] However, according to others, like Norman Cantor, the answer is no: the risk is more alarming for never-competent individuals than for formerly competent ones. This is because, for formerly competent persons who left no clear indications of their own end-of-life medical choices, it is common for SDMs to draw "guidance from a projection of what most people would want done for themselves in the circumstances of the particular case."[100] For such formerly competent individuals, it is generally assumed that they "want their interests furthered and to have those interests defined according to majority preferences—absent personal indications to the contrary."[101] Such an approach seeks to "honor a form of self-determination by implementing the now incompetent patient's likely, albeit putative, wishes."[102] Thus, following this logic, if ableist and ageist stereotypes as well as a hypercognitive perspective (the perspective that cognition is integral to an individual's identity and consequently their externally and internally constructed societal/moral value, including the dignity of their existence) inform generally what constitutes a life worth living[103] and if hypercognitive perspectives motivate a majority of

99 *See generally* Schuster et al., *supra* note 94 (finding that decisions made by Minesota State Guardians as substitute decision-makers are made within a framework that includes non-problematized ableist assumptions); Jacobs & Lemmens, *supra* note 94 (arguing that the *Truchon* decision overturning certain access criteria for medical assistance in dying should be appealed, partially due to a failure to consider how expanded access to MAiD risks reinforcing or normalizing problematic ableist and agist assumptions).

100 CANTOR, *supra* note 63, at 103.

101 *Id.* at 104.

102 *Id.*

103 *See* Gastmans & Lepeleire, *supra* note 81, at 80, 84; Jonas Beaudry, *MAiD Monitoring and the Carter Compromise*, VULNERABLE PERSONS STANDARD (Mar. 26, 2018), http://www.vps-npv.ca/blog/2018/3/26/maid-monitoring-and-the-carter-compromise ("[T]he notion that the lives of old, sick or disabled people are 'less worth living' is one of the most damaging and longstanding

competent individuals in a given society to express a desire for MAiD should they become demented, then consequently their children can only approximate what they surmise their parent's wish would have been. In other words, if ableist or ageist assumptions inform decisions made by autonomous people, why not apply this prejudiced lens to an understanding of their suffering and best interests when they are old and disabled by impairments or illnesses?

Objection to this line of thought may challenge the assumption that the fully competent person writing a living will to decide when her older, sicker self ought to die has strong moral or legal claims to make life and death choices for her older self. For instance, if that claim is based on an identity between younger and older selves, one may object that the older self is a quite different person from the younger one. Giving a younger, more intelligent and cognitively apt self a right to decide whether their older, cognitively impaired self must die would become as questionable as giving anyone a right of life and death over anyone else than themselves.[104] Policies granting such power to the former self would seem prima facie ableist and ageist, all the more so if research indicates that the older self is overall experiencing an acceptable level of contentment. The younger self may feel that this ending to their previously more productive and richer life is an unfitting or even degrading end to their lives. Intuitions on this issue hinge on controversial conceptions of identity, autonomy, and dignity.[105]

It is, however, different for never-competent individuals. Severely cognitively disabled individuals "have never had the capacity for autonomy—have never had the ability to issue instructions concerning end-of-life treatment (or other serious medical matters) or to form values and preferences that would guide surrogate decision makers."[106] It is thus nonsensical to attribute to them majoritarian values, because compared to individuals who "once had the perspective of a competent person," their "values are either nonexistent or opaque."[107] What needs to guide SDMs is a never-competent patient's best interests, understood from their point of view as a severely cognitively disabled human.[108] Here, the question is whether this individual would be better off dead than alive in the circumstances that they are facing, not whether their SDMs would want to live in those circumstances.[109]

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ableist and ageist belief in our productivity-obsessed culture.").

104 *See e.g.,* Rich, *supra* note 5, at 139.

105 On identity, see generally Helga Kuhse & Peter Singer, *The Quality/Quantity-of-Life Distinction and Its Moral Importance for Nurses*, 26 INT'L J. NURSING STUD. 203 (1989). On autonomy and beneficence, see generally RONALD DWORKIN, LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM (1st ed. 1994) [hereinafter DWORKIN, LIFE'S DOMINION]; Dresser, *supra* note 72.

106 CANTOR, *supra* note 63, at 104.

107 *Id.*

108 *Id.* at 107.

109 *Id.* at 106.

In such an exercise, there is a real risk that SDMs transpose or project their feelings, values, and personal perception of a life worth living onto the individual,[110] which is a seriously alarming prospect in the case of never-competent individuals.[111]

While some argue that the risk created by the inherent subjectivity of third-party assessment of suffering and quality of life renders non-voluntary MAiD unethical,[112] others advocate instead for greater scrutiny of end-of-life substitute decision-making.[113] Susan Martyn, for example, calls for "caring interpreters" to determine what incompetent patients "find meaningful in life"[114] and "how that person experiences life."[115] Such an approach allows for sensitivity to "noncognitive notions of well-being" that are grounded in "emotional and relational well-being."[116] It allows for a better understanding of incompetent patients' lived experiences and thus for a more accurate assessment of what constitutes their best interests.

Finally, in the context of newborns and young children, the subjectivity of third-party assessments of suffering and the related risk of SDMs imposing their own values, perceptions, emotions, and feelings is not seen as a risk at all by some scholars. For example, Lindemann and Verkerk argue that for parents to impose their values and vision of a life worth living onto their severely disabled or sick child is desirable.[117] Indeed, parents are "major contributors to the long process of shaping their children's selves, enveloping their children with their own 'thick' normative framework and in that way giving them some rich and comprehensive notion of what matters in life."[118] Parents "so directly mark the child in its first few years when children are at their most receptive, parents provide a window into the values and settled preferences, the particular outlook on life, that might well characterize the child when grown."[119] Thus, in assessing suffering and their

110 *Id.* at 108–09.

111 *Id.* at 109 (noting that this line of reasoning applies equally to disabled newborns or infants). For a different view on the ethical considerations surrounding end-of-life decisions for disabled infants, see generally HELGA KUHSE & PETER SINGER, SHOULD THE BABY LIVE?: THE PROBLEM OF HANDICAPPED INFANTS (1985), at 184-189; Lindemann & Verkerk, *supra* note 44, at 46–50.

112 *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, *supra* note 81, at 145 (explaining that the Canadian Association for Community Living holds such a view).

113 CANTOR, *supra* note 63, at 108.

114 *Id.* at 109 (citing Susan R. Martyn, *Substituted Judgment, Best Interests, and the Need for Best Respect*, 3 CAMBRIDGE Q. HEALTHCARE ETHICS 195, 201 (1994)).

115 Susan R. Martyn, *Substituted Judgment, Best Interests, and the Need for Best Respect*, 3 CAMBRIDGE Q. HEALTHCARE ETHICS 195, 199 (1994).

116 Stephen G. Post, *Dementia in Our Midst: The Moral Community*, 4 CAMBRIDGE Q. HEALTHCARE ETHICS 142, 143–44 (1995).

117 Lindemann & Verkerk, *supra* note 44, at 49–50.

118 *Id.* at 49.

119 *Id.*

child's current and future quality of life, parents can and should rely on their personal value structure.

While it is true that parents are generally given a wide berth of discretion in raising their children in light of their own value system, there are limits to analogizing child-rearing to making life and death choices, since the state typically interferes with parental discretion when it is used in a way that risks seriously injuring the best interests of the child.[120] Moreover, the importance of giving parents the freedom to imprint their value system onto their child must be weighed against the importance of a number of parental virtues that would support constraining this freedom, such as welcoming or accepting one's child's differences or uniqueness and being committed to fulfilling the particular needs of that child.[121] While some parents may be exceptionally well-attuned to their child's best interests, [122]others may make the decision to end their child's life in reaction to their own emotional state, or before having developed a full "understanding of the reality of caring for a disabled child."[123]

2. SDMs' Personal and Utilitarian Interests

Another circumstantial objection is that SDMs' personal and utilitarian interests risk conflicting with the person's best interests, thereby distorting their assessment. Providing care for non-competent patients can be financially, emotionally, and physically burdensome, and some people therefore fear that SDMs may have an interest in ceasing to provide care.[124] For example, in the context of individuals with dementia, caregivers face both the physical burden of

120 For example, child welfare legislation in Canada typically allows for a court order that dispenses for the need for parental consent to medical treatment, where that consent is denied or cannot be obtained. *See e.g.*, Medical Consent of Minors Act, S.N.B. 1976, c. M-6.1, s 4 (Can.); Child and Family Services Act, R.S.O. 1990, c. C-11, s 62(3) (Can.).

121 Rosalind McDougall, *Impairment, Flourishing, and the Moral Nature of Parenthood*, *in* DISABILITY AND DISADVANTAGE 352, 354–64 (Kimberley Brownlee & Adam Cureton eds., 2009). On acceptance and approbation in the context of gene editing, see generally HUMAN FLOURISHING IN AN AGE OF GENE EDITING (Erik Parens & Josephine Johnston eds., 2019). On familial welcome in the context of prenatal testing, see generally Adrienne Asch & David Wasserman*, Where Is the Sin in Synecdoche?: Prenatal Testing and the Parental-Child Relationship*, *in* QUALITY OF LIFE AND HUMAN DIFFERENCE: GENETIC TESTING, HEALTH CARE, AND DISABILITY 172 (David Wasserman, Jerome Bickenbach & Robert Wachbroit eds., 2005).

122 *See* Sabine Vanacker, *The Story of Isabel*, *in* A GOOD DEATH?: LAW AND ETHICS IN PRACTICE 167, 167–76 (Lynn Hagger & Simon Woods eds., 2013).

123 *See* Perring, *supra* note 93, at 160.

124 *See The State of Knowledge on Advance Requests for Medical Assistance in Dying*, *supra* note 81, at 146; Giulia Cuman & Chris Gastmans, *Minors and Euthanasia: A Systematic Review of Argument-Based Ethics Literature*, 176 EUR. J. PEDIATRICS 837, 842 (2017); CANTOR, *supra* note 63 at 136; Chervenak et al., *supra* note 77, at 31; A.B. Jotkowitz & S. Glick, *The Groningen Protocol: Another Perspective*, 32 J. MED. ETHICS 157, 157 (2006).

performing a range of caregiving responsibilities and the mental stress of being in an altered relationship with a loved one (e.g., various forms of grief or guilt).[125] Similarly, some have pointed out that disabled children can strain their family's financial resources and induce burnouts, usually on the part of their mothers who carry an unequal share of the burden of care.[126] Therefore, some worry that SDMs' assessment of suffering and quality of life may be distorted by self-interested and utilitarian considerations, such as the financial and emotional costs of care.[127] This poses a risk for non-voluntary MAiD to be administered to individuals in circumstances where it is not obvious that death rather than continued existence is in their best interests.

For some, in the context of never-competent severely disabled or ill children, the critique that parents may want "to wiggle out from under the responsibility" of looking after their child is both "unmotivated and mean-spirited."[128] For others, this concern is ill-founded. For example, Peter Singer sees no problem in prioritizing the interests of SDMs over those of nonautonomous, non-rational and non-self-aware beings: as we will see in the next Part, Singer considers the lives of severely cognitively impaired people to be of lesser value and, thus, their interests to remain alive may in some cases be of lesser importance than various important interests of SDMs.[129] Finally, scholars like Cantor weigh the risks of prioritizing SDMs' interests over those of incompetent patients according to whether the individual in question is either a formerly or never-competent individual. According to this view, third parties' interests in being discharged from the burden of care can be rightly considered in the case of formerly competent individuals, but not for never-competent ones. In the context of formerly competent persons who left no clear indications of their own end-of-life medical choices, taking into consideration the putative wish of these individuals not to burden their loved ones can be reasonable if, in a given population, there is a shared belief that "most people have such strong solicitude for their immediate families

125 Chris Gastmans, *Euthanasia in Persons with Severe Dementia, in* EUTHANASIA AND ASSISTED SUICIDE: LESSONS FROM BELGIUM 202, 205 (David Albert Jones, Chris Gastmans & Calum MacKellar eds., 2017).

126 SUMNER, *supra* note 18, at 121–22 (citing KUHSE & SINGER, *supra* note 111, at 146).

127 Mary Crossley, *Ending-Life Decisions: Some Disability Perspectives*, 33 GA. STATE U. L. REV. 893, 905 (2017) (citing Mary Crossley, *Medical Futility and Disability Discrimination,* 81 IOWA L. REV. 179 (1995)).

128 Lindemann & Verkerk, *supra* note 44, at 49 (highlighting that "parental conflicts of interest arise routinely, yet responsibility for the care of the young continues to be assigned to their progenitors. . . . To create public policy on the assumption that parents are likely to sacrifice their desperately ill child's interests to their own would be to overturn deep-seated, widely shared understandings about who is responsible for the care of the young. Concern about conflict of interest in parents' making end-of-life decisions of any kind for their children needs to be specific and substantial, not general and notional.").

129 *See, e.g.*, SINGER, *supra* note 1, at 160.

that they would want such interests to be considered."[130] In the context of never-competent patients, it is, however, more difficult to ascribe "an altruistic wish to have the interests of loved ones considered"[131] in end-of-life decisions because they never possessed the capacity to weigh third-party interests against their own well-being. They were never capable of deliberating "about the positives and negatives of self-sacrifice."[132] Attributing to them a desire for self-sacrifice may be nothing but a "convenient fiction."[133]

D. A Defeasible Duty of Beneficence to Sometimes Provide NVE Exists, but Never Obtains in Practice

In conclusion, the most compelling beneficence argument in favor of NVE is that the suffering of non-competent patients matters. Arguments that seek to deny this relatively obvious claim appear unconvincing. The crux of the ethical disagreement is not whether non-competent people can suffer intolerably or could potentially benefit from euthanasia. On the contrary, the claim that NVE may be the most *beneficent* course of action in specific circumstances is relatively intuitively plausible.

We nonetheless have three main reasons for rejecting the view that legalizing NVE is justified on the basis of beneficence, all things being equal. First, in the vast majority of cases considered as candidates for NVE, the suffering of non-competent patients is not so severe that it would typically be considered intolerable.[134] Second, even in the exceptionally rare cases where there are grounds to believe that death may be in a patient's best interests, the subjectivity of the experience of suffering, communicational challenges with non-autonomous people, and the morally irrelevant emotions, interests, and considerations of the SDM render the accuracy of this assessment questionable.

However, the theoretical possibility of inflicting a life worse than death on a patient unable to wish for euthanasia will remain, unless there are other ways of controlling pain. The thorniest ethical disagreement about NVE is *how* one ought to respond to the suffering of non-competent patients in light of this epistemic

130 CANTOR, *supra* note 63, at 141.

131 *Id.*

132 *Id.*

133 *Id.*

134 In the pediatric context, see generally Chervenak et al., *supra* note 77. In the context of dementia, see generally Dresser, *supra* note 72. On the much-discussed under-evaluation of the quality-of-life of people with disabilities, see generally Stephen M. Campbell & Joseph A. Stramondo, *The Complicated Relationship of Disability and Well-Being*, 27 KENNEDY INST. ETHICS J. 151 (2017). Even proponents of the Groningen Protocol emphasize the exceptional character of this norm. *E.g.*, Lindemann & Verkerk, *supra* note 44, at 48; *see also* Manninen, *supra* note 15, at 650 (expressing concerns that the assessments of unbearable suffering reaches a "grey area very quickly," creating the potential for euthanasia of infants who may have survived).

opacity, not with *whether* this suffering matters or even whether it may, in theory, call for NVE in some exceptional circumstances and under conditions attenuating documented risks.

The third reason for rejecting non-voluntary MAiD on the basis of beneficence is that pain management treatments are generally sufficient to alleviate suffering that would otherwise be extreme. This is not true in the same way for autonomous patients who may, for example, suffer from being forced to receive pain-management treatment against their will. Incompetent patients offer no such autonomous resistance to receiving pain-management treatments. Of course, patients may show frustration and displeasure at experiencing certain treatments (no one enjoys dialysis, with or without dementia). The challenge lies in understanding their pain/suffering and responding to it[135] with "comfort-only care,"[136] rather than projecting ableist suicidal ideations onto moderate restlessness or resisting behaviors that are not so much a resistance to any particular course of *treatment* as they are a resistance to or an expression of displeasure at the specific *steps* taken to achieve said treatment. Life-saving treatments should not be interrupted, nor should patients be euthanized, when the patient is unable to understand the consequences of receiving a given treatment or not. Alternative ways of delivering life-sustaining treatments can be considered when possible to minimize this displeasure. Note here the distinction between situations where a patient with limited intellectual capacities still has enough residual autonomy to reject the *treatment*, as opposed to simply pushing back the hand administering it because it is experienced as an unpleasant stimulus. Our concern in this Part is rather with the questionable imputation of residual autonomy—and of a wish to die—to patients who never expressed an understanding that their life was threatened in any way, and whose resistance may just as well point to the fact that they personally dislike a nurse administering a treatment.

One final objection to legalizing NVE on the basis of beneficence is a pragmatic one: it is risky policymaking to create a rule that has a broad and ambiguous scope of application (such as the Groningen Protocol) where it only applies to a few excessively rare cases. It is even more dangerous when the risks it raises (over-application of the rule because of systemic ableist, ageist, diseasist assumptions) are, by contrast, insidious and widespread.

While pain management will always or almost always suffice to respond to the kind of grave physical suffering we have been considering here, one may object that it may still not be available for socioeconomic reasons, and that in certain contexts (e.g., low-income countries with extremely poor access to health care), NVE may well be the most beneficent available solution in many cases.

135 CASSELL, *supra* note 80, at 219–30.

136 ARTHUR J. DYCK, LIFE'S WORTH: THE CASE AGAINST ASSISTED SUICIDE (2002) at 31.

The weight of this objection will vary on a case-by-case basis, since it must be assessed along with the circumstantial risks that we have explored in this Part. Incidentally, those risks would in fact direct those professing to take the ethical principle of beneficence seriously to invest more into research on the suffering of non-competent patients. That said, even if (i) such research would reveal that NVE is the most beneficent course of action in certain exceptional circumstances, and (ii) even assuming, counterfactually, that all aforementioned risks could be controlled and that beneficence would require ending a patient's life in this situation (where no pain management care is available), the desirability of legalizing NVE would still need to be assessed globally, in light of considerations of morality and justice weighing against the legalization of NVE, that we will explore below.

IV. VALUING LIFE

Of course, all the aforementioned risks become irrelevant if the lives of non-competent people are judged as not worth living in the first place. If, for instance, incompetent patients are not the kinds of beings who can enjoy a continued existence or who can benefit from a right to life, or if one assumes that ending their lives is either morally neutral or much less wrong than ending the life of a more cognitively able person, euthanizing them would be either morally neutral or more easily justified. We turn now to such arguments. First, we discuss how, like the principle of beneficence, the value of life can be understood through different ethical paradigms, potentially leading to contradictory outcomes: legalizing or banning NVE. We then introduce various ways in which the value of life of those which limited cognitive ability has been evaluated, before turning to critiques of these valuations in the literature.

A. Valuing All Human Lives

On the one hand, arguments for a blanket prohibition on—or strict limits on access to—MAiD have often revolved around the principle of the sanctity of human life.[137] Sanctity of life is a principle rooted in the idea that "[a]ll human beings possess, in virtue of their common humanity, an inherent, inalienable, and ineliminable dignity."[138] This dignity renders all human lives intrinsically valuable, independently of the subjective negative assessment of the value of one's life due,

137 *See* Nathalie Burlone & Rebecca Grace Richmond, *Between Morality and Rationality: Framing End-of-Life Care Policy through Narratives*, 51 POL'Y SCI. 313, 323–25 (2018); Carter v. Canada (A.G.), [2015] 1 S.C.R. 5 (Can.), para. 2.

138 *See* JOHN KEOWN, THE LAW AND ETHICS OF MEDICINE: ESSAYS ON THE INVIOLABILITY OF HUMAN LIFE 5 (2012).

for instance, to illness, cognitive impairment, or dependence on others.[139] A prohibition on *intentionally* taking away a life follows from this view, as such an action, in implying a negative assessment of someone's life value, would be contrary to the sanctity of life principle.[140]

The sanctity of human life principle remains, for some, the "ultimate discussion stopper"[141] when debating the ethics of MAiD or the possibility of its expansion.[142] Following this principle, a critic of the legalization of NVE might maintain that allowing SDMs to request the administration of a fatal substance to end the life of incompetent patients violates "the precept that all human life is intrinsically valuable" and "[undermines] the status, morale, and well-being" of incompetent patients through stigmatizing behaviors.[143] Further, it might be said that such devaluation of incompetent patients' lives risks becoming a self-fulfilling prophecy: "the negative valuation leads to indifferent care; indifferent care leads to a poor quality of day-to-day experiences; and the poor quality of experiences provides grounds for the negative valuation."[144] Finally, some might suggest that a

139 *Id.* at 5–6. For an overview of the concept of the sanctity of life, see SUMNER, *supra* note 18, at 48–54.

140 *See* KEOWN, *supra* note 138, at 6 ("Although the value of human life is not absolute, the prohibition on taking it is."); Helga Kuhse, *Sanctity of Life, Voluntary Euthanasia and the Dutch Experience: Some Implications for Public Policy*, *in* SANCTITY OF LIFE AND HUMAN DIGNITY 19, 19 (Kurt Bayertz ed., 1996). *But see* DWORKIN, LIFE'S DOMINION, *supra* note 105, at 179, 218 (explaining that belief in the sanctity of human life is not necessarily incompatible with the legalization of assisted dying; it is important for each life to go well, and when a life is not going well, and never will, deliberately bringing it to an end might be legitimate).

141 Stephen Wear, *Sanctity of Life and Human Dignity at the Bedside*, *in* SANCTITY OF LIFE AND HUMAN DIGNITY 57, 60 (Kurt Bayertz ed., 1996).

142 *See, e.g.*, André Schutten, *Lethal Discrimination: A Case Against Legalizing Assisted Suicide in Canada*, 73 SUP. CT. L. REV. 143, para. 115 (2016).

143 Norman L. Cantor, *Déjà Vu All Over Again: The False Dichotomy Between Sanctity of Life and Quality of Life* 8 (Rutgers L. Sch. (Newark) Faculty Papers No. 22, 2005) https://law.bepress.com/cgi/viewcontent.cgi?article=1023&context=rutgersnewarklwps; *see also The State of Knowledge on Advance Requests for Medical Assistance in Dying*, *supra* note 81, at 146 (arguing that allowing MAiD could convey the message that our "society tacitly approves of the notion that life with a decline in mental capacity is not worth living, contributing to the stigma associated with such a decline");*The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition: The Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition*, COUNCIL OF CANADIAN ACADS. 29, 48 (2018) [hereinafter *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition*], https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-Where-a-Mental-Disorder-is-the-Sole-Underlying-Medical-Condition.pdf (arguing that allowing MAiD "more broadly may be seen as perpetuating an ideology that devalues people with mental disorders by suggesting that their lives may not be worth living").

144 *Dementia: Ethical Issues*, NUFFIELD COUNCIL ON BIOETHICS 26 (2009), https://www.nuffieldbioethics.org/assets/pdfs/Dementia-report-for-web.pdf. Although this risk is highlighted in the context of patients with dementia, it can apply *mutatis mutandis* to any vulnerable and stigmatized population (e.g., the disabled, the sick, the mentally ill).

blanket prohibition on NVE should be maintained to prevent a further "weakening [of] the social perception of the value of human life,"[145] which has already been eroded by the legalization of voluntary MAiD.

On the other hand, scholars advocating in favor of NVE are likely to consider these fears ill-founded or simply irrelevant. These proponents argue that allowing MAiD for incompetent patients who are suffering will not stigmatize vulnerable populations as a whole, nor will it compromise the value a society accords to human life. For example, writing about mental illnesses rendering a patient incompetent, Jukka Varelius maintains that advocating that some people with severe cognitive impairments would be better off dead "does not entail that the lives of the severely mentally ill have no value or that human life has no significant worth."[146] This is because his specific claim "concerns only the cases of the severely mentally ill who have a persistent wish to die because of their continuing unbearable and incurable suffering."[147] Such an argument "does not entail that their lives have no value, but that the value of their lives can be outweighed by the worth of relieving their distress and enabling them to avoid the kind of existence they would most plausibly autonomously eschew."[148] From this view, any argument to the effect that NVE for individuals suffering intolerably will affect the value we collectively place on incompetent patients' lives and on human life in general is likely to be labelled as false and alarmist.

Scholars likely to find these fears irrelevant generally include those who believe that human beings under a certain threshold of cognitive functioning should not enjoy the full moral status ascribed to personhood.[149] For them, such concerns are irrelevant because there is nothing inherently valuable or sacred about the life of any human being. These scholars question the inherent and invariable dignity ascribed to all human beings by virtue of their membership in the human species and independently of their quality of life.[150] They consider the reasoning justifying the unique value of all human beings to be rationally flawed and conclude that such a belief is not only a matter of faith but is also speciesist.[151]

145 Cuman & Gastmans, *supra* note 124, at 844 (citing Giglio & Spagnolo, *supra* note 74).

146 Varelius, *Lack of Autonomy*, *supra* note 17, at 62.

147 *Id.*

148 *Id.*

149 KEOWN, *supra* note 138, at 5.

150 *See, e.g.,* Universal Declaration of Human Rights, G.A. Res. 217 (III) A, preamble, U.N. Doc. A/RES/217(III) (Dec. 10, 1948). Although the inherent dignity of all human beings is not explicitly mentioned in the Canadian Charter, the Supreme Court has repeatedly indicated that it is an underlying value of all guaranteed rights and freedoms. *See, e.g.*, Charter of Human Rights and Freedoms, C.Q.L.R., c C-12, arts. 1, 4, 10, (Can. Que.); Canadian Charter of Rights and Freedoms, s. 7, Part I of the Constitution Act, 1982, *being* Schedule B to the Canada Act, 1982, c 11 (U.K.); Blencoe v. British Columbia (Human Rights Commission), 2000 SCC 44, para. 78 (Can.); Hill v. Church of Scientology of Toronto, [1995] 2 S.C.R. 1130, para. 120 (Can.).

151 Emily Jackson, *Secularism, Sanctity and the Wrongness of Killing*, 3 BIOSOCIETIES 125,

From their perspective, under a certain quality threshold, prolonged life is less valuable than death, and intentionally ending one's life is ethically sound.[152] Thus, even if the legalization of MAiD can stigmatize vulnerable populations, they maintain that there is nothing fundamentally alarming about this result. Conveying the message that some lives are of lesser value constitutes, for them, a fair reflection of reality. We turn now to illustrations of this position.

B. Limited Cognitive Abilities and the Value of a Life

For some, what matters in assessing the ethics of the practice of MAiD is not death or suffering "but loss of psychological continuity and connectedness."[153] According to Julian Savulescu, "when a human organism does not have mental states, it is not wrong to kill it."[154] Following this view, NVE for advanced demented patients or people with severe cognitive impairments is justified because their lives are of "little or no value."[155] For others, like Peter Singer and Jeff McMahan, NVE of an incompetent patient can be justified when the individual lacks intrinsic capacities essential for personhood.[156] The essential capacities entitling one to personhood—and thus to full moral status—may vary depending on the scholars, but they generally relate to a minimal level of cognitive functioning (e.g., capacity for rational thinking, practical reasoning, self-awareness, etc.).[157] Such scholars reject the widely shared view—entrenched in most, if not all, Western countries' legal frameworks—that membership in the human species guarantees full and equal moral status to all independently living beings.[158] For them, the moral worth of the lives of severely cognitively impaired individuals is akin to that of other (non-human) animals.[159] Once an individual falls

125, 133 (2008).

152 *Id.* at 125, 139–40 (citing MCMAHAN, *supra* note 1, at 98).

153 Savulescu, *supra* note 81, at 44.

154 *Id.* (citing Walter Sinnott-Armstrong & Franklin G. Miller, *What Makes Killing Wrong?* 39 J. MED. ETHICS 3 (2013)).

155 *Id.*

156 MCMAHAN, *supra* note 1, at 486; SINGER, *supra* note 1, at 87.

157 *See, e.g.*, SINGER, *supra* note 1, at 87; MCMAHAN, *supra* note 1, at 203–32; *see also* Eva F. Kittay, The Moral Significance of Being Human, Presidential Address Delivered at the One Hundred Thirteenth Eastern Division Meeting of the American Philosophical Association in Baltimore, MD (Jan. 6, 2017), *in* 91 PROC. & ADDRESSES AM. PHIL. ASS'N, at 22, 26 (2017) [hereinafter Kittay, Being Human] (discussing how the moral significance of being human, while often attributed to possession of supposedly intrinsic properties to humanity like cognition, should be justified through humans real and potential relations to other human beings).

158 *See, e.g.*, G.A. Res. 217, *supra* note 150, preamble; Charter of Human Rights and Freedoms, *supra* note 150, arts. 1, 4, 10; G.A. Res. 61/106 Convention on the Rights of Persons with Disabilities (Dec. 12, 2006), arts. 1, 5, 12; Canadian Charter of Rights and Freedoms, *supra* note 150; Blenco v. British Columbia*, supra* note 150, at para. 78; Hill v. Church of Scientology of Toronto, *supra* note 150, at para. 120.

159 *See, e.g.*, Eva Feder Kittay, *The Personal Is Philosophical Is Political: A Philosopher and*

below the threshold of minimal cognitive abilities required for personhood, both his death and his killing are more easily justifiable because they do not carry the same moral significance as the death and the killing of a "person."[160]

C. Valuing Lives in Spite of Limited Cognitive Abilities

The view that one's value of life depends on cognitive ability has been criticized for numerous reasons, notably for conceiving personhood in an incomplete and hypercognitive fashion[161] and for making abhorrent comparisons between severely cognitively impaired individuals and animals.[162] In response to such arguments, scholars such as Eva F. Kittay and Agnieszka Jaworska have offered alternate bases for rationalizing the conferral of equal moral status to human beings with limited intrinsic capacities. These scholars fall broadly under the category of care ethicists.

Kittay proposes to confer personhood to all human beings based on "relational properties," rather than intrinsic ones.[163] Relational properties are "properties that

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Mother of a Cognitively Disabled Person Sends Notes from the Battlefield, *in* COGNITIVE DISABILITY AND ITS CHALLENGE TO MORAL PHILOSOPHY 393, 394–95 (Eva F. Kittay & Licia Carlson eds., 2010) (discussing the arguments raised by MCMAHAN, *supra* note 1).

160 *See, e.g.*, SINGER, *supra* note 1, at 87, 90 and 182; KUHSE & SINGER, *supra* note 111, at 133; Peter Singer, *Speciesism and Moral Status*, *in* COGNITIVE DISABILITY AND ITS CHALLENGE TO MORAL PHILOSOPHY 330 (Eva F. Kittay & Licia Carlson eds., 2010), at 338–40; MCMAHAN, *supra* note 1, at 204–09; Jeff McMahan, *Radical Cognitive Limitation*, *in* DISABILITY AND DISADVANTAGE 240 (Kimberley Brownlee & Adam Cureton eds., 2009), at 243–59; Jackson, *supra*, note 151, at 125.

161 *See, e.g.*, CHARLES A. FOSTER & JONATHAN HERRING, IDENTITY, PERSONHOOD AND THE LAW 39 (2017); *Dementia: Ethical Issues*, *supra* note 144, at 32.

162 For a discussion of the use of animal comparisons in rhetoric justifying the marginalization, abuse, and killing of severely cognitively impaired human beings, see Alice Crary, *The Horrific History of Comparisons Between Cognitive Disability and Animality (and How to Move Past It)*, *in* ANIMALADIES: GENDER, ANIMALS, AND MADNESS 117 (Lori Gruen & Fiona Probyn-Rapsey eds., 2018) at 117–33; Peter Singer, *A Response to Alice Crary's "Horrific History*,*"* 2 ZEITSCHRIFT FÜR ETHIK UND MORALPHILOSOPHIE [Z.E.M.O.] 135 (2019) (Ger.) [hereinafter Singer, *Response to Alice Crary*], at 135–37; Eva Feder Kittay, *Comments on Alice Crary's The Horrific History of Comparisons Between Cognitive Disability and Animality (and How to Move Past It) and Peter Singer's Response to Crary*, 2 ZEITSCHRIFT FÜR ETHIK UND MORALPHILOSOPHIE [Z.E.M.O.] 127 (2019), at 127–32; Alice Crary, *Animals, Cognitive Disability and Getting the World in Focus in Ethics and Social Thought: A Reply to Eva Feder Kittay and Peter Singer*, 2 ZEITSCHRIFT FÜR ETHIK UND MORALPHILOSOPHIE [Z.E.M.O.] 139 (2019), at 139–46; *see also* Kittay, *supra* note 159, at 396–97 (discussing how arguments like Jeff McMahan's use of comparisons between the philosophical treatment those with severe intellectual disabilities and animals in MCMAHAN, *supra* note 1, at 221–22, have a devastating impact on the loved ones and individuals within the disability community, who are historically marginalized from the field of philosophy).

163 Kittay, Being Human, *supra* note 157, at 26; *see also* Eva Feder Kittay, *At the Margins of Moral Personhood*, 116 ETHICS 100, 149 (2005) ("group membership (a relational concept) is the wrong sortal for moral consideration, whereas the intrinsic properties of an individual, such as certain psychological capacities, are the right sortals.").

we have only in virtue of the relationships we are in with other human beings."[164] Kittay defines humans as all beings that are the "offspring[s] of a human mother and a human father."[165] This definition is, of course, not only biological but also relational,[166] and the moral status enjoyed by all humans is based on the relational aspect of this definition. According to Kittay,

> [the] relational property of being human binds all humans, as all humans stand in this relation. The relation is morally and conceptually prior to any intrinsic properties. We have moral obligations to other human beings for the simple reason that we find ourselves in relation to them. We cannot be the sorts of creatures we are except by being in relationship to other human beings.[167]

As a result, by virtue of their relational nature, all human beings stand in morally significant relations to each other "prior to knowing anything of the morally salient traits of the other human being."[168] Thus, concluding that the lives of non-competent people are neither worth living nor worth preserving is a serious moral wrong.

Jaworska, for her part, argues that the "emotional capacity to care is a sufficient condition" for conferring the full moral status ascribed to personhood.[169] Consequently, we should not interfere with severely cognitively impaired individuals' interests as dictated by their caring about certain things, as not respecting what they care about undermines the inviolability to which they are entitled as persons, and therefore constitutes a significant moral wrong.[170] In the context of NVE, this means that individuals who enjoy personhood (and thus full moral status) because of their capacity to care should not be euthanized when it goes against their interests as caring beings. It would therefore be wrong to end the

164 Kittay, Being Human, *supra* note 157, at 26.

165 *Id.* at 36.

166 *Id.*

167 *Id.*

168 *Id.* at 38–39. It is, however, different for animals, according to Kittay. Although we can also confer a special moral status on animals, "the main route to our moral obligations to animals is not through relations but through knowledge of the intrinsic traits a particular animal or species of animal. When an animal exhibits what we take to be morally significant traits, behaviours, or relationships, we ought to respond in a morally responsible fashion. Being human is a sufficient condition for the stringent moral obligations we have to humans, but it needn't be a necessary condition." *Id.*

169 Agnieszka Jaworska, *Caring and Full Moral Standing Redux*, *in* COGNITIVE DISABILITY AND ITS CHALLENGE TO MORAL PHILOSOPHY 369, 369 (Eva F. Kittay & Licia Carlson eds., 2010).

170 *Id.*; Agnieszka Jaworska, *Caring and Full Moral Standing*, 117 ETHICS 460, 460 (2007); Agnieszka Jaworska, *Respecting the Margins of Agency: Alzheimer's Patients and the Capacity to Value*, 28 PHIL. & PUB. AFFS. 105, 125–37 (1999).

life of people with cognitive impairments who would retain the capacity to care for certain things, be it listening to music, watching cartoons, or participating even passively in social activities.[171]

These relational accounts of personhood assert broad conditions for personhood beyond high intellectual capacities. However, they do not morally prohibit euthanasia in all cases. Having a duty to "hold [someone] in personhood," to use Lindemann's expression, is distinct from having a duty to "hold [them] in [their] life."[172] However, even if the pro-euthanasia beneficence argument is still theoretically available to theorists like Kittay or Jaworska, it would reflect a way to care for the incompetent patient rather than deny their personhood. This would notably imply that the value of an incompetent patient's life benefits from equally robust protection as that of a competent person, and cannot be more easily traded off (e.g., for less suffering, or reduced costs for others).

Moreover, epistemic limitations would incite care ethicists like Kittay to prudence and "epistemic modesty,"[173] which includes reducing the reach of certain unavoidably opaque or ambivalent decisions to an urgent minimum. Responding to immediate, observable, excruciating physical pain may fall within the category of "urgent minimum." Ending the life of those who are unable to communicate whether or not they enjoy their life on the assumption that they probably do not benefit from existence is problematic, since it is either questionably speculative[174] or questionably eugenicist.[175]

In summary, the perspective adopted in terms of the appropriate valuation of life for individuals with limited cognitive functioning intersects a great deal with positioning on the ethics of NVE, both in terms of the possibility of an increased devaluation of the life of certain persons, and how the interests of individuals with limited cognitive functioning are assessed and acted upon in the context of suffering.

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171 *But see* Thomas R.V. Nys, *The Wreckage of Our Flesh: Dementia, Autonomy and Personhood*, *in* JUSTICE, LUCK & RESPONSIBILITY IN HEALTH CARE: PHILOSOPHICAL BACKGROUND AND ETHICAL IMPLICATIONS FOR END-OF-LIFE CARE 189, 197–99 (Yvonne Denier, Chris Gastmans & Antoon Vandevelde eds., 2013) (contending that Jaworska's view neglects the importance of assessing the value of what we are left caring about once severely demented).

172 HILDE LINDEMANN, HOLDING AND LETTING GO: THE SOCIAL PRACTICE OF PERSONAL IDENTITIES 22–30 (2014).

173 Kittay, *supra* note 162, at 617.

174 Beaudry, *supra* note 25, at 335–41.

175 Since we refer to eugenics in this paper as problematic, we must also note that there are contemporary defenses of eugenic practices. However, the practices that are defended do not include euthanasia, which is the topic of this paper. They include other kinds of technologies, such as human enhancement. *See* NICHOLAS AGAR, LIBERAL EUGENICS: IN DEFENCE OF HUMAN ENHANCEMENT, at vi (2004) (defending a version of eugenics that is primarily concerned with "the protection and extension of reproductive freedom" rather than the strict regulation of reproductive freedom typically associated with 20th-century eugenics).

V. VULNERABILITY

In recent legal debates, the protection of vulnerable individuals has become a central argument against the legalization of MAiD. Vulnerability can be understood at both individual and social levels. This part will address each of these levels in turn, outlining the specific ways in which NVE has significant implications for each level of vulnerability.

A. Individual Vulnerability

Those opposing NVE are likely to argue that incompetent patients are too vulnerable for NVE to be legalized. Contrary to competent individuals, they are generally not "able to stand up for themselves."[176] Thus, abuses of MAiD laws will be "much more likely in the cases of patients who are incapable of autonomously deciding about ending their lives than in cases of competent patients."[177] A total ban on NVE would not affect those who have the capacity for autonomous decision-making in the end-of-life context and would protect the most vulnerable citizens. This vulnerability-based argument was sometimes rejected in the context of voluntary MAiD on the basis that it insulted people with disabilities or illnesses, by depicting them as less than autonomous and in need of protection against their will.[178] However, this objection does not hold for incompetent patients for whom a certain degree of paternalism and care is morally required.

As a counterargument, some may invoke the ethical principle of justice according to which "like cases should be treated alike," and the possibility of implementing safeguards.[179] Even though incompetent patients are more vulnerable, their situation is morally equivalent to that of competent individuals because they too can experience intolerable suffering. Because they ought to be treated equally, some may argue that it is "unfair not to extend eligibility for MAiD to them."[180] Such basic principles of justice cannot be outweighed by incompetent patients' vulnerability. Not only is the risk of abuse already part and parcel of our medical system, but appropriate safeguards can also be implemented to protect

176 Varelius, *Lack of Autonomy*, *supra* note 17, at 62; *see also* Singh, *supra* note 16, at 30 (exploring the vulnerability counterargument in the context of expanding MAiD to minors).

177 Varelius, *Lack of Autonomy*, *supra* note 17, at 62.

178 *See, e.g.*, Joan Brydan, *MAID Litigant Says Disability Doesn't Make Her Vulnerable to Pressure to End Her Life,* CTV NEWS, (Dec. 16, 2020, 4:28 AM), https://www.ctvnews.ca/canada/maid-litigant-says-disability-doesn-t-make-her-vulnerable-to-pressure-to-end-her-life-1.5233205.

179 TOM BEAUCHAMP, STANDING ON PRINCIPLES: COLLECTED ESSAYS 41 (2010).

180 Singh, *supra* note 16, at 30–31.The argument is made with reference to minors but is applicable *mutatis mutandis* to all incompetent patients. This "additional justification invokes the principle of justice by proposing an argument in the form, *if X is available to Y, and Y=Z in some morally relevant way, then X ought to be available to Z*.") *Id.*

incompetent patients from such abuse, as is already the case for other important medical decisions, like invasive surgery or organ donation.[181]

To rebut this counterargument, one may argue that it puts too much faith in the efficacy of safeguards and in the ability of policymakers to formulate their content. Unlike safeguards for voluntary MAiD, safeguards for NVE would have to handle unsolvable disagreements between deeply controversial value judgments. In the context of voluntary MAiD, safeguards mostly consist of a series of steps to ensure free and informed consent, whether or not the patient has internalized ableism. We cannot similarly rely on the principle of respect for autonomy in the case of incompetent patients to solve the hard question of when a life could or should be ended. As we saw, the risks of abuse are higher and more insidious in the case of incompetent patients: they notably include the risk that SDMs would not make decisions in the beneficiary's best interests or would entertain a notion of "best interests" skewed by ableism.[182] Limiting the impact of far-reaching ableist assumptions is no small feat. The very limited ways in which current MAiD safeguards address ableist oppression[183] do not bode well for the likelihood that they would succeed in the case of NVE.

Not only would these safeguards have to address new and harder to curtail dimensions of abuse, but they would also need to propose generalizable protective criteria. It is hard to imagine what these criteria would be or how they would operate in practice. In the case of voluntary MAiD, to secure conditions of uncoerced consent is a potentially achievable and monitorable criterion (whether states will actually carry out effective monitoring is a different question, but it is at least feasible in theory). Curtailing SDMs' ableism and self-interest, and making more room for the idea that a life with severe disabilities may still be worth living, is a much less clear-cut goal. Procedural solutions like requiring two medical practitioners to sign off on the request for NVE, or compelling SDMs to provide reasons for their decision or take a number of days to reflect on it (i.e., voluntary MAiD safeguards) will not resolve deep social disagreements about the value of life. Moreover, such "proceduralist" criteria would multiply foci for potential ableist judgments. The advantage of relying on an autonomous decision-maker to choose death or not is that it circumvents difficult, potentially unsolvable disagreements about the value of life and the morality of euthanasia.

In sum, the individual vulnerability of incompetent patients cannot be addressed by autonomy-protecting measures elaborated for voluntary MAiD and is unavoidably connected to social dimensions of vulnerability, to which we now

181 *Id.* at 31; Brown, *supra* note 63, at 185; Varelius, *Lack of Autonomy*, *supra* note 17, at 63; Manninen, *supra* note 15, at 649.

182 *See supra* Section III.C.

183 *See* Jonas-Sébastien Beaudry, *Somatic Oppression and Relational Autonomy: Revisiting Medical Aid in Dying Through a Feminist Lens*, 53 UBC L. REV. 241, 270 (2020).

turn.

B. Collective Vulnerability

Incompetent patients may also be vulnerable due to their membership in a historically marginalized group.[184] The SDMs of members of such vulnerable populations (e.g., people who are disabled, sick, mentally ill, or of older age) risk opting for MAiD because of societal failures to provide incompetent patients with the social, economic, and medical means to live a worthy existence.[185] Lack of "rewarding activities that could help improve their daily life,"[186] inhumane treatment in nursing homes,[187] "chronically difficult circumstances (e.g., poverty, homelessness, unemployment),"[188] limited access to "adequate and culturally appropriate mental healthcare"[189] and limited access to palliative care[190] are but a few of the factors that can negatively affect the quality of life of members of one or more of the groups identified above.

For some scholars, these factors provide reasonable grounds to question the immutability or permanency of certain negative quality of life assessments because they could be changed through proper policies and resource allocation decisions.[191]

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184 This risk is often mentioned in the context of voluntary MAiD, but it applies equally to nonvoluntary MAiD.

185 *See, e.g.*, *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, *supra* note 81, at 56–57, 142, 145, 147; Jonas-Sébastien Beaudry, *What's Missing from the Conversation About Assisted Death*, POL'Y OPTIONS (Oct. 16, 2019), https://policyoptions.irpp.org/magazines/october-2019/whats-missing-from-the-conversation-about-assisted-death; Anita Ho & Joshua S. Norman, *Social Determinants of Mental Health and Physician Aid-in-Dying: The Real Moral Crisis*, 19 AM. J. BIOETHICS 52, 52–53 (2019); Jacobs & Lemmens, *supra* note 94; Lemmens, *supra* note 26, at 501.

186 Beaudry, *supra* note 185.

187 Jacobs & Lemmens, *supra* note 94 (citing Charlie Fidelman, *Saying Goodbye to Archie Rolland, Who Chose to Die: 'It Is Unbearable*,*'* MONTREAL GAZETTE (Oct. 21, 2016), https://montrealgazette.com/news/local-news/saying-goodbye-to-archie-rolland).

188 *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition*, *supra* note 143, at 161.

189 *See id.* at 172–73 (explaining that although accessing mental health care is a challenge across Canada, it is particularly difficult for Indigenous peoples and in rural areas); *see also* Ryan Tanner, *An Ethical-Legal Analysis of Medical Assistance in Dying for Those with Mental Illness*, 56 ALBERTA L. REV. 149, 164 (2018) (discussing how "in a substantial number of cases, a contributor to the suffering of mental illness is the failure of the healthcare system to appropriately respond to mental illness in the first place" (citing Mark Henick, *Why People with Mental Illness Shouldn't Have Access to Medically Assisted Death*, GLOBE & MAIL (May 8, 2016), https://www.theglobeandmail.com/life/health-and-fitness/healthlwhy-people-with-mental-illness-shouldnt-have-acce ss-to-medically-assisted-death/ article29912867.

190 *See The State of Knowledge on Medical Assistance in Dying for Mature Minors*, *supra* note 43, at 132; Davies, *supra* note 8, at 128–29; *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, *supra* note 81, at 147.

191 *See, e.g.*, Ho & Norman, *supra* note 185, at 53; Beaudry, *supra* note 185.

From this perspective, if "the lack of a broad array of social resources exacerbates people's hopelessness and despair, to the point that death appears to be the only relief from relentless trauma, the right 'treatment' may lie in first building a just society that can reduce people's burden and give them access to opportunities and hope."[192] Helping historically marginalized and stigmatized people to "access the means to live a worthwhile life in a society that has given up on them" is much more challenging than providing them with equal access to MAiD.[193] If we do not want MAiD to become a "release valve"[194] for a collective failure to provide adequate social, economic, and medical support to the most vulnerable individuals, these socioeconomic inequalities should be addressed before expanding MAiD.

For others, although the lack of adequate social, economic and medical means to live a worthwhile existence is problematic, limiting access to MAiD is not a sustainable option if policy changes are not imminent. It is neither just nor humane to impose continued living when it is not in these individuals' interest and their situation is not likely to change anytime soon because of a lack of political will.[195] Rather than protecting vulnerable and marginalized individuals, limiting the expansion of MAiD in this context "compounds our abandonment of them."[196] Some even speculate that allowing MAiD in cases where vulnerable and marginalized individuals or their SDMs are "forced" into hastening their death because of a lack of appropriate support and care could highlight socioeconomic inequalities and motivate the needed change in resource allocation and policy.[197]

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192 Ho & Norman, *supra* note 185, at 53.

193 Beaudry, *supra* note 185.

194 *The State of Knowledge on Advance Requests for Medical Assistance in Dying*, *supra* note 81, at 146.

195 Tanner, *supra* note 189, at 164.

196 *Id.*; *see also* Brown, *supra* note 63, at 163 (arguing for access to euthanasia by stating that "it is unacceptable to put patients through dreadful suffering now simply because we might, at some point in the future, be able to reduce the suffering of others [through improved palliative care] to a bearable level")

197 *See, e.g.*, Tanner, *supra* note 189, at 164–65 ("Allowing assisted dying in these cases offers the sufferers a way out where they otherwise have none, and furthermore, seeing people forced into assisted dying in such cases could bring into relief the inadequacies of mental health treatment and motivate positive change. *Everyone* would hate for someone to not get proper treatment and feel like there is really no other way to relieve themselves of the suffering but to consider physician-assisted death."). Note that although Tanner makes this argument in the context of expanding MAiD to competent mental health patients, it could apply also in the context of incompetent patients lacking meaningful access to resources other than mental health resources. *See also The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition*, *supra* note 143, at 171 (speculating that expanding access to MAiD where a mental disorder is the sole underlying medical condition "may increase resources directed to mental healthcare and social support services, as was the case with palliative care in Oregon, Belgium, Quebec, and the rest of Canada following legalization of assisted dying"); Joshua James Hatherley, *Is the Exclusion of Psychiatric Patients from Access to Physician-Assisted Suicide Discriminatory?*, 45 J. MED. ETHICS 817, 818–19 (2019) ("It is equally plausible that the institutionalization of PAS for psychiatric

Existing MAiD safeguards, which are largely centered on classical liberal conceptions of consent and autonomy, suggest that states where MAiD is legal have limited capacity or political will to palliate social vulnerability in the context of MAiD. Legalizing NVE, given these shortcomings, would normalize, rather than problematize, the eugenic dimensions and implications of NVE programs. It would *also* make it possible to end the lives of incompetent patients who would truly benefit from euthanasia. It is therefore necessary to finetune unique responses to reconcile these grave and tragically diverging ethical pulls. We use the word "tragic" because there may not be a perfect solution that is without moral blemish. However, even tragic and imperfect policies can be democratic (committed to serving as many perspectives and interests as possible) if they duly avoid unnecessarily sacrificing the interests of some to protect the interests of others. Securing access to robust pain management measures for incompetent patients is an example of such an imperfect compromise. The evolution of MAiD policies so far, and our commitment to taking rights seriously (as we discuss in the next Part), makes the alternative of embracing NVE a less democratic solution, with unavoidable eugenic dimensions. This assessment may change if and when our societies take social vulnerability more seriously.

VI. CONSIDERATIONS OF JUSTICE

The final part focuses on considerations of justice with inform NVE discussions. First, we introduce the concept of distributive justice, in which NVE is argued for on the basis of appropriate and equitable distribution of resources and note the how NVE advocates focused on beneficence may object to or alter the scope of distributive justice justifications in the context of NVE. Finally, we provide a framework for analyzing the question of justice through a disability lens to demonstrate the weakness of distributive justice as argument for NVE.

A. Distributive Justice: MAiD as a Form of Rationing

Some argue that non-voluntary MAiD must be legalized by virtue of distributive justice. This notion refers to "fair, equitable, and appropriate distribution in society."[198] Margaret Battin, for instance, argues that when resources are limited, "it is better to deny [treatment] just to those people who are . . . medically unsalvageable and will die soon anyway: the terminally ill, the extremely aged, and the seriously defective neonate."[199] She extends this logic to justify actively ending individuals' lives through MAiD. From her perspective,

suffering may stimulate greater care and productivity in psychiatry and medical research.").

198 BEAUCHAMP, *supra* note 179, at 41.

199 MARGARET PABST BATTIN, THE LEAST WORST DEATH: ESSAYS IN BIOETHICS ON THE END OF LIFE 114 (1994).

MAiD is more economical than prolonged care and could result in significant resource savings; hence, legalization helps to bring about justice in a society with finite resources.[200]

Scholars in favor of MAiD on grounds of beneficence may disagree with this conclusion. For instance, Savulescu believes such claims to be invalid because we cannot "harm someone to save resources."[201] As he explains, distributive justice "is about who gets a slice of some finite cake. It is about giving public goods to some, but not others. It is not typically about doing things to people actively, in particular killing them, to bring about a just state of affairs."[202] Thus, to bring about justice, MAiD has to be considered only in cases where death is in the individual's best interests.[203] Otherwise, the action amounts to murder, not MAiD.[204] Yet, scarce resources can legitimately limit the social, economic, and medical means available to support someone. If such deprivation is the source of a person's intolerable suffering, MAiD can be envisioned as an option to relieve her.[205] If so, the person's interests, "given the constraints of scarce resources and the moral imperative to distribute these justly,"[206] justify MAiD. Distributive justice, however, "does not directly or necessarily require that we kill."[207]

In short, from this perspective, MAiD is justified solely when it can be shown that it is in the individual's best interests.[208] However, determining when death is in an incompetent patient's interests is, as we have seen so far, subject to great debate.[209] It is almost impossible to identify an objective threshold which, once crossed, allows us to confidently affirm that one's quality of life is so poor that death is better than continued existence.[210] This is why Savulescu identifies two additional circumstances when NVE can be justified by virtue of distributive justice: regardless of the difficulty of assessing objectively someone's interest in dying, he contends that NVE is ethically justifiable for cost-saving reasons when the individuals in question will certainly die soon (in a matter of days or weeks)[211] or when they display a lack of psychological continuity and connectedness.[212]

200 *Id.* at 115.
201 Savulescu, *supra* note 81, at 36.
202 *Id*.
203 *Id.*
204 *Id.*
205 *Id.* at 36–37.
206 *Id*. at 37
207 *Id*.
208 *Id.* at 40.
209 *See supra* Part III.
210 Savulescu, *supra* note 81, at 42.
211 *Id.* at 46–47 ("Their deaths could be caused either by their disease or by limitation of life prolonging medical treatment, including the withholding or withdrawing of artificial nutrition. In such cases, non-voluntary AME would save resources over a slower death.").
212 *Id.* at 42–44, 47 (explaining that in such cases, death is not harmful, and the wrongness of

These two arguments are susceptible to attract the support of scholars who adhere to a hypercognitive understanding of personhood for whom either the state of personhood is restricted to patients with a certain threshold of cognition, or those with a lack of psychological continuity or connectedness mean they have less moral value than those currently with a sufficient level of cognition. However they are likely to be opposed by a number of scholars for whom NVE in the absence of suffering results in an unjustifiable violation of the incompetent patient's right to life, on the basis that incompetent patients have the same intrinsic right to life as any person, which is not disrupted by their level of cognition, psychological continuity or connectedness.[213]

B. Justice Through a Disability Lens

Theorists of fairness, following a "luck egalitarian" logic (i.e., a commitment to redressing misfortunes resulting from unchosen natural or social situations[214] may argue that enhanced, rather than reduced, health resources ought to be redirected towards incompetent patients for two possible reasons. First, incompetent patients suffering a great deal may be said to be disadvantaged through no fault of their own, and therefore deserve compensation. Second, in the case of infants who have not had the opportunity of experiencing key facets of a human life, assuming this is an experience worth having at all, an egalitarian logic could justify prioritizing their needs considering this particular disadvantage. This argument is more powerful if one conceives of the value of experiencing a human life and/or certain of its benefits (e.g., a relationship with a caregiving parent) as quantitatively or qualitatively superior to, or even incommensurable with, the value of diminishing the subjective experience of pain.

Liberal rights-based approaches also have trouble accommodating the notion of tradability of human life for economic reasons. This is because of the qualitative or "lexical" priority such approaches give to basic liberties, including the right to life, as life is a *sine qua non* condition to enjoy any other rights or liberties.[215] Rights, if they are to be meaningful, must be able to trump this utilitarian logic.[216] The idea that "[b]udgetary considerations in and of themselves cannot normally be invoked as a free-standing, pressing and substantial objective for the purposes [of

killing is lessened and sometimes even eliminated).

213 *See, e.g.*, Singh, *supra* note 16, at 72; Hertogh, *supra* note 69, at 223.

214 *See, e.g.*, KASPER LIPPERT-RASMUSSEN, LUCK EGALITARIANISM 1–4 (2015).

215 *See generally* JOHN RAWLS, A THEORY OF JUSTICE (1971) (articulating this particular argument). In Rawls's framework, this means that the right to life is so fundamental that it cannot be traded or compromised for other benefits.

216 *See generally* RONALD DWORKIN, TAKING RIGHTS SERIOUSLY (2013) (articulating this particular argument). Within Dworkin's framework, if rights are to be taken seriously, they cannot be overridden by ordinary utilitarian considerations.

justifying a violation to the rights listed in the Canadian Charter of Rights and Freedoms in the Canadian Constitution]" is present in legal interpretations of constitutional rights as well.[217] In bioethics, the practice of using quality of life assessments to manage limited health resources and justify the sacrificing of a life has been criticized for failing to treat individuals with equal concern and respect.[218]

More specifically, Western political and legal cultures do not rank rights along a spectrum of stringency, whereby the rights of some warrant greater protection than those of others. While it seems logical to treat rights in this scalar way if they are conceptualized as mapping onto a scalar conception of moral status, or as reflecting varying interests and capacities, this conception of rights would be incompatible with egalitarian commitments and the universalism of human rights.[219] Even scholars who problematize the foundations of Western legal orders' egalitarian commitments and defend a scalar view of moral status agree that

> it would be dangerously invidious to give public expression to a view that accords a higher degree of moral inviolability to people with higher psychological capacities or a worthier moral nature. Even if such a view were true, it is virtually certain that if it were widely exposed and recognized as true, it would then be distorted or otherwise abused in efforts to justify the unjustifiable.[220]

In terms of equality rights, some have suggested that "disability," in and of itself, should never constitute a basis for granting MAiD.[221] This is because disability is a marker of identity, like being Black, Indigenous, or Jewish, and clearly, none of these other identities should be used as a basis to qualify for

217 Nova Scotia (Workers' Compensation Board) v. Martin*,* 2003 SCC 54, at para. 109 (Can.).

218 *See* Harris, *supra* note 61, at 118–22.

219 *See, e.g.*, G.A. Res. 217, *supra* note 150, preamble; Charter of Human Rights and Freedoms, *supra* note 150, arts. 1, 4, 10; G.A. Res. 61/106, *supra* note 158, at arts. 1, 5, 12; Canadian Charter of Rights and Freedoms, *supra* note 150. For a critique of this common egalitarian presumption and an unusual defence of a "two-tiered" theory of moral standing justifying gradients in the wrongness of killing below a certain cognitive threshold, see Jeff McMahan, *Challenges to Human Equality*, 12 J. ETHICS 81, 104 (2008).

220 *Id*.

221 United Nations Special Rapporteur on the Rights of Persons with Disabilities, the Rapporteur on Extreme Poverty and Human Rights & the Independent Expert on the Enjoyment of All Human Rights by Older Persons, quoted in *Disability Is Not a Reason to Sanction Medically Assisted Dying – UN Experts*, UNHR OFFICE OF THE HIGH COMMISSIONER (Jan. 25, 2021), https://www.ohchr.org/en/press-releases/2021/01/disability-not-reason-sanction-medically-assisted-dying-un-experts ("[The experts expressed] alarm at the growing trend to enact legislation enabling access to medically assisted dying based largely on having a disability or disabling conditions, including in old age. . . . Under no circumstance should the law provide that it could be a well-reasoned decision for a person with a disabling condition who is not dying to terminate their life with the support of the State.").

euthanasia programs.

More importantly, equality rights can also be interpreted to entail positive obligations on the part of states to remedy systemic discrimination and widespread harms, be they symbolic or not.[222] Interpreted in this way, rights to life and equality may not necessarily require banning voluntary MAiD, but would require providing a wider array of options to citizens. Societies committed to respecting life, liberty, and equality ought to ensure that sufficient resources and supports are provided to people who are contemplating MAiD, so that citizens do not die "deaths of despair"[223] due to neglect and social injustice, or insufficient care and support system arrangements. Equipped with more options and resources, individuals faced with the decision of whether to die would therefore be more autonomous and less subject to the forces of ageist and ableist oppression, both external and internalized.

However, first, this particular remedy (redistribution to enhance autonomy) does not apply in the same way for incompetent patients and, second, distributive injustice is only one of the various kinds of injustice suffered by people with disabilities. Other forms of injustice experienced by people with disabilities include epistemic injustice and status-based injustice. Epistemic injustice may correspond to an assumption that their quality of life and well-being is lower than it is.[224] Status-based injustice occurs when their standing as right-holders and legal personhood are unduly challenged.[225] Incompetent patients face incommensurably greater obstacles in overcoming the epistemic and status-based injustice victimizing them. In particular, the epistemic distance between their subjective experience of life and society's appreciation of their suffering can be abyssal; after all, they belong to a category of human beings whose status as members of political and moral communities has been systemically put into question. Given this bleak, longstanding history of injustice, vulnerable citizens are at the mercy of medical experts and their SDMs and can, in some cases, only rely on robust conceptions of the rights to life and equality to stand between themselves and rightlessness.

In summary, legalizing NVE in the name of considerations of *justice,*

222 *See e.g.*, Sandra Fredman, *Providing Equality: Substantive Equality and the Positive Duty to Provide,* 21 SAJHR 163, 163 (2005).

223 We borrow this expression from CASE & DEATON, *supra* note 86, to refer to deaths of potentially socially preventable despair—in contrast to deaths that are medically unavoidable.

224 Epistemic injustice refers to the systematic devaluation or disregard of statements made by certain groups, often due to prevailing negative social stereotypes associated with them. This concept is instrumental in recognizing instances of unjust exclusion, such as the marginalization of patients, and the disproportionate privileging of certain voices, typically those of experts, in discourse. *See* ELIZABETH BARNES, THE MINORITY BODY: A THEORY OF DISABILITY 168–84 (2016).

225 *See* Elizabeth Purcell, *Oppression's Three New Faces: Rethinking Iris Young's "Five Faces of Oppression" for Disability Theory*, *in* DIVERSITY, SOCIAL JUSTICE, AND INCLUSIVE EXCELLENCE: TRANSDISCIPLINARY AND GLOBAL PERSPECTIVES 185, 198–200 (Seth N. Asumah & Mechthild Nagel eds., 2014).

including the distributive arguments incorporating best interests discussed in Part 7.1, is a *prima facie* weak or paradoxical argument. This is because the countervailing distributive, epistemic and status-based injustices experienced by incompetent patients outweigh positive justice-based considerations in favour of NVE.

CONCLUSION

In addition to providing a broad, interdisciplinary survey of recent ethical and legal scholarship on the topic, this Article concludes that the strongest arguments in favor of legalizing NVE are based on the beneficent goal of attenuating the intense suffering of incompetent patients. However, beneficence-based arguments are insufficient to justify legalizing NVE, because of countervailing considerations. These countervailing considerations sufficiently implicate equality and human rights, such that the main objections to this Article's conclusion that beneficence is an insufficient justification for legalizing NVE, are based on a position that is incompatible with typical liberal commitments to human rights and equality.

Fleshing out a substantive theory of the ethical and legal permissibility of NVE would require further work. However, our critical review of theoretically and politically salient arguments about NVE leads to the following tentative conclusions. First, the beneficence-based argument is by far the strongest argument in favor of legalizing NVE. Second, as they currently stand, beneficence-based arguments are insufficient to justify legalizing NVE, because of countervailing considerations. Third, these countervailing ethical considerations have not received sufficient attention within policy discourses dominated by values of autonomy[226] and pain-relief,[227] and deserve further research. They include concerns with systemic oppression, social inclusion and the rights of stigmatized populations, individual and social vulnerability, and the fact that (potentially aggressive) palliative care would often suffice to respond to immediate physical pain. Fourth, these considerations apply more forcefully to the case of incompetent patients. Not only do these considerations not pertain to voluntary MAiD to the same degree, but they are also—sometimes—outweighed by extremely compelling autonomy-based reasons in favor of voluntary MAiD. In summary, that these considerations weigh against NVE suggests that its legalization would rest on morally and legally precarious grounds. Lifting the express prohibition on NVE without more robust socio-economic or technological reforms addressing these concerns seems *prima facie* incompatible with typical liberal commitments to

226 *See* Jonas-Sébastien Beaudry, *The Way Forward for Medical Aid in Dying: Protecting Deliberative Autonomy is Not Enough,* 85 SUP. CT. L. REV. 335 (2018) at 337.

227 *See* Beaudry, *supra* note 26, at 341, 352.

human rights and equality. States should nonetheless, for many of the reasons examined in this Article, encourage the development of targeted palliative measures to respond to the physical suffering experienced by incompetent patients. Furthermore, a comprehensive discussion of the ethical complexities surrounding prospective autonomy[228] and supported decision-making[229] in the context of assisted dying requires future exploration.

228 *See generally* Rich, *supra* note 5 (describing the major arguments for and against the moral and legal authority of advanced directives and finding the narrative articulation of a single self with multiple life stages the most persuasive defence for advanced directives).

229 *See, e.g.*, Brenna M. Rosen, *Supported Decision-Making and Merciful Health Care Access: Respecting Autonomy at End of Life for Individuals with Cognitive Disabilities*, 80 WASH. & LEE L. REV. 555, 560 (2023); Leslie Francis, *Supported Decision-Making: The CRPD, Non-Discrimination, and Strategies for Recognizing Persons' Choices About their Good*, 1 J. PHIL. DISABILITY 57, 57–60 (2021).

Housing is Health: Prioritizing Health Justice and Equity in the U.S. Eviction System

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Abstract:

The public health field has long recognized the association between housing and health. In one of the most poignant examples of housing as a social determinant of health, the COVID-19 pandemic amplified the link between an individual's housing instability and community-wide health. "Housing is health" became the justification for halting the eviction system: Policymakers nationwide adopted moratoria, eviction protections, emergency rental assistance, and other housing supports with the goal of protecting community-wide health. These robust measures resulted in unprecedented low eviction filing rates and extensive benefits to individual and public health. Today, with the lapse of pandemic interventions, the eviction crisis is reemerging as a pervasive threat to public health. Eviction filing rates have returned to or surpassed historical averages in jurisdictions across the United States. Policymakers across the country are called to address the eviction system as an urgent public health priority.

This Article applies the World Health Organization Conceptual Social Determinants of Health model and the Health Justice Framework to the United States eviction system to demonstrate how it operates a structural determinant of health inequity that severely harms historically marginalized groups. Eviction disproportionately affects Black renters, who are filed against at more than five times the rate of white renters. Overwhelmingly, Black women and families with

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young children are evicted at the highest rates. In a typical year, 7.6 million people —40 percent of whom are children—live in households that receive one or more eviction filings and are at risk of housing loss. For all of these people, interaction with the ostensibly neutral eviction system is associated with severe and lasting health harms across the life course. This Article extensively documents the public health and social science evidence demonstrating that housing is health and linking eviction to negative health outcomes. It provides evidence-based examples of structural determinants in the eviction system—including court processes, laws, policies, and landlord management and screening practices—that comprise the scaffolding of health inequity. Finally, this Article offers a model for achieving health equity and housing stability through the application of the Health Justice Framework to the U.S. eviction system.

INTRODUCTION

The COVID-19 pandemic underscored the interdependence between individual and community level health outcomes, as well as the social and structural determinants of health—such as eviction—that thwart best attempts to control the spread of disease. The pandemic precipitated pandemic-related job and wage loss and subsequent evictions due to nonpayment of rent. Eviction placed tenants at heightened risk of contracting COVID-19 and, in turn, the risk of infection in the entire community increased.[1] In recognition of the cascading health effects of individual housing loss on the community, policymakers nationwide issued eviction moratoria to prevent widespread eviction and its health consequences at the outset of the pandemic.[2] The Centers for Disease Control and Prevention (CDC) and policymakers in twenty-seven states and the District of Columbia justified eviction moratoria on the relationship between eviction and the spread of COVID-19.[3] For example, the New Jersey governor provided a public health justification for the statewide eviction moratorium: "housing security and stability are important to public health, particularly as homelessness can increase vulnerability to COVID-19; and . . . removals of residents pursuant to evictions . . . can increase the risk to those residents of contracting COVID-19, which in turn increases the risks to the rest of society and endangers public health."[4] Indeed, multiple studies demonstrated that eviction-related housing insecurity and the lifting of moratoria were associated with increased COVID-19 infection and mortality,[5] with one study estimating that the lifting of eviction moratoria in the first six months of the pandemic resulted in 433,700 excess COVID-19 cases and 10,700 excess deaths by September 20, 2020.[6] Despite the demonstrated relationship between COVID-19 transmission and eviction, the vast majority of policymakers narrowed eviction protections or allowed moratoria to lapse by the end of 2020, at the height of the pandemic and before vaccines were available. At a time when health justice and equity should have been prioritized, the failure to attain it was evident throughout the COVID-19 pandemic.

Extreme racial and socioeconomic health inequity and the health threat of

1 Emily A. Benfer et al., *Eviction, Health Inequity, and the Spread of COVID-19: Housing Policy as a Primary Pandemic Mitigation Strategy*, 98 J. URB. HEALTH 1 (2021).

2 Emily A. Benfer et al., *COVID-19 Housing Policy: State and Federal Eviction Moratoria and Supportive Measures in the United States During the Pandemic*, 33 HOUS. POL'Y DEBATE 1390 (2022) [hereinafter *COVID-19 Housing Policy*].

3 *Id.*

4 *Id.*

5 Sebastian Sandoval-Olascoaga et al., *Eviction Moratoria Expiration and COVID-19 Infection Risk Across Strata of Health and Socioeconomic Status in the United States*, 4 JAMA NETWORK OPEN e2129041 (2021).

6 Kathryn M. Leifheit et al., *Expiring Eviction Moratoriums and COVID-19 Incidence and Mortality*, 190 AM. J. EPIDEMIOLOGY 2563 (2021).

eviction on the individual and community levels is not contained to pandemics. Eviction consistently functions as a social and structural determinant of health inequity. It is undisputed that housing loss related to eviction is associated with numerous negative physical and mental health outcomes, including increased risk of premature death, and particularly harmful effects on children, elderly people, and people with disabilities.[7] For women, it is associated with physical and sexual assault and future housing precarity. Eviction is particularly devastating to children, resulting in emotional trauma, developmental delay, lead poisoning, food insecurity, and decreased life expectancy. For infants who are born during or soon after their mothers experience an eviction, it leads to adverse birth outcomes, such as low birthweight or pre-term birth. Eviction also narrows a family's housing options, forcing renters with a history of an eviction filing to move into substandard housing in disadvantaged, higher crime neighborhoods divorced from resources, transportation, and access to opportunity. In this way, eviction dismantles pillars of resiliency, locking families out of safe and decent housing, disrupting employment and education, and preventing access to well-resourced schools and communities.

The negative impact of eviction reverberates through whole communities, destabilizing neighborhoods, dismantling social networks, straining non-evicted households that provide temporary shelter and other material support,[8] and increasing the rate of violent crime, among other harms at the neighborhood level.[9] Ultimately, eviction deepens long-standing patterns of economic and housing instability and poor health among historically marginalized groups. Majority-Black communities, which have the highest rates of eviction,[10] are particularly vulnerable to the increased cycles of crime, poverty, and community disinvestment precipitated by eviction. However, policy makers have yet to adopt eviction prevention as a public health strategy beyond the pandemic. By Fall of 2023, any remaining eviction prevention measures, such as federal Emergency Rental Assistance and changes to the eviction court processes, ended at the state and local

7 *See infra* Section II.B.

8 Danya E. Keene et al., *Filling the Gaps in an Inadequate Housing Safety Net: The Experiences of Informal Housing Providers and Implications for Their Housing Security, Health, and Well-Being*, 8 SOCIUS (2022); Gabriel L. Schwartz et al., *Eviction as a Community Health Exposure*, 340 SOC. SCI. & MED. 116496 (2024).

9 *See* Schwartz et al., *supra* note 8; Danya E. Keene et al., *"A Little Bit of a Security Blanket": Renter Experiences with COVID-19-Era Eviction Moratoriums*, 97 SOC. SERV. REV. 423 (2023); Daniel C. Semenza et al., *Eviction and Crime: A Neighborhood Analysis in Philadelphia*, 68 CRIME & DELINQUENCY 707 (2022); Danya Keene, *The Affordable Rental Housing Crisis and Population Health Equity: A Multidimensional and Multilevel Framework*, 100 J. URB. HEALTH 1212 (2023).

10 Breanca Merritt & Morgan D. Farnworth, *State Landlord-Tenant Policy and Eviction Rates in Majority-Minority Neighborhoods*, 31 HOUS. POL'Y DEBATE 562 (2021).

levels, with few exceptions.[11]

This Article posits that the "housing is health" principle should not be limited to the pandemic, but rather the pandemic should serve as a catalyst to adopt eviction prevention as a major public health aim that is critical to health equity among historically marginalized populations, as well as our collective health. The public health field frequently tackles social issues, like eviction and housing displacement, that function as social determinants of poor health. For example, public health strategies and evaluation methods are frequently employed to address interpersonal and gun violence,[12] food insecurity,[13] homelessness,[14] early childhood education inequity and barriers to educational attainment,[15] and built environment deficiencies,[16] among other social issues.

This Article proposes the Health Justice Framework, which emphasizes social justice and health equity, as a holistic approach to understanding the roots and effects of the eviction crisis, as well as viable interventions that promote housing stability and health equity. The health justice frame complements and widens other relevant frames (e.g., access to justice, right to housing, economic, or race) to surface the full extent of the problem and robust interventions. The broader and historical scope offered by health justice principles prevents partial issue spotting or solutions that can occur when other frames are applied in isolation. For example, non-health frames might surface the need for a tenant right to counsel that provides attorneys for eviction defense or rental subsidies and rent caps to increase housing affordability. A health justice lens would also surface the need to address

11 Some states (and the District of Columbia) created their own emergency rental assistance programs that persist even after their federal ERA funding ran out. *See, e.g.*, *Emergency Rental Assistance Program*, D.C. DEP'T OF HUM. SERV., https://dhs.dc.gov/service/emergency-rental-assistance-program (last visited Sept. 13, 2023); *Illinois Court-Based Rental Assistance Program*, ILL. HOUS. DEV. AUTH., https://www.illinoishousinghelp.org/cbrap (last visited Sept. 13, 2023).

12 *See, e.g.*, Michael Decker et al., *An Integrated Public Health Approach to Interpersonal Violence and Suicide Prevention and Response*, 133 PUB. HEALTH REPS. 655 (2018); Daniel W. Webster, *Public Health Approaches to Reducing Community Gun Violence*, 151 AM. ACAD. OF ARTS & SCI. (2022).

13 *See, e.g.*, Emmanuel Ezekekwu, *Community-Based and System-Level Interventions for Improving Food Security and Nutritious Food Consumption: A Systematic Review*, 17 J. HUNGER & ENV'T NUTRITION 149 (2021).

14 *See, e.g.*, Marybeth Shinn et al., *Efficient Targeting of Homelessness Prevention Services for Families*, 103 AM. J. PUB. HEALTH S324 (2013); Thomas Byrne, Benjamin F. Henwood & Brynn Scriber, *Residential Moves Among Housing First Participants First*, 45 J. BEHAV. HEALTH SVCS. & RSCH. 124 (2018).

15 *See, e.g.*, Patrice L. Engle et al., *Strategies for Reducing Inequalities and Improving Developmental Outcomes for Young Children in Low-Income and Middle-Income Countries*, 378 LANCET 1339 (2011); Guthrie Gray-Lobe, Parag A. Pathak & Christopher R. Walters, *The Long-Term Effects of Universal Preschool in Boston*, 138 Q. J. ECON. 363 (2022).

16 *See, e.g.*, Ethan M. Berke & Anne Vernez-Moudon, *Built Environment Change: A Framework to Support Health-Enhancing Behavior Through Environmental Policy and Health Research,* 68 J. EPIDEMIOLOGY CMTY. HEALTH 586 (2014).

substandard housing conditions, barriers to access, power structures, and lack of enforcement mechanisms, among others. The health justice lens expands the problem identification to include an assessment of socioeconomic and political contexts, the historical underpinnings, as well as the role of discrimination and power hierarchy. In health justice, any solution defers to the needs and goals of the affected community.

This Article first combines literature from public health and housing fields with the World Health Organization (WHO) Conceptual Social Determinants of Health (SDOH) model to demonstrate the public health context of the eviction system. This examination highlights how eviction laws, policies, practices, and courts operate as structural determinants of health inequity among historically marginalized groups. It then applies the Health Justice Framework to the eviction system to develop a multi-pronged policy strategy to address eviction and health inequity, thereby offering a point of intervention and roadmap for remedying the crisis. Part I describes the Health Justice Framework and its relationship to the SDOH. Parts II, III and IV demonstrate how eviction is a structural and intermediary determinant of health inequity within the WHO Conceptual SDOH Framework. Part II describes how eviction is a driver of poor health that disproportionately affects historically marginalized people. Part III describes the relationship between eviction and the intermediary determinants of health. Part IV demonstrates how eviction courts, laws, policies, and practices operate as structural determinants of health inequity. Finally, Part V applies the Health Justice Framework and demonstrates how courts and policy makers can achieve health equity and eviction prevention.

I. THE HEALTH JUSTICE FRAMEWORK

It is widely documented that the "unequal health status of marginalized populations is primarily a product of systemic forces, not individual behavior."[17] The World Health Organization's Conceptual SDOH model demonstrates how hierarchies of power influence social, economic, and political mechanisms that, in turn, shape health status. The model was developed to surface the deepest roots of health differences, pathways from those root causes to stark differences in health status at the population level, and points of intervention to reduce health inequity.[18] The WHO identified multiple mechanisms that impact health and well-being, including socioeconomic and political contexts, structural determinants of health

17 Jamila Michener, *Health Justice Through the Lens of Power*, 50 J. LAW, MED. & ETHICS 656, 657 (2022).

18 *See generally* WORLD HEALTH ORGANIZATION, A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH (2010).

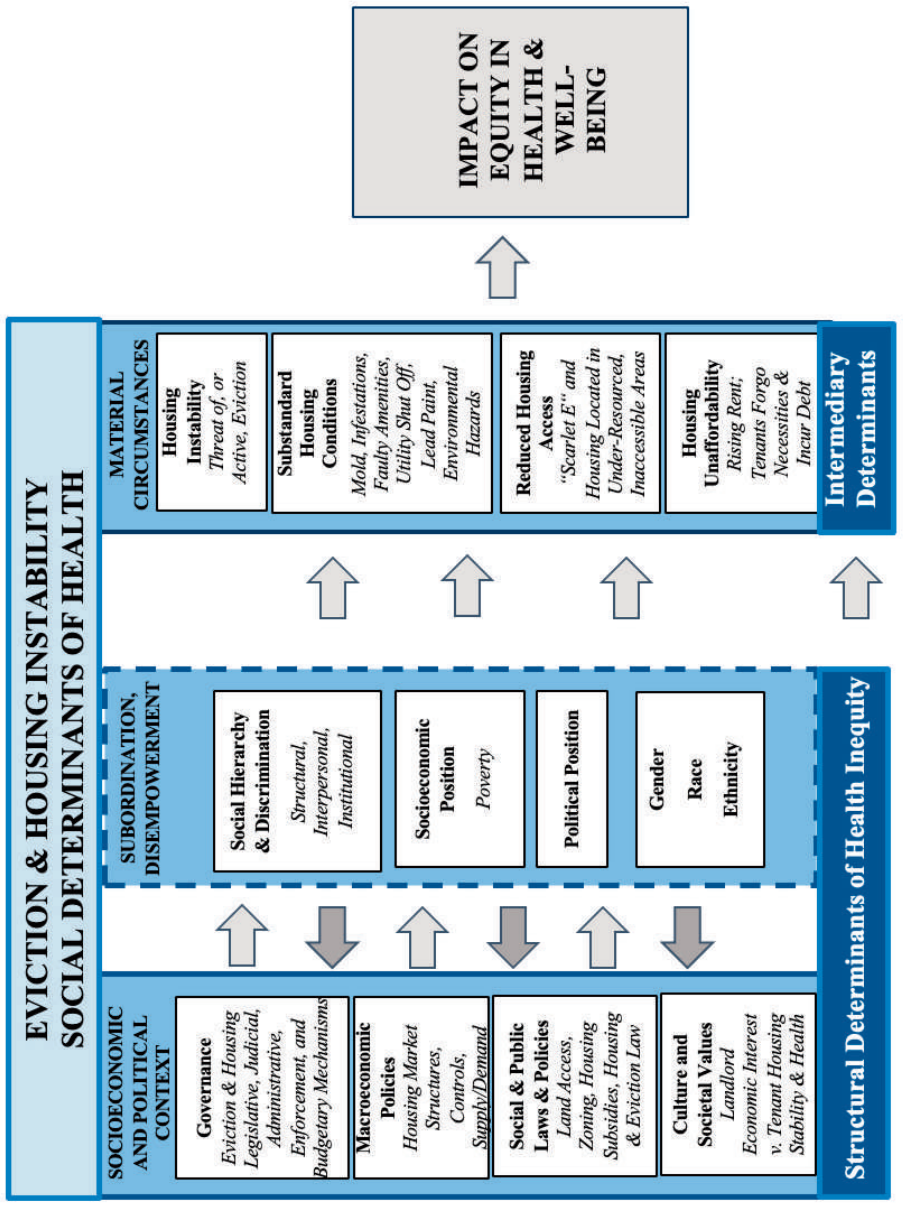
inequity, and intermediary determinants of health.[21] The socioeconomic and political contexts include public policy and social policies that affect factors like housing access. Structural determinants are those that "generate or reinforce social stratification in the society and that define individual socioeconomic position [and] configure health opportunities of social groups based on their placement within hierarchies of power, prestige and access to resources."[19] They, in turn, influence the extent to which individuals have access to intermediary determinants, such as education, employment, housing, food access, and health care, and, ultimately, inequity in health and well-being.

The WHO Conceptual SDOH model provides a mechanism for parsing the roots of the United States' eviction crisis and its effect on health equity among historically marginalized and race-class subjugated populations (Figure 1). The model divides SDOH into 1) structural determinants and 2) intermediary determinants. In the context of eviction, the structural determinants of health inequity include the United States' sordid history of exclusionary, racially discriminatory, and inequitable housing policy that led to the subjugation of communities of color. These structural determinants influence the intermediary determinants of health inequity, as seen in the widespread racial disparities in access to necessities, wealth, and material resources. Despite advances in landlord-tenant law, the passage of Civil Rights and Fair Housing Acts, today, that disparity continues and is perpetuated most clearly by structural determinants of health inequity. In particular, structural determinants in the form of laws, policies, and practices that comprise the eviction system serve as the scaffolding of health inequity. As described in this Article, the ostensibly race-neutral eviction court process, landlord practices, and state and local landlord-tenant laws, or lack thereof, (i.e., socioeconomic and political context) are drivers of racial exclusion and de facto segregation (i.e., social hierarchy and discrimination). For example, the eviction system overwhelmingly preferences the economic and property interests of landlords over the rights and health of tenants, and defaults to forcible removal of tenants over the provision of financial supports and legal protections. Since the eviction system disproportionately affects Black people, especially Black women with children, it perpetuates the disempowerment of communities of color and health inequity across generations.

19 *Id.* at 30.

20 Adapted from WORLD HEALTH ORGANIZATION, A CONCEPTUAL FRAMEWORK FOR ACTION ON

Figure 1. Relationship Between Eviction & Health, Adapted from the World Health Organization Conceptual SDOH Model[20]



THE SOCIAL DETERMINANTS OF HEALTH 35 (2010).

The Health Justice Framework responds to each prong of the WHO Conceptual SDOH model to address the structural determinants of health inequity, especially those caused by racial discrimination and other forms of subordination, like eviction. I first developed the Health Justice Framework a decade ago,[21] in tandem with Professor Lindsay Wiley,[22] and revisited the Framework with health law experts and professors Lindsay Wiley, Ruqaiijah Yearby, and Seema Mohapatra, during the COVID-19 pandemic.[23] The Framework has since been applied, expanded, and refined.[24] It has been adopted by the Association of American Medical Colleges[25] and the focus of conferences and symposia,[26] policy briefs, academic books,[27] and full journal volumes,[28] resulting in a robust body of

21 Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275, 325 (2015) [hereinafter *Health Justice*].

22 *See* Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J. L. PUB. POL'Y 47 (2014).

23 Emily A. Benfer et al., *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Inequity During and After COVID-19*, 19 YALE J. HEALTH POL'Y, L., & ETHICS 122 (2019) [hereinafter *Health Justice Strategies*].

24 *See, e.g.*, *id.*; Emily A. Benfer et al., *Setting the Health Justice Agenda: Addressing Health Inequity & Injustice in the Post-Pandemic Clinic*, 28 CLINICAL L. REV. 45 (2021) [hereinafter *Post-Pandemic Clinic*]; Medha D. Makhlouf, *Health Justice for Immigrants*, 4 U. PA. J. L. & PUB. AFFS. 235 (2019); Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758 (2020); Matthew B. Lawrence, *Against the "Safety Net,"* 72 FLA. L. REV. 49 (2020); Robyn M. Powell, *Applying the Health Justice Framework to Address Health and Health Care Inequities Experienced by People with Disabilities During and After COVID-19*, 96 WASH. L. REV. 93 (2021); Thalia González, Alexis Etow & Cesar De La Vega, *A Health Justice Response to School Discipline and Policing*, 71 AM. UNIV. L. REV. 1927 (2021); Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable High-Quality Health Care*, 37 CARDOZO L. REV. 833 (2015) [hereinafter *Patient Rights to Health Justice*]; Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes as a Community-Managed Social Phenomenon*, 16 HOUS. J. HEALTH L. & POL'Y 191 (2016); Lindsay F. Wiley, *Tobacco Denormalization, Anti-Healthism, and Health Justice*, 18 MARQ. BENEFITS & SOC. WELFARE L. REV. 203 (2016); Lindsay F. Wiley, *Universalism, Vulnerability, and Health Justice*, 70 UCLA L. REV. DISCOURSE 204 (2022); *Health Justice*, *supra* note 21; ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, ESSENTIALS OF HEALTH JUSTICE: A PRIMER (2018); Yael Cannon, *Injustice is an Underlying Condition*, 6 U. PA. J. L. & PUB. AFFS. 201 (2020); Ruqaiijah Yearby & Seema Mohapatra, *Systemic Racism, the Government's Pandemic Response, and Racial Inequities in COVID-19*, 70 EMORY L. J. 1419 (2020); Lindsay F. Wiley et al., *Health Reform Reconstruction*, 55 U.C. DAVIS L. REV. 657 (2021) [hereinafter *Health Reform Reconstruction*]; DAYNA BOWEN MATTHEW, JUST HEALTH: TREATING STRUCTURAL RACISM TO HEAL AMERICA (2022); Lindsay F. Wiley et al., *Introduction: What is Health Justice?*, 50 J.L MED. & ETHICS 636 (2022) [hereinafter *What is Health Justice?*].

25 *Center for Health Justice*, ASS'N OF AM. MED. COLL., https://www.aamchealthjustice.org (last visited Jul. 29, 2023).

26 *Health Justice Conference Videos*, AM. UNIV. HEALTH L. & POL'Y PROGRAM (Oct. 2, 2020), https://www.wcl.american.edu/impact/initiatives-programs/health/events/healthjustice2020/videos.

27 TOBIN-TYLER & TEITELBAUM, *supra* note 24.

28 J. LAW, MED. & ETHICS, HEALTH JUSTICE: ENGAGING CRITICAL PERSPECTIVES IN HEALTH LAW AND POLICY (2022), https://www.cambridge.org/core/journals/journal-of-law-medicine-and-ethics/issue/11F662007A2A91DCCFB43267147417A0.

scholarship.[29]

The achievement of health justice requires that all persons have equal ability to be free from the social determinants[30] that jeopardize their health and well-being.[31] At the same time, it requires equal access to opportunity and the ability to fully participate in society.[32] This necessarily requires addressing the socioeconomic and political contexts, including laws and policies that are rooted in power imbalance, and structural discrimination by social class, gender, race, and ethnicity.[33] Where the WHO Conceptual SDOH model identifies root causes and pathways of intervention, the Health Justice Framework offers the principles and models for identifying solutions and implementing interventions. (Figure 2) Applied to eviction, it is a holistic approach to increasing housing stability and health equity among historically marginalized individuals and communities.[34]

The Framework emphasizes four key tenets to addressing the structural determinants of health inequity: (1) community empowerment and community-driven structural change, wherein imbalanced power dynamics are shifted and historically marginalized populations drive solutions; (2) truth and reconciliation that emphasizes investigating and healing the historical mechanisms of structural racism undergirding health inequity; (3) the development of laws and policies that address the structural determinants of health inequity, including the social, political, and legal mechanisms of subordination; and (4) the provision of supports and legal protections to ensure that material and environmental circumstances transition from negative to positive determinants of health.[35] (Figure 2)

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29 For a description of the health justice scholarship, see *What is Health Justice?*, *supra* note 24.

30 The social determinants of health are defined as the conditions in which people are born, grow, work, play, and live. *Social Determinants of Health,* WORLD HEALTH, http://www.who.int/social_determinants/sdh_definition/en (last visited Jul. 28, 2023).

31 For an overview of the health justice approach to policymaking, see *Health Justice Strategies*, *supra* note 23.

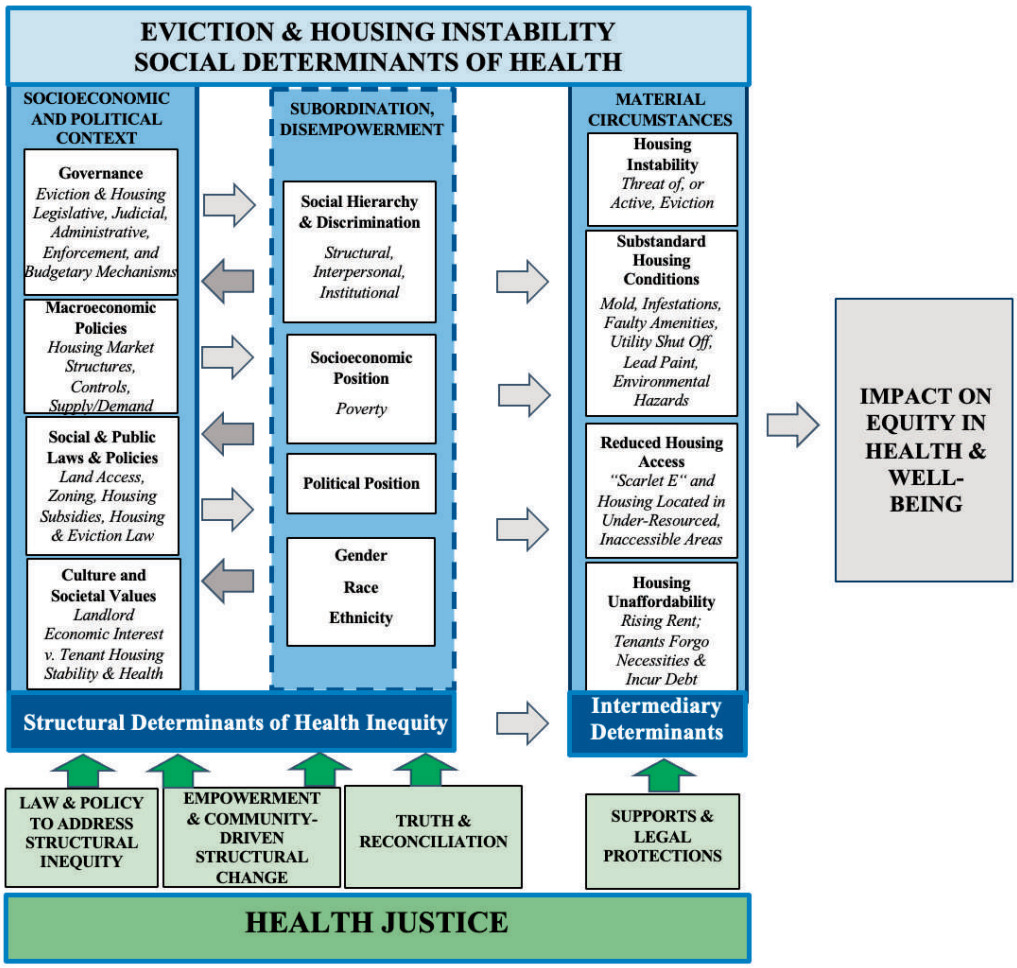
32 *Id*. at t 281; *see also* Paula Braveman et al., *What is Health Equity?*, 4 BEHAV. SCI. & POL'Y 1 (2018) ("Health equity . . . requires removing obstacles to health such as poverty and discrimination and their consequences, which include powerlessness and lack of access to . . . housing.").

33 Structural discrimination is a form of discrimination that is embedded in and throughout laws, policies, institutional practices, and entrenched norms. Where discrimination is race-based, it is structural racism. *See Health Justice Strategies*, *supra* note 23; Paula A. Braveman, et al. *Systemic and Structural Racism: Definitions, Examples, Health Damages and Approaches to Dismantling,* 41 HEALTH AFFS. 171 (2022).

34 *Health Justice Strategies*, *supra* note 23.

35 This definition of health justice describes the developing framework laid out in: *Health Justice*, *supra* note 21, at 278–79; *see also* Ruqaiijah Yearby, *The Social Determinants of Health, Health Disparities, and Health Justice*, 50 J. LAW, MED. & ETHICS 641 (2022); Michener, *supra* note 17; Wiley, *supra* note 22; *Health Justice Strategies*, *supra* note 23; *What is Health Justice?*, *supra* note 24; *Patient Rights to Health Justice*, *supra* note 24; *Health Reform Reconstruction*, *supra* note 24; *Post-Pandemic Clinic*, *supra* note 24.

Figure 2. Health Justice Framework & Housing as a Social Determinants of Health[36]



36 Adapted from *Health Justice Strategies*, *supra* note 23; *see also* Yearby, *supra* note 35.

II. THE EFFECT OF EVICTION ON HEALTH EQUITY & WELL-BEING

A. Disparities in Eviction by Race, Ethnicity, and Familial Status

Inequity in the eviction system is seen most starkly in the disproportionate rate of eviction filings and judgments against Black and other historically marginalized people and communities.[37] Between 2007 and 2016, Black renters were filed against at more than five times the rate of white renters, with 22.4 percent of Black adult renters filed against for eviction, compared to 4.2 percent of white adult renters.[38] Racial disparities in eviction are evidenced in numerous studies.[39] Generally, Black renters face eviction at higher rates than other groups. In one study, Black renters were filed against at twice the rate of white renters in seventeen out of thirty-six examined states.[40] Another study determined that Black households are more than twice as likely as white households to be evicted.[41] In another study, approximately 80 percent of people facing eviction in multiple cities were Black.[42]

Black women are evicted at higher rates than any other group, with 1 in 5 Black female renters reporting that they have experienced eviction compared with 1 in 12 Hispanic women and 1 in 15 white women.[43] In the seminal study of

37 Peter Hepburn, Renee Louis & Matthew Desmond, *Racial and Gender Disparities Among Evicted Americans*, EVICTION LAB (Dec. 16, 2020), https://evictionlab.org/demographics-of-eviction; Peter Hepburn, Renee Louis & Matthew Desmond, *Racial and Gender Disparities Among Evicted Americans*, 7 SOCIO. SCI. 649 (2020); Matthew Desmond, *Eviction and the Reproduction of Urban Poverty*, 118 AM. J. SOC. 88, 91 (2012) [hereinafter *Eviction and the Reproduction of Urban Poverty*]; Matthew Desmond et al., *Evicting Children*, 92 SOC. FORCES 303, 303 (2013) [hereinafter *Evicting Children*].

38 Nick Graetz et al., *A Comprehensive Demographic Profile of the U.S. Evicted Population*, 120 PROCEEDINGS NAT'L ACAD. SCI. USA e2305860120 (2023) ("Our estimates indicate that, between 2007 and 2016, 22.4% of Black adult renters were living in a household filed against for eviction, and roughly one in ten were evicted each year (Fig. 3). By contrast, the average annual eviction filing and eviction rates for white adult renters were 4.2% and 2.5%, respectively. Eviction filing and eviction rates for Hispanic adult renters were comparable to those for white renters. Asian renters consistently had the lowest eviction filing and eviction rates.").

39 Deena Greenberg et al., *Discrimination in Evictions: Empirical Evidence and Legal Challenges*, 51 HARV. C.R.-C.L. L. REV. 115 (2016); BENJAMIN F. TERESA, RVA EVICTION LAB, THE GEOGRAPHY OF EVICTION IN RICHMOND: BEYOND POVERTY (2017).

40 Sophie Beiers et al., *Clearing the Record: How Eviction Sealing Laws Can Advance Housing Access for Women of Color*, ACLU (Jan. 10, 2020), https://www.aclu.org/news/racial-justice/clearing-the-record-how-eviction-sealing-laws-can-advance-housing-access-for-women-of-color.

41 Matthew Desmond et al., *Discrimination in Eviction and Legal Challenges,* 51 HARV. C.R.-C.L. L. REV. 117, 117 (2016).

42 Cities studied included New York, Chicago, Baltimore, Philadelphia, Los Angeles, and Oakland. *See* Chester Hartman & David Robinson, *Evictions: The Hidden Housing Problem*, 14 HOUS. POL'Y DEBATE 461, 467 (2003).

43 Rachel Dovey, *What 80 Million Eviction Records Can Tell City Leaders*, NEXT CITY (Apr.

eviction in Milwaukee conducted by Dr. Matthew Desmond, founder of the Eviction Lab at Princeton University, women from Black neighborhoods made up only 9.6 percent of the city's population but accounted for 30 percent of evicted tenants.[44] During the pandemic, a study of eviction in Arkansas revealed that 50 percent of evictions were of single women,[45] even though female-led households only constituted approximately 16 percent of all households in the state.[46] Notably, Black women saw the highest rates of COVID-19 hospitalization in communities nationally, constituting approximately 7 percent of the population, and 10 percent of the population hospitalized.[47]

The high rate of eviction among Black women is, in part, explained by the fact that women from impoverished majority-Black neighborhoods are the leaseholder the majority of the time and have a harder time making rent than male leaseholders from other neighborhoods.[48] The higher rates of eviction suffered by Black women compared to other groups is mirrored by the higher rates of incarceration suffered by Black men compared to other groups.[49] As Dr. Desmond has observed, "Poor Black men are locked up while poor Black women are locked out."[50]

Familial status is also a contributing factor to eviction risk. The single greatest predictor of eviction is the presence of a child, with Black families at the highest risk.[51] According to one study, an astounding 14.8 percent of all children and 28.9 percent of children in families living below the poverty line experience an eviction by the time they are fifteen.[52] In a recent national study of eviction filings, 32.9

9, 2018), https://nextcity.org/daily/entry/what-80-million-eviction-records-can-tell-city-leaders.

44 *Eviction and the Reproduction of Urban Poverty*, *supra* note 37; *see also* Matthew Desmond, *Poor Black Women Are Evicted at Alarming Rates, Setting Off a Chain of Hardshi*p, MACARTHUR FOUND. (Mar. 2014), https://www.macfound.org/media/files/hhm_research_brief_-_poor_black_women_are_evicted_at_alarming_rates.pdf [hereinafter *Poor Black Women are Evicted at Alarming Rates*].

45 Ninette Sosa*, A Closer Look: Arkansas Evictions During COVID-19; Tenant Stories*, KNWA FOX24 (Aug. 3, 2020, 5:36 PM CDT), https://www.nwahomepage.com/news/a-closer-look/a-closer-look-arkansas-evictions-during-covid-19-tenant-stories.

46 *Arkansas: Families*, CENSUS REPORTER, https://censusreporter.org/profiles/04000US05-arkansas (last visited Sep. 12, 2023) (visualization of data collected through the U.S. Census Bureau's 2021 American Community Survey 1-Year Estimates).

47 Suman Pal et al., *Gender and Race-Based Health Disparities in COVID-19 Outcomes Among Hospitalized Patients in the United States: A Retrospective Analysis of a National Sample*, 10 VACCINES 2036 (2022).

48 *Eviction and the Reproduction of Urban Poverty*, *supra* note 37.

49 In 2018, 2,272 per 100,000 Black men were imprisoned under the jurisdiction of state or federal correctional officials, compared to 392 per 100,000 white men and 88 per 100,000 Black women. E. ANN CARSON, BUREAU JUST. STATS., PRISONERS IN 2018 16 (2020).

50 *Poor Black Women Are Evicted at Alarming Rates, supra* note 44, at 3.

51 *Evicting Children*, *supra* note 37, at 303.

52 Ian Lundberg & Louis Donnelly, *A Research Note on the Prevalence of Housing Eviction Among Children Born in U.S. Cities*, 56 DEMOGRAPHY 391 (2019).

percent of the population threatened with eviction was below age fifteen.[53] Children under five make up 9 percent of people living in rental units, but 12 percent of renters affected by an eviction filing each year. Of all children aged zero to four living in renting households, 5.7 percent were evicted each year, with 12.4% of Black children aged 0 to 4 evicted annually.[54] Eviction among families can be partially attributed to the landlord's misperception that children contribute to overcrowding, noise, defacement of property; increase the potential for additional costs and scrutiny of the property if a child is lead poisoned; are responsible for increased gang activity and the presence of law enforcement and/or Child Protective Services.[55] A study conducted of this phenomenon found that on average a household with children owed slightly less than the households without children and on average committed fewer lease violations, yet the probability of receiving an eviction judgment was 16 to 17 percent higher for households with children.[56]

Housing instability and eviction burdens additional historically marginalized and vulnerable groups. Individuals with disabilities are disproportionately represented in eviction filings; in a questionnaire of 670 households (or 1,657 people) who had evictions filed against them, approximately 40 percent reported having a disability.[57] LGBTQ status can increase risk of eviction.[58] In the 2015 U.S. Transgender Survey, transgender adults reported facing eviction at a rate approximately five times higher than the general population.[59] Undocumented immigrants may also be more likely to experience eviction due to extreme rates of rent burden. In Los Angeles, 71 percent of undocumented immigrants were rent burdened compared to 55 percent of U.S. born citizens.[60] Intersectionality across

53 Nick Graetz et al., *A Comprehensive Demographic Profile of the US Evicted Population*, 120 PNAS e2305860120 (2023).

54 *Id.*

55 *Evicting Children*, *supra* note 37, at 306.

56 *Id.* at 314–17.

57 *See* Matt Koz, *Issue Spotlight: Who is Being Evicted?*, TENANT RES. CTR. (Apr. 25, 2023), https://www.tenantresourcecenter.org/issue_spotlight_who_is_being_evicted. *See also* Jaboa Lake, Valerie Novack & Mia Ives-Rublee, *Recognizing and Addressing Housing Insecurity for Disabled Renters*, CENTER FOR AM. PROGRESS (May 27, 2021), https://www.americanprogress.org/article/recognizing-addressing-housing-insecurity-disabled-renters; *Advancing Tenant Protections: Source-of-Income Protections*, NAT'L LOW INCOME HOUS. COAL. (Feb. 7, 2023), https://nlihc.org/resource/14-1-advancing-tenant-protections-source-income-protections.

58 Maya Brennan, *Five Facts About Housing Access for LGBTQ People*, URBAN INST. (June 13, 2018), https://housingmatters.urban.org/articles/five-facts-about-housing-access-lgbt-people.

59 SANDY E. JAMES ET AL., NAT'L CTR. FOR TRANSGENDER EQUAL., THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY (2015); CAITLIN ROONEY ET AL., CTR. FOR AM. PROGRESS, DISCRIMINATION AGAINST TRANSGENDER WOMEN SEEKING ACCESS TO HOMELESS SHELTERS (2016).

60 USC DORNSIFE CENTER FOR THE STUDY OF IMMIGRANT INTEGRATION, STATE OF IMMIGRANTS

race, class, and gender is also common among people at heightened risk of eviction, resulting in increased exposure to structural discrimination and health inequity.[61]

B. Eviction as a Major Driver of Poor Health

As social science and public health research demonstrates, eviction is a well-documented SDOH that has a negative effect on health and well-being with high health care expenditures and steep societal costs and community impacts.[62] (Table 1) Eviction disrupts employment,[63] education,[64] social networks,[65] access to services,[66] and negatively impacts long-term health outcomes for adults and children.[67] Eviction is associated with unemployment,[68] diminished mental and physical health, depression,[69] suicidal ideation,[70] suicide,[71] increased risk of

IN LA COUNTY 46 (2020). It should also be noted that undocumented immigrants may be particularly vulnerable to informal evictions, due to their understandable hesitance to challenge landlord actions in court. Albinson Linares & Juliana Jiménez, *Evictions are on the Rise – and It's Harder for Those Who Are Undocumented*, NBC NEWS (Aug. 16, 2023, 2:44 PM) https://www.nbcnews.com/news/latino/evictions-are-rise-impacting-many-undocumented-latinos-rcna99478.

61 *See, e.g.*, Megan Buckles, *10 Policies to Improve Economic Security for Black Women With Disabilities*, CTR. FOR AM. PROGRESS (Feb. 15, 2022), https://www.americanprogress.org/article/10-policies-to-improve-economic-security-for-black-women-with-disabilities; *see* Kimberlé Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241 (1991).

62 Lauren A. Taylor, *Housing and Health: An Overview of the Literature*, HEALTH AFFS. (June 7, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full; Kim M. Blankenship et al., *Structural Racism, the Social Determination of Health, and Health Inequities: The Intersecting Impacts of Housing and Mass Incarceration*, 113 AM. J. PUB. HEALTH S58 (2023).

63 Matthew Desmond & Rachel Tolbert Kimbro, *Eviction's Fallout: Housing, Hardship, and Health*, 94 SOC. FORCES 295, 316 (2015); Matthew Desmond & Carl Gershenson, *Housing and Employment Insecurity Among the Working Poor*, 63 SOC. PROBS. 46 (2016).

64 *Evicting Children*, *supra* note 37, at 320.

65 *Id.*

66 Taylor, *supra* note 62.

67 Robert Collinson et al., *Eviction and Poverty in American Cities*, NAT'L BUREAU OF ECON. RSCH. (2022), https://www.nber.org/system/files/working_papers/w30382/w30382.pdf.

68 Desmond & Gershenson, *supra* note 63.

69 Desmond & Kimbro, *supra* note 63.

70 Hugo Vásquez Vera et al., *The Threat of Home Eviction and its Effects on Health Through the Equity Lens: A Systematic Review,* 175 SOC. SCI. & MED. 199, 202 (2017).

71 Katherine A. Fowler et al., *Increase in Suicides Associated with Home Eviction and Foreclosure During the US Housing Crisis: Findings from 16 National Violent Death Reporting System States, 2005–2010*, 105 AM. J. PUB. HEALTH 311 (2015).

sexually transmitted diseases,[72] HIV sexual risk,[73] drug overdose,[74] increased mortality,[75] homelessness, decreased access to medical care, and other negative outcomes.[76] In addition, eviction is associated with respiratory disease[77] and increased COVID-19 infection and mortality.[78] The mere threat of eviction can increase stress levels, anxiety, and depression, and weaken the immune system, which can increase the risk of comorbidities.[79] (Table 1)

For women, eviction is associated with physical and sexual assault, increased drug use, and behaviors that increase contraction of sexually transmitted diseases.[80] Eviction among women is also associated with future housing displacement.[81] Evicted mothers experience higher levels of depression, stress, and greater material hardship than mothers who are stably housed.[82] (Table 1)

For children, eviction functions as a major life event that has damaging effects long after they are forced to leave their homes.[83] It negatively affects emotional

72 Linda M. Niccolai, Kim M. Blankenship & Danya E. Keene, *Eviction from Renter-Occupied Households and Rates of Sexually Transmitted Infections: A County-Level Ecological Analysis*, 46 SEXUALLY TRANSMITTED DISEASES 63 (2019).

73 Allison K. Groves et al., *Housing Instability and HIV Risk: Expanding Our Understanding of the Impact of Eviction and Other Landlord-Related Forced Moves*, 25 AIDS BEHAV. 1913 (2021).

74 Ashley C. Bradford & David W. Bradford, *The Effect of Eviction on Accidental Drug and Alcohol Mortality*, 55 HEALTH SERV. REV. 9 (2020); *Homelessness as a Public Health Law Issue: Selected Resources*, CTR. DISEASE CONTROL & PREVENTION https://www.cdc.gov/phlp/publications/topic/resources/resources-homelessness.html (last updated Apr. 23, 2020).

75 Nick Graetz et al., *The Impacts of Rent Burden and Eviction on Mortality in the United States, 2000-2019*, 340 SOC. SCI. & MED. 116398 (2024); *see also* Desmond & Kimbro, *supra* note 63; Thomas Kottke et al., *Access to Affordable Housing Promotes Health and Well-Being and Reduces Hospital Visits*, 22 PERMANENTE J. 1, 2–3 (2017).

76 *See* Benfer et al., *supra* note 1; Collinson et al., *supra* note 67.

77 Paula Braverman et al., *How Does Housing Affect Health?*, ROBERT WOOD JOHNSON FOUND. (May 1, 2011), https:// www.rwjf.org/en/library/research/2011/05/housing-and-health.html.

78 Kathryn M. Leifheit et al., *Expiring Eviction Moratoriums and COVID-19 Incidence and Mortality*, 190 AM. J. EPIDEMIOLOGY 2503 (2021).

79 Vera et al., *supra* note 70; Gabriel L. Schwartz et al., *Eviction, Healthcare Utilization, and Disenrollment Among New York City Medicaid Patients*, 62 AM. J. PREVENTIVE MED. 157 (2022).

80 *See* Nihaya Daoud et al., *Pathways and Trajectories Linking Housing Instability and Poor Health Among Low-Income Women Experiencing Intimate Partner Violence (IPV): Toward a Conceptual Framework*, 56 WOMEN HEALTH 208 (2016); Alexandra B. Collins et al., *Surviving the Housing Crisis: Social Violence and the Production of Evictions Among Women Who Use Drugs in Vancouver, Canada*, 51 HEALTH & PLACE 174 (2018); Niccolai, Blankenship & Keene, *supra* note 72.

81 Craig Evan Pollack, Kathryn M. Leifheit & Sabriya L. Linton, *When Storms Collide: Evictions, COVID-19, and Health Equity*, HEALTH AFF. FOREFRONT (Aug. 4, 2020), https://www.healthaffairs.org/content/forefront/storms-collide-evictions-covid-19-and-health-equity.

82 Desmond & Kimbro, *supra* note 63.

83 *See generally* Emily A. Benfer, *U.S. Eviction Policy is Harming Children: The Case for*

and physical well-being;[84] increases the likelihood of lead poisoning[85] and food insecurity;[86] leads to academic decline and delays;[87] and is linked to increased all-cause mortality.[88] Strongly associated with adverse childhood experiences, eviction increases long-term negative health impacts, including increased risk of cardiovascular disease in adulthood and decreased life expectancy.[89] In a recent study that concluded eviction is a perinatal, pediatric, and adult health concern, researchers found that for young children, eviction was associated with significantly greater odds of poor health, developmental risk, and hospital admission from the emergency department.[90] Newborn infants whose mothers were evicted during their pregnancy are more likely to have low birth weight, preterm birth, shorter gestation, neonatal intensive care unit stays, extended hospitalization, and a trend toward increased infant mortality.[91] In this way, eviction has negative effects across the life course and creates intergenerational harm. Because eviction often increases household instability, which is particularly damaging to children and impacts their educational development and well-being for years,[92] the harm of exposure may be chronic and long-term. (Table 1)

In addition to the devastating effects of eviction—from homelessness to the

Sustainable Eviction Prevention to Promote Health, HARV. L. SCH. BILL OF HEALTH (Nov. 2, 2022), https://blog.petrieflom.law.harvard.edu/2022/11/02/pandemic-eviction-policy-children; Benfer et al., *supra* note 1.

84 *See* Matthew Desmond, *Unaffordable America: Poverty, Housing, and Eviction*, 22 FAST FOCUS 1, 1–6 (2015) [hereinafter *Unaffordable America*]; Kottke et al., *supra* note 75; *see also* Stephen Gaetz et al., *Youth Homelessness and Housing Stability: What Outcomes Should We Be Looking For*?, 32 HEALTHCARE MGMT. F. 73 (2019).

85 Francisca García-Cobián Richter et al., *An Integrated Data System Lens Into Evictions and Their Effects*, 31 HOUS. POL'Y DEBATE 762 (2021).

86 Kathryn M. Leifheit et al., *Eviction in Early Childhood and Neighborhood Poverty, Food Security, and Obesity in Later Childhood and Adolescence: Evidence from a Longitudinal Birth Cohort*, 11 SSM–POP. HEALTH 100575 (2020).

87 Diana H. Gruman et al., *Longitudinal Effects of Student Mobility on Three Dimensions of Elementary School Engagement*, 79 CHILD DEV. 1833 (2008); Gabriel L. Schwartz et al., *Childhood Eviction and Cognitive Development: Developmental Timing-Specific Associations in an Urban Birth Cohort*, 292 SOC. SCI. & MED. 114544 (2022).

88 Yerko Rojas, *Evictions and Short-Term All-Cause Mortality: A 3-year Follow-up Study of a Middle-Aged Swedish Population*, 62 INT'L J. PUB. HEALTH 343 (2017).

89 Maxia Dong et al., *Childhood Residential Mobility and Multiple Health Risks During Adolescence and Adulthood: The Hidden Role of Adverse Childhood Experiences*, 159 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1104, 1107 (2005).

90 Diana B. Cutts et al., *Eviction and Household Health and Hardships in Families with Very Young Children*, 150 PEDIATRICS 1 (2022).

91 Kathryn M. Leifheit et al., *Severe Housing Insecurity During Pregnancy: Association with Adverse Birth and Infant Outcomes*, 17 INT'L J. ENV. RSCH. & PUB. HEALTH 8659 (2020); Gracie Himmelstein & Matthew Desmond, *Association of Eviction with Adverse Birth Outcomes Among Women in Georgia, 2000 to 2016*, 175 JAMA PEDIATRICS 494 (2021).

92 HEATHER SANDSTROM & SANDRA HUERTA, URBAN INST., THE NEGATIVE EFFECTS OF INSTABILITY ON CHILD DEVELOPMENT: A RESEARCH SYNTHESIS 6 (2013).

life-long detrimental health impacts to increased risk of death[93]—eviction haunts families as they attempt to piece their lives back together, which can include seeking employment, securing childcare, identifying new schools, and coping with financial and personal loss. Renters who attempt to move forward with their lives after eviction are often met with barriers when they search for a new home.[94] Eviction records can result in the denial of housing[95] and damage to credit scores if the landlord reports nonpayment to credit agencies or pursues debt collection related to unpaid rent, which in turn negatively affects employment opportunities (where credit checks are used to evaluate employees), one's ability to obtain home and auto insurance, eligibility for a mortgage, financial aid for educational purposes, home and car purchases, and other activities that involve credit.[96] This has the effect of pushing tenants with a history of an eviction filing to substandard housing in higher crime and higher poverty neighborhoods that have under-resourced schools, are removed from necessities, and lack employment opportunities, among other critical sources of livelihood.[97] Children living in inadequate homes and low-income communities are at increased risk of behavioral and developmental problems, infectious and chronic diseases, and injury.[98] (Table 1)

93 *See supra* Section II.B.

94 *Eviction Filings Are Barrier to Finding Future Housing—Even for Tenants Who Are Not Evicted*, HOUS. ACTION IL. (Mar. 7, 2018), https://www.lcbh.org/news/ eviction-filings-are-barrier-to- finding-future-housing.

95 *See infra* Section IV.C.7.

96 Jasmin Suknanan, *Does Getting Evicted Lower Your Credit Score? Here's What You Need to Know*, CNBC (Nov. 28, 2023) https://www.cnbc.com/select/how-eviction-affects-credit; Robert Collinson et al., *Eviction and Poverty in American Cities*, NAT'L BUREAU ECON. RSCH. (2022). Credit checks in employment have independently been criticized as a "vicious cycle" with a "greater impact on minority job applicants." Sharon Goott Nissim, *Stopping a Vicious Cycle: The Problems with Credit Checks in Employment and Strategies to Limit Their Use*, 18 GEO. J. L. & POL'Y 45, 46 (2010).

97 Matthew Desmond & Tracey Shollenberger, *Forced Displacement from Rental Housing: Prevalence and Neighborhood Consequences*, 52 DEMOGRAPHY 1751 (2015); Matthew Desmond, Carl Gershenson & Barbara Kiviat, *Forced Relocation and Residential Instability Among Urban Renters*, 98 SOC. SERV. REV. 227 (2015).

98 *Housing's and Neighborhoods' Role in Shaping Children's Future*, U.S. DEP'T OF HOUS. & URB. DEV. (2014), https://www.huduser.gov/portal/periodicals/em/fall14/highlight1.html.

Table 1. Eviction as a Structural Determinant of Health Inequity: Conditions Associated with Eviction

Physical Health	Mental Health	Associated Conditions Among Women	Associated Conditions Among Children	Exposure to Hazardous Living Conditions	Barriers to Livelihood
All-Cause Mortality	Depression	Physical Assault	Lead Poisoning	Lead	Falling Credit Scores, Inaccess to Credit
Respiratory Disease	Anxiety	Sexual Assault	Educational Barriers, Academic Delay and Decline	Mold	Downward Moves
High Blood Pressure	Toxic Stress	Drug Use, Drug Exposure, and Related Harms	Food Insecurity	Poor Ventilation	Unemployment, Reduced Earnings
Self-Rated Poor General Health	Mental Health Hospitalization	Pre-term Pregnancies	Emotional Trauma	Infestations	Residential Instability
Coronary Heart Disease	Exposure to Violence	Future Housing Displacement	Risk of Chronic Diseases in Adulthood	Crowding	Homelessness
Sexually Transmitted Infections, HIV Risk	Suicide	Material Hardship	Low Birthweight and Preterm Birth	Asbestos	Inability to Access Social Services
Drug Use, Oveerdose			Neonatal Intensive Care Unit Stays	Higher Crime	Greater Debt
Increased Emergency Room and Hospital Visits and Admissions			Adverse Childhood Experiences		Social Network Disruption
COVID-19 infection, mortality			All-Cause Mortality, Descreased Life Expectancy		Decreased Medical Care
Weakened Immune System					

III. EVICTION AND THE INTERMEDIARY DETERMINANTS OF HEALTH

In the WHO Conceptual SDOH model, the intermediary determinants are antecedent to structural determinants of health inequity. Intermediary determinants are the material circumstances that influence equity in health and well-being. They include the physical and neighborhood environment and the ability to afford necessities, among other factors. In the housing context, housing instability and reduced access, substandard conditions, unaffordability, and location all impact health.

A. Housing Instability and Reduced Housing Access

Housing instability due to eviction, in particular, has a negative impact on health equity. Eviction is widespread throughout the United States. The Eviction Lab at Princeton University determined that between 2000 and 2018, over 69.7 million eviction cases were filed in the U.S., an average of 3.6 million eviction filings annually against 2.7 million unique households, affecting 9 percent of renter households.[99] The prevalence of eviction filings and judgments varies by city and state and, on average, North Charleston, South Carolina has the highest rate of eviction filings (16.5 percent) and New York City, New York, the highest volume (36,343 eviction cases filed).[100] In many cities, a small share of landlords are responsible for the majority of eviction filings and drive the local eviction crisis.[101] Some of the highest annual eviction filing rates are observed in Maryland, South Carolina, and Georgia, indicating that eviction risk is not primarily a concern of high-cost or high-population metropolitan areas.[102] Indeed, eviction risk is common in suburban contexts[103] and eviction rates and housing inequality have increased in suburban communities over time.[104]

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99 Ashley Gromis et al., *Estimating Eviction Prevalence Across the United States*, 119 PNAS e2116169119 (2022); Juan Pablo Garnham, Carl Gershenson & Matthew Desmond, *New Data Release Shows that 3.6 Million Eviction Cases Were Filed in the United States in 2018*, EVICTION LAB (July 11, 2022), https://evictionlab.org/new-eviction-data-2022.

100 EVICTION LAB, *Top Evicting Large Cities in the United States*, https://evictionlab.org/rankings/#/evictions (last visited July 27, 2023).

101 Devin Rutan & Matthew Desmond, *Top Evicting Landlords Drive U.S. Eviction Crisis*, EVICTION LAB (Apr. 5, 2021), https://evictionlab.org/top-evicting-landlords-drive-us-eviction-crisis.

102 *Id.*

103 Peter Hepburn et al., *Uncovering the Suburban Eviction Crisis*, EVICTION LAB (Mar. 23, 2022), https://evictionlab.org/suburban-eviction; Peter Hepburn, Devin Q. Rutan & Matthew Desmond, *Beyond Urban Displacement: Suburban Poverty and Eviction*, 59 URB. AFFS. REV. 759 (2023).

104 Devin Q. Rutan, Peter Hepburn & Matthew Desmond, *The Suburbanization of Eviction: Increasing Displacement and Inequality Within American Suburbs*, 9 RSF: THE RUSSELL SAGE FOUND. J. SOC. SCIS. 104 (2023); Devin Q. Rutan, Peter Hepburn & Matthew Desmond, *The Growing*

Eviction is also prevalent in federally assisted and public housing.[105] Residents of public housing complexes with majority Black tenants are disproportionately threatened with eviction compared to those with majority white residents.[106] This is especially damaging, as eviction not only results in displacement, but also leads to the loss of federally assisted housing—a rare and "life-saving" benefit.[107]

According to Dr. Matthew Desmond, "eviction diminishes one's chance of securing affordable housing in a decent neighborhood, stymies the ability to secure housing assistance, and often leads to homelessness and increased residential mobility. All of these factors lead to reproduction of urban poverty."[108] As described herein, because many landlords reject applicants with a history of eviction ("Scarlet E"), these renters are left with few options and are often forced into run-down properties.[109] For children and young adults named as defendants in an eviction case, they are practically excluded from the housing market before they are legally able to enter a binding lease due to common categorical bans on renting to applicants with an eviction history. Consequently, eviction almost always leads to a downward move, doubling up or homelessness, to substandard housing, and to communities with higher rates of crime, poverty, and under-resourced schools.[110]

During the COVID-19 pandemic, the Biden-Harris Administration's whole-of-government response to the eviction crisis—that was matched with swift local action to implement programs and adopt legislation—led to an unprecedented reduction in eviction filings nationwide: eviction filings dropped to less than half of historical levels through 2021 and well below historical averages in 2022. (Figure 3) As described herein, interventions attributed with quelling the pandemic eviction crisis included the issuance of eviction moratoria in forty-three states, the District of Columbia and five American territories; the CDC eviction moratoria; rapid distribution of $46.5 billion in federal Emergency Rental Assistance; investments in tenant right to counsel and eviction diversion programs; outreach from the Attorney General and Associate Attorney General to the legal community

Risk of Eviction in the Suburbs, EVICTION LAB (Feb. 28, 2023), https://evictionlab.org/growing-risk-of-suburban-eviction.

105 Ashley Gromis, James R. Hendrickson & Matthew Desmond, *Eviction from Public Housing in the United States*, 127 CITIES 103749 (2022); REINVESTMENT FUND, POLICY BRIEF: EVICTIONS IN PHILADELPHIA: A DATA & POLICY UPDATE (Oct. 2019).

106 Gromis et al., *supra* note 99; *see also* Gregory Preston & Vincent J. Reina, *Sheltered from Eviction? A Framework for Understanding the Relationship Between Subsidized Housing Programs and Eviction*, 31 HOUS. POL'Y DEBATE 785 (2021).

107 Gromis et al., *supra* note 99.

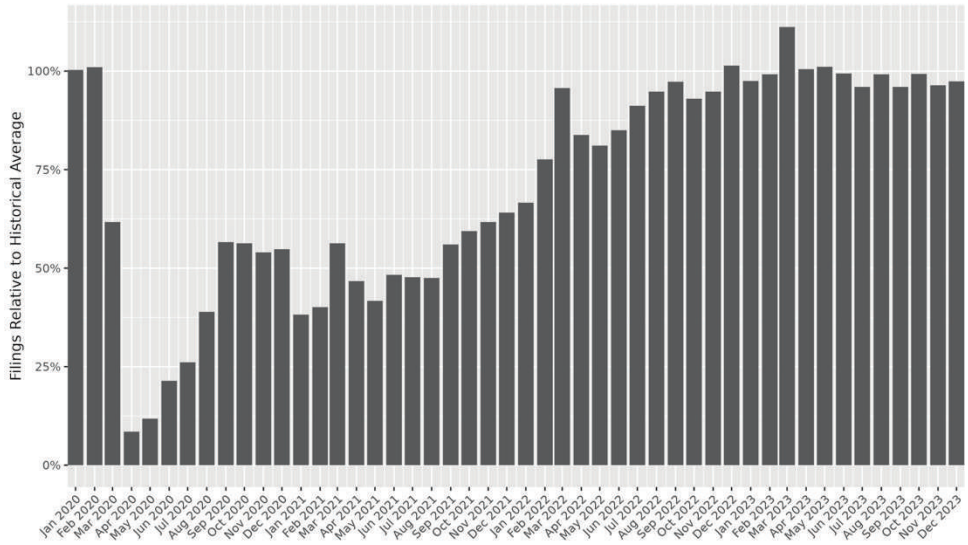
108 *Eviction and the Reproduction of Urban Poverty*, *supra* note 37.

109 *Id.*; *see also infra* Section IV.C.7.

110 *Unaffordable America*, *supra* note 84; Desmond, Gershenson & Kiviat, *supra* note 97; Desmond & Shollenberger, *supra* note 97.

and courts; best practices and technical assistance from the U.S. Treasury; as well as the historic supports offered to Americans under the American Rescue Plan Act. By the summer of 2023, due to the sunsetting of pandemic era interventions and the lack of their permanent adoption on the state and local level, eviction filing rates began to approach or surpass historical levels in multiple jurisdictions, by as much as 140 percent (Minnesota), 150 percent (Houston, Texas), and 170 percent (Las Vegas, NV).[111]

Figure 3. Eviction Filings Compared to Historical Averages January 2020 to December 2023[112]



B. Substandard Housing Conditions

Majority Black and Latino communities are affected by substandard conditions at a higher rate than predominately white communities. Approximately thirty-five million (40 percent) homes in U.S. metropolitan areas have one or more health and safety hazards, and rental properties in these areas have a greater prevalence of health-harming conditions than owner-occupied units.[113]

111 *Eviction Tracking System*, EVICTION LAB, https://evictionlab.org/eviction-tracking (last visited July 27, 2023).

112 Peter Hepburn, Jacob Haas, Renee Louis, Adam Chapnik, Danny Grubbs-Donovan, Olivia Jin, Jasmine Rangel, and Matthew Desmond, *Eviction Tracking System: Version 2.0,* Princeton: Princeton University, 2020.

113 Emily A. Benfer & Allyson E. Gold, *There's No Place Like Home: Reshaping Community Interventions and Policies to Eliminate Environmental Hazards and Improve Population Health for*

Substandard homes are concentrated in low-income communities and communities of color.[114] Undocumented migrants are more likely than immigrants to be exposed to pests, insects, exposed wires, and holes in the walls.[115] Overall, Black renter households disproportionately suffer from conditions associated with substandard housing, including asthma, respiratory distress, carbon monoxide poisoning, high blood pressure, heart disease, lead poisoning, mental health impairment, and cancer, among others.[116] Tenants who have a history of interaction with the eviction system are not only exposed to hazardous housing conditions at higher rates, but they also have little recourse due to underenforcement of housing codes and warranties of habitability and the immediate threat or fear of retaliatory eviction that may occur after a tenant reports a violation.

C. Housing Unaffordability

Eviction is linked to the severe and chronic affordable housing crisis in the United States. As the country emerged from the pandemic and pandemic-era housing supports lapsed, the number of cost-burdened[117] rental households reached a record 21.6 million (roughly half of all renter households), the highest level since 2001, including 11.6 million who were severely cost burdened (defined as paying over 50 percent or more of income toward rent).[118] Most renter households below the poverty line spend at least half of their income on rent, with one in four

Low-Income and Minority Communities, 11 HARV. L. & POL'Y REV. ONLINE S1 11 (2017) [hereinafter *There's No Place Like Home*].

114 *See Health Justice Strategies*, *supra* note 23.

115 Matthew Hall & Emily Greenman, *Housing and Neighborhood Quality Among Undocumented Mexican and Central American Immigrants*, 42 SOC. SCI. RES. 1 (2013).

116 *There's No Place Like Home*, *supra* note 113; Benfer et al., *supra* note 1; Douglass S. Massey & Jonathan Tannen, *A Research Note on Trends in Black Hypersegregation*, 52 DEMOGRAPHY 1025 (2015); Douglas S. Massey, *American Apartheid: Segregation and the Making of the Underclass*, 95 AM. J. OF SOCIO. 1153 (1990); Douglas S. Massey & Nancy A. Denton, *Hypersegregation in U.S. Metropolitan Areas: Black and Hispanic Segregation Along Five Dimensions*, 26 DEMOGRAPHY 373 (1989); DOUGLAS S. MASSEY & NANCY A. DENTON, AMERICAN APARTHEID: SEGREGATION AND THE MAKING OF THE UNDERCLASS (1998); Douglas S. Massey & Mary J. Fischer, *How Segregation Concentrates Poverty*, 23 ETHNIC & RACIAL STUD. 670 (2000).

117 Cost-burdened is defined as those spending more than 30 percent of their income on housing. Molly Cromwell, *Renters More Likely Than Homeowners to Spend More Than 30% of Income on Housing in Almost All Counties*, U.S. CENSUS BUREAU (Dec. 8, 2022), https://www.census.gov/library/stories/2022/12/housing-costs-burden.html; *see* Sean Veal & Jonathan Spader, *Nearly a Third of Americans Were Cost Burdened Last Year*, HARV. JOINT CTR. FOR HOUS. STUD. (Dec. 7, 2018), https://www.jchs.harvard.edu/blog/more-than-a-third-of-american-households-were-cost-burdened-last-year.

118 THE STATE OF THE NATION'S HOUSING 2023, HARV. JOINT CTR. FOR HOUS. STUD. (2023), https://www.jchs.harvard.edu/sites/default/files/reports/files/Harvard_JCHS_The_State_of_the_Nations_Housing_2023.pdf.

spending over 70 percent of their income on housing costs.[119] Between the scarcity of federal assistance and the loss of nearly four million affordable housing units over the last decade,[120] many renters were at heightened risk of housing instability prior to the economic recession of 2020. The current housing shortfall is substantial with a deficit of 1.5 million units generally,[121] and a shortage of 7.3 million affordable and available rental homes for extremely low-income renters.[122] To date, no state has an adequate supply of affordable and available housing for low-income renters.[123]

At the same time, every region of the country has experienced a surge in rent, with median rent more than doubling in the last two decades. In the first quarter of 2022, rental prices increased by 15.3 percent year over year, the highest increase in more than 20 years.[124] Between the first quarter of 2020 and the first quarter of 2023, rental prices rose 23.9 percent.[125] The rate of tenant exploitation[126] and inflated rental prices is higher in low-income neighborhoods and neighborhoods with high concentrations of African Americans.[127] Other intermediary determinants of health, including lack of annual earnings gains and stagnant incomes for many American families, increase housing precarity for many Americans.[128]

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119 U.S. CENSUS BUREAU, AMERICAN HOUS. SURVEY, TABLE 10 (2017).

120 THE STATE OF THE NATION'S HOUSING 2023, *supra* note 118.

121 *Id.*

122 ANDREW AURAND ET AL., NAT'L LOW INCOME HOUS. COAL. THE GAP: A SHORTAGE OF AFFORDABLE HOMES (2023), https://nlihc.org/gap.

123 *Id.*; LOURDES ASHLEY HUNTER ET AL., SOCIAL JUSTICE SEXUALITY PROJECT, INTERSECTING INJUSTICE: A NATIONAL CALL TO ACTION: ADDRESSING LGBTQ POVERTY AND ECONOMIC JUSTICE FOR ALL (2018).

124 *On the Brink of Homelessness: How the Affordable Housing Crisis and the Gentrification of America Is Leaving Families Vulnerable: Hearing Before the H. Fin. Serv. Comm.,*116th Cong. 2 (2020) (statement of Matthew Desmond, Principal Investigator, Eviction Lab Princeton University) [hereinafter *On the Brink of Homelessness*]; THE STATE OF THE NATION'S HOUSING 2023, *supra* note 118, at 1.

125 THE STATE OF THE NATION'S HOUSING 2023, *supra* note 118, at 2.

126 Tenant exploitation is defined as being over charged relative to the market value of the property. Matthew Desmond & Nathan Wilmers, *Do the Poor Pay More for Housing? Exploitation, Profit, and Risk in Rental Markets*, 124 AM. J. SOCIOLOGY 1090 (2019).

127 *Id.* at 1113; *see also* THE STATE OF THE NATION'S HOUSING 2023, *supra* note 118.

128 *On the Brink of Homelessness, supra* note 124. Between 1980 and 2010, workers at the bottom 90 percent of the workforce realized annual earnings gains of only 50 percent. *Id.* Post-pandemic, in 2023, the Economic Policy Institute determined that 19.5 million American workers still earn less than $15 per hour, with 18 percent of Black and Hispanic workers under this threshold, compared to 12 percent of white workers. *Low-Wage Workforce Tracker*, ECON. POL'Y INST. (Apr. 2023), https://economic.github.io/low_wage_workforce; *see also* OXFAM AM., FEW REWARDS: AN AGENDA TO GIVE AMERICA'S WORKING POOR A RAISE (June 22, 2016) https://s3.amazonaws.com/oxfam-us/www/static/media/files/Few_Rewards_Report_2016_web.pdf.

Yet, there is a lack of federal funding to ensure the affordability of housing: only one in four eligible households receive federal financial rental assistance, with Black households disproportionately represented on waitlists.[129] Even the lucky few who receive rental assistance often struggle to obtain housing due to barriers that include landlord unwillingness to accept vouchers (denial rates were as high as 78 percent in one study), short lease terms that necessitate constant searching for new housing, and substandard conditions in available housing that pose risks to health and safety.[130]

The shortage of affordable and available rental housing disproportionately affects Black, Latino, and Indigenous households, with low-income renters making up 19 percent of Black non-Latino households, 17 percent of American Indian or Alaska Native households, and 14 percent of Latino households, compared to only 6 percent of white non-Latino households.[131] The combination of these factors place renters of color at the highest risk of eviction and housing insecurity.

IV. EVICTION AS A STRUCTURAL DETERMINANT OF HEALTH INEQUITY

The negative impact of eviction on health equity and well-being is not merely a byproduct of the intermediary determinants of health described in Part III, such as housing stability and access, affordability, and conditions. Applying the WHO Conceptual SDOH Model, these are all material circumstances that are directly influenced by structural determinants of health inequity, which include socioeconomic and political elements, as well as subordination and disempowerment. As a whole, the American eviction system operates as a structural determinant of health inequity, influenced by socioeconomic and political contexts, that perpetuates the disproportionate rate of eviction among Black renters. Structural determinants of health inequity do not require individual action or intent. Rather, in the eviction context, the whole system, including laws, policies, processes, practices, and entrenched norms, perpetuates widespread

129 "With just one of every four income-eligible households receiving rental assistance, there are also not enough subsidies to bridge the gap between rents and what these households can afford." THE STATE OF THE NATION'S HOUSING 2023, *supra* note 118, at 40; *see also* Sonya Acosta & Brianna Guerrero, *Long Waitlists for Housing Vouchers Show Pressing Unmet Need for Assistance*, CTR. ON BUDGET & POL'Y PRIORITIES (Oct. 6, 2021), https://www.cbpp.org/research/housing/long-waitlists-for-housing-vouchers-show-pressing-unmet-need-for-assistance.

130 *See* MARY CUNNINGHAM ET AL., U.S. DEP'T HOUS. & URBAN DEV., A PILOT STUDY OF LANDLORD ACCEPTANCE OF HOUSING CHOICE VOUCHERS 3 (2018); Abby Vesoulis, *Including Housing Voucher Funds in Democrats' Reconciliation Bill is the First Challenge. Getting Landlords to Accept Them is Another*, TIME (Oct. 4, 2021, 6:00 PM), https://time.com/6103813/housing-voucher-problem; Teresa Wiltz, *Getting a Section 8 Voucher Is Hard. Finding a Landlord Willing to Accept It Is Harder.*, STATELINE (Aug. 31, 2018 12:00 AM), https://stateline.org/2018/08/31/getting-a-section-8-voucher-is-hard-finding-a-landlord-willing-to-accept-it-is-harder.

131 AURAND ET AL., *supra* note 122.

health inequity.[132] Where laws and policies (formal or informal) disproportionately and negatively affect a specific race, as eviction disproportionately affects Black renters, they operate as structural racism. Structural racism is pervasive and self-perpetuating, as it is constantly "reconstituting the conditions necessary to ensure [its] perpetuation."[133] It is the "most influential . . . level[] at which racism may affect racial and ethnic health inequities."[134] Structural racism "is also present in housing decisions that seem 'neutral' but disproportionately harm low-income individuals and people of color."[135] As described below, eviction law, policy and practice has consistently had a negative impact on the health and well-being of historically marginalized groups.[136]

A. Historical Political Context of Landlord-Tenant Law

Eviction law descends from feudal and common law property principles, where tenants had few (if any) rights: tenants paid rent and accepted hazards on the property, and landlords had the ability to forcibly eject tenants from the property at will.[137] As the Supreme Court noted in *Lindsey v. Normet*, "[t]he landlord-tenant relationship was one of the few areas where the right to self-help was recognized by the common law of most States, and the implementation of this right has been fraught with 'violence and quarrels and bloodshed.'"[138] Because the lease was solely a property interest, independent of habitability, the tenant accepted any defects in the apartment and the landlord remained immune from tort liability for any harm the property caused the tenant. In the late eighteenth and early-to-mid-nineteenth century, summary judgment proceeding statutes were adopted by the "white male property-owning electorate, who were themselves white male property owners," to provide landowners with immediate possession of the property.[139] While the move reduced violent expulsions from property, it cemented

132 Gilbert C. Gee & Chandra L. Ford, *Structural Racism and Health Inequities*, 8 DU BOIS REV. 115 (2011) [hereinafter *Structural Racism and Health Inequities*]; *see also* Madina Agénor et al., *Developing a Database of Structural Racism–Related State Laws for Health Equity Research and Practice in the United States*, 136 PUB. HEALTH REPS. 428 (2021).

133 *Structural Racism and Health Inequities*, *supra* note 132 (citing Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. 80 (1995)).

134 *Id.*; Zinzi D. Bailey, Justin M. Feldman & Mary T. Bassett, *How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities*, 384 N. ENG. J. MED. 768 (2021).

135 *Health Justice Strategies*, *supra* note 23, at 157.

136 Ruqaiijah Yearby, *Racial Disparities in Health Status and Access to Health Care: The Continuation of Inequality in the United States Due to Structural Racism*, 77 AM. J. ECON. & SOC. 1113 (2018).

137 Javins v. First Nat'l Realty Corp., 428 F.2d 1071 (D.C. Cir. 1970).

138 Lindsey v. Normet, 405 U.S. 56 (1972) (citing Entelman v. Hagood, 95 Ga. 390, 392 (1895)).

139 Andrew Scherer, *The Case Against Summary Eviction Proceedings: Process as Racism and*

the landlords' power over the tenant's access to the property.

The tension between a tenant's housing rights and a landlord's property and economic interests has been present throughout U.S. history. A century ago, during times of economic distress, renting families frequently doubled and tripled up and endured hazardous and even life-threatening conditions.[140] Before legal reform, poor sanitary conditions—like standing water, rotted floorboards, infestations, and inoperable or nonexistent toilets—led to chronic and serious illness among families.[141] Where tenants were behind on rent, landlords shut off heat and water or went to extreme measures, such as removing windowpanes to freeze tenants out.[142] Tenants were frequently forced out of their homes without recourse. During the Great Depression, eviction and housing displacement increased due to prolonged unemployment and local governments' prioritization of food subsidies over rental assistance.[143] In 1933, 1 in every 6 families in Philadelphia, Pennsylvania, was forced out of their home and evictions increased by 100 percent over two years in Chicago, Illinois.[144] In response to squalid conditions, abject poverty, and forced evictions, protests erupted, often drawing thousands of people.[145] In Chicago, over 2,000 people fought an eviction by moving the evicted family's belongings back into the building.[146] The protests drew citywide attention to the plight of tenants and prompted the bailiff of Chicago's renters court to withhold service of eviction warrants until "every humane consideration" could be given to the families at risk of harm.[147]

Sweeping reform of landlord-tenant law, often attributed to the Civil Rights Movement, arrived on a national scale in the late 1960s and early 1970s when some of the earliest rent control[148] and tenant protections were adopted.[149] State and federal lawmakers adopted antidiscrimination laws and prohibitions against retaliatory eviction.[150] Jurisdictions reformed forcible entry and detainer laws,

Oppression, 53 SETON HALL L. REV. 1, 55 (2022).

140 Edith Abbott & Katherine Kiesling, *Evictions During the Chicago Rent Moratorium Established by the Relief Agencies, 1931-33*, 9 SOC. SERV. REV. 34, 54 (1935).

141 *Id.* at 56–57.

142 *Id.* at 41–42.

143 *Id.* at 37.

144 *Id.* at 52, 57.

145 *Id.* at 35.

146 *Id.*

147 *Id.*

148 The earliest and typically temporary rent control laws were adopted during World War II and justified by the "emergencies growing out of the War, resulting in rental conditions dangerous to the public health . . ." *See, e.g.*, Block v. Hirsch, 25 U.S. 135 (1921).

149 Symposium, *Revolution in Residential Landlord-Tenant Law: Causes and Consequences*, 69 CORNELL L. REV. 517 (1984).

150 42 U.S.C. §§ 3601-3619 (1968); *see also* Michelle Adams, *The Unfulfilled Promise of the Fair Housing Act*, THE NEW YORKER (Apr. 11, 2018) https://www.newyorker.com/news/news-desk/the-unfulfilled-promise-of-the-fair-housing-act; Fred McGhee, *The Most Important Housing*

treating leases as contracts with mutual obligations, as opposed to conveyances.[151] These shifts helped to prevent, but did not eliminate, the detrimental ramifications of extrajudicial informal ("self-help") evictions that occur when landlords force tenants to vacate the unit through coercive tactics outside the formal legal process—like making the property unsafe, denying utilities, changing locks, raising rents, threatening eviction, harassment, intimidation, and other measures designed to force a tenant to leave.[152] In addition, the warranty of habitability was implied in nearly every lease,[153] and landlords could be held accountable for tort violations. By 1968, nearly 5,000 communities had mandated housing standards, up from just over fifty in 1956.[154]

However, even with increased habitability standards and improvements to forcible entry and detainer laws, many tenants are denied substantive and procedural justice. Although landlords in the vast majority of states are now prohibited from engaging in extrajudicial evictions that evict a tenant outside of the legal process, these "self-help" evictions are thought to be widespread, and indeed may be considerably more common than court-ordered formal evictions.[155] In addition, the lease contract between tenants and landlords can contain terms that are unfavorable to tenants: a study by Professor David Hoffman found that the majority of people facing eviction during the study period had signed a lease containing exculpatory and unfair clauses that waived the tenant's right to notice and required acceptance of the premises "as is."[156] Similarly, while many communities have adopted housing codes, they are rarely enforced, and tenants

Law Passed in 1968 Wasn't the Fair Housing Act, SHELTER FORCE, (Sept. 5, 2018) https://shelterforce.org/2018/09/05/the-most-important-housing-law-passed-in-1968-wasnt-the-fair-housing-act; *Fair Housing Act Overview and Challenges*, NAT'L LOW INCOME HOUS. COAL. (Oct. 23, 2018), https://nlihc.org/resource/fair-housing-act-overview-and-challenges.

151 Scherer, *supra* note 139, at 6.

152 735 ILL. COMP. STAT. 5/9-101 (2015); Robinson v. Chi. Hous. Auth., 54 F.3d 316, 321–22 (7th Cir. 1995); LAWYERS' COMM. FOR BETTER HOUS., NO TIME FOR JUSTICE: A STUDY OF CHICAGO'S EVICTION COURT 6 (Dec. 2003), http://lcbh.org/sites/default/files/ resources/ 2003-lcbh-chicago-eviction-court-study.pdf [hereinafter NO TIME FOR JUSTICE]; *see generally* Randy G. Gerchick*, No Easy Way Out: Making the Summary Eviction Process a Fairer and More Efficient Alternative to Landlord Self-Help*, 41 UCLA L. REV. 759 (1994).

153 Javins v. First Nat'l Realty Corp., 428 F.2d 1071 (D.C. Cir. 1970); Paula A. Franzese, Gorin Abbott & David J. Guzik, *The Implied Warranty of Habitability Lives: Making Real the Promise of Landlord-Tenant Reform*, 69 RUTGERS L. REV. 1 (2016); Nicole Summers, *The Limits of Good Law: A Study of Housing Court Outcomes*, 87 UNIV. CHI. L. REV. 145 (2020).

154 *Revolution in Residential Landlord-Tenant Law: Causes and Consequences*, *supra* note 149, at 551; *see also* NYU FURMAN CTR., CRACKING CODE ENFORCEMENT: HOW CITIES APPROACH HOUSING STANDARDS (Aug. 2021), https://furmancenter.org/files/Up_To_Code-How_Cities_Enforce_Housing_Standards_Final.pdf.

155 Desmond & Shollenberger, *supra* note 97.

156 David Hoffman & Anton Strezhnev, *Leases as Forms*, 19 J. EMPIRICAL LEG. STUD. 90 (2022).

often lack enforcement powers.[157] Today, despite policy advances and meritorious tenant claims, researchers have determined that the warranty of habitability is rarely upheld[158] and building codes are underenforced,[159] resulting in negative health outcomes for renters and retaliatory eviction for tenants who request remediation.[160] While every jurisdiction, with the exception of Arkansas,[161] now has an implied (forty-nine states) and/or codified (forty-five states) warranty of habitability,[162] only a handful of states require a demonstration of building code compliance prior to renting a unit,[163] and states generally lack "clean hands" eviction laws that would require compliance with state and local housing codes before filing an eviction.[164] Even where tenants are afforded rights, it is generally impossible for them to assert those rights without legal counsel. While modern law has improved from archaic times, there is still ample room to address broad injustice and the harm it causes tenants.

B. Judicial Governance of the Eviction Process

Evictions fall into three categories: court-ordered that occur through a court process; extrajudicial ("self-help") evictions wherein the landlord takes measures to forcibly remove or compel the tenant to vacate;[165] and administrative evictions

157 *See* Kathryn A. Sabbeth, *(Under)Enforcement of Poor Tenants' Rights*, 27 GEO. J. POVERTY L. & POL'Y 97 (2019); Summers, *supra* note 153; Jessica K. Steinberg, *Informal, Inquisitorial, and Accurate: An Empirical Look at a Problem-Solving Housing Court*, 42 LAW & SOC. INQUIRY 1058 (2017).

158 Summers, *supra* note 153; Franzese, Abbott & Guzik., *supra* note 153; Michele Cotton, *When Judges Don't Follow the Law: Research and Recommendations*, 19 CUNY L. REV. 57, 67–69 (2015).

159 *See* Sabbeth, *supra* note 157; *see generally* ROBIN BARTRAM, STACKED DECKS: BUILDING INSPECTORS AND THE REPRODUCTION OF URBAN POVERTY (2022).

160 Evan Lemire et al., *Unequal Housing Conditions and Code Enforcement Contribute to Asthma Disparities in Boston, Massachusetts*, 41 HEALTH AFFS. 563 (2022); *There's No Place Like Home*, *supra* note 113.

161 Ashley E. Bachelder et al., *Health Complaints Associated with Poor Rental Housing Conditions in Arkansas: The Only State Without a Landlord's Implied Warranty of Habitability*, 4 FRONTIERS PUB. HEALTH 226642 (2016).

162 Memorandum from Alice Noble-Allgire, Reporter, to Members of the URLTA Drafting Comm. (Feb. 12, 2012), https://www.nhlp.org/wp-content/uploads/Research-Memo-re-50-State-Survey-of-the-Warranty-of-Habitability.pdf.

163 *Id.*; *There's No Place Like Home*, *supra* note 113; Emily A. Benfer et al., *Health Justice Strategies to Eradicate Lead Poisoning: An Urgent Call to Action to Safeguard Future Generations*, 19 YALE J. HEALTH POL'Y, L. & ETHICS 146 (2020).

164 A New York bill proposed landlords must be free of all outstanding building code violations to proceed with an eviction proceeding. S.B. 4788, 2019 GEN. ASSEMB., REG. SESS. (N.Y. 2019); *There's No Place Like Home*, *supra* note 113.

165 Based on jurisdiction and method of study, extrajudicial evictions are estimated to occur at anywhere from twice to five times the rate of formal evictions. Sabiha Zainulbhai & Nora Daly, *Informal Evictions: Measuring Displacement Outside the Courtroom* (last updated Jan. 20, 2022),

that allow public housing authorities ("PHA") in certain jurisdictions to terminate the tenancy of a public housing resident.[166] This section focuses primarily on the first category, court-ordered evictions.

The court-based eviction process is governed by varied state and local law and can generally be divided into five stages, which are described in greater detail below: (1) the landlord provides their tenants with a notice of intent to terminate the tenancy; (2) the landlord files the eviction case with the court; (3) the court holds a hearing; (4) the court issues a judgment and orders a writ of eviction; (5) if the judgment is in the landlord's favor, law enforcement or other contracted parties, who can be armed, execute the order of eviction by removing the tenant and their belongings from the property.[167] (See Figure 4)

In each of the stages of eviction, the exact process differs from state to state and even across local jurisdictions,[168] including variation in the type of notice required, the cost of filing an eviction, the time between notice and filing, the hearing process and access, and possible causes of action.[169] Some states, such as California, adopted extensive tenant defenses and sealing of eviction cases until and unless the landlord prevails in court.[170] Other states, like Kansas, have adopted policies, such as low filing fees (as low as $25), and maintain a public record of all landlord-tenant filings.[171] This allows for low cost evictions and easy identification of tenants with a history of interacting with the eviction court system. Across states, confusing and inconsistent rules, asymmetrical legal representation across parties, along with shadow procedures and hallway settlements, create power imbalances between landlords and tenants.[172]

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https://www.newamerica.org/future-land-housing/reports/informal-evictions-measuring-housing-displacement-outside-the-courtroom.

166 OFF. OF POL'Y DEV. & RSCH., REPORT TO CONGRESS ON THE FEASIBILITY OF CREATING A NATIONAL EVICTIONS DATABASE, U.S. DEP'T OF HOUS. & URB. DEV. (2021).

167 *COVID-19 Housing Policy*, *supra* note 2.

168 Megan E. Hatch, *Statutory Protection for Renters: Classification of State Landlord–Tenant Policy Approaches*, 27 HOUS. POL'Y DEBATE 98 (2017).

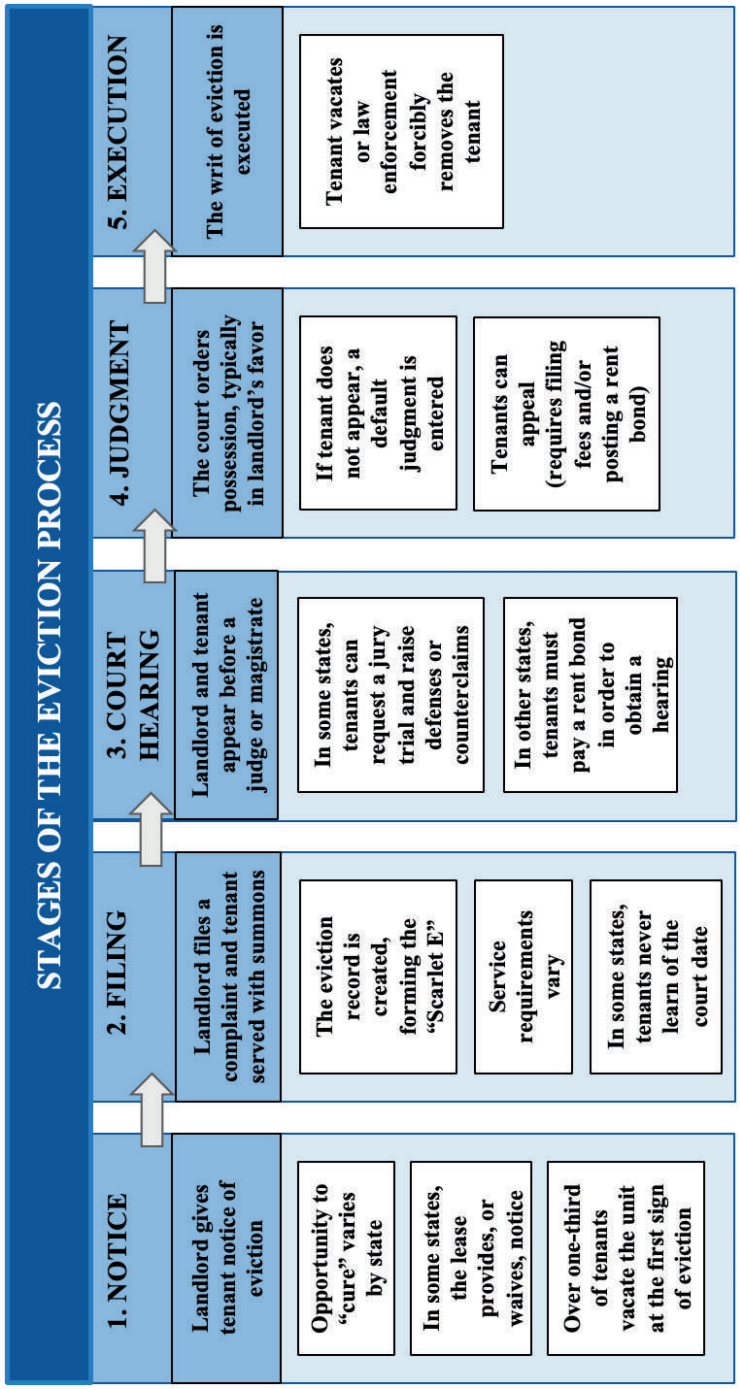
169 *Id.*; *Residential Eviction Laws in 40 U.S. Cities*, THE POL'Y SURVEILLANCE PROGRAM (Aug. 1, 2018), https://lawatlas.org/datasets/eviction-laws-1530797420; Sabbeth, *supra* note 157.

170 Emily A. Benfer, *The American Eviction Crisis, Explained*, THE APPEAL (Mar. 3, 2021), https://theappeal.org/the-lab/explainers/the-american-eviction-crisis-explained.

171 *Id.*

172 Isaiah Fleming-Klink, Brian J. McCabe & Eva Rosen, *Navigating an Overburdened Courtroom: How Inconsistent Rules, Shadow Procedures, and Social Capital Disadvantage Tenants in Eviction Court*, 22 CITY & CMTY. 220 (2015).

Figure 4. Forcible Entry and Detainer: Stages of the Eviction Process



In the first stage, the landlord provides the tenant with a notice of the landlord's intent to terminate the tenancy.[173] Tenants' ability to cure any violation described in the notice varies by jurisdiction.[174] In some jurisdictions, the notice is included in the lease and the landlord can move immediately to stage two.[175] Researchers have determined that even small increases in the notice period decreases the eviction filing rate.[176] Many tenants vacate the property at the notice stage, likely to avoid the damaging eviction record and judgment and seeing no alternative.[177]

Second, the landlord files the eviction complaint with the court and the tenant is served a summons.[178] Few jurisdictions shield infants and children from being named as defendants in the complaint. This has the effect of creating an intimidation tactic and weaponizing the eviction process.[179] In some jurisdictions, all members of the household must be named, despite child protection and privacy considerations, before a warrant of eviction can be executed. For example, in New York, state warrant law requires that all members of the household, including minors, be listed as defendants for any warrant to be enforceable.[180] While this law was adopted to provide increased protection to household members who might not otherwise receive notice, in some cases, it has had negative consequences. Housing attorneys have anecdotally reported that children are being listed as defendants in multiple states and jurisdictions.[181]

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173 *Id.*

174 Sarah Abdelhadi, *LSC Eviction Laws Database*, LEG. SERVS. CORP., https://lsc.gov/initiatives/effect-state-local-laws-evictions/lsc-eviction-laws-database (last visited July 27, 2023); Hatch, *supra* note 168.

175 Abdelhadi, *supra* note 174.

176 GROMIS ET AL., *supra* note 99, at 6.

177 A tenant vacating a unit in response to a notice is an example of extrajudicial (or informal) evictions. Thanks to the lack of legal records on this type of eviction, it is difficult to say exactly what proportion of tenants experience this particular eviction pathway. However, data collected in the Milwaukee Area Renter's Study found that 34% of tenants moved out without going to court after receiving eviction notice. *See* Desmond & Shollenberger, *supra* note 987, at 1754-55; @just_shelter, TWITTER (Jan. 28, 2021, 5:51 PM), https://twitter.com/just_shelter/status/13549251 82499102722?s =20.

178 *COVID-19 Housing Policy*, *supra* note 2.

179 Kathryn A. Sabbeth, *Erasing the "Scarlet E" of Eviction Records*, THE APPEAL (Apr. 12, 2021) https://theappeal.org/the-lab/report/erasing-the-scarlet-e-of-eviction-records.

180 In 2019, the New York legislature amended the relevant law to state that the court shall issue a warrant "commanding the officer to remove all persons *named in the proceeding*." N.Y. REAL PROP. ACTIONS & PROCEEDINGS § 749(1) (emphasis added).

181 Civil Court of the City of New York held that New York State's warrant law, N.Y. REAL PROP. ACTS. § 749, applies to children in eviction cases, despite confidentiality laws protecting children's identity. *See* Dunn v. 583 Riverside Drive LP, 117 N.Y.S.3d 524 (N.Y. Civ. Ct. 2019). However, in January 2021, Massachusetts passed a law prohibiting landlords from naming minors in eviction filings. 2020 Mass. Acts. 358.

The service requirements at the filing stage are state specific and can be inconsistently followed, resulting in meager attempts to inform tenants of their eviction hearing and some tenants never learning of the hearing at all.[182] The amount of time between the summons and the hearing also varies by state, which may factor into the default rate among tenants who may need to secure childcare, time off work, legal representation, and transportation, or overcome other barriers. The allowable service methods, which include sending via uncertified mail or posting on the property, are arguably substandard from legal norms.[183] While the notice periods in the summons vary by state, the typical timeframe is truncated to three to fourteen days prior to the hearing, compared to twenty to thirty days in general civil litigation.[184] All of these factors contribute to high default rates. In Dr. Matthew Desmond's pivotal book, "Evicted," approximately 70 percent of tenants in Milwaukee did not appear at their eviction hearing, which resulted in the majority of tenants being evicted.[185]

Third, the court holds a summary hearing.[186] Eviction dockets are designed to be fast and high volume. Across court watch studies, the average hearing lasts between ninety seconds and three minutes and twenty-one seconds, and a typical urban court hears an average of 40-100 cases a day.[187] In Chicago, hearings lasted an average of one minute and forty-four seconds (and if a landlord was represented by an attorney, the hearing was even shorter).[188] In Cleveland eviction hearings lasted an average of one minute and fifty-one seconds when only the landlords was present[189] and five minutes and fifty seconds when the tenant appeared.[190] In Maricopa County, Arizona (population four million),[191] most eviction hearings

182 Josh Kaplan, *Thousands of D.C. Renters Are Evicted Every Year. Do They All Know To Show Up To Court?*, DCIST (Oct. 5, 2020 1:43 PM), https://dcist.com/story/20/10/05/thousands-of-d-c-renters-are-evicted-every-year-do-they-all-know-to-show-up-to-court; The Editorial Board, *Evicted without Warning*, PHILA. INQUIRER (July 28, 2020 5:00 AM), https://www.inquirer.com/opinion/editorials/a/philadelphia-eviction-system-philly-renters-tenants-blindsided-20200728.html.

183 Kathryn A. Sabbeth, *Eviction Courts*, 18 U. ST. THOMAS L. J. 359 (2022).

184 *Id.*; Abdelhadi, *supra* note 174. This timeframe has been upheld by the Supreme Court as constitutional. Lindsey v. Normet, 405 U.S. 56 (1972).

185 MATTHEW DESMOND, EVICTED: POVERTY AND PROFIT IN THE AMERICAN CITY 96 (2016).

186 *COVID-19 Housing Policy*, *supra* note 2.

187 *See, e.g.*, R.A. Schuetz, *Harris County's Growing Eviction Dockets Means Many Cases are Decided in Less Than 90 Seconds*, HOUS. CHRON. (Feb. 15, 2023), https://www.houstonchronicle.com/news/houston-texas/housing/article/harris-county-evictions-process-court-docket-17782265.php; Texas Housers Staff, *'Case Dismissed!' What Does This Mean for Tenants in Eviction Hearings?*, TX. HOUSERS (June 14, 2022), https://texashousers.org/2022/06/14/tenant-eviction-hearing-case-dismissal; APRIL HIRSH URBAN ET AL., CTR. ON URB. POVERTY & COMM. DEV., CASE WESTERN RESERVE UNIV., THE CLEVELAND EVICTION STUDY: OBSERVATIONS IN EVICTION COURT AND THE STORIES OF PEOPLE FACING EVICTION 22 (Oct. 2019).

188 NO TIME FOR JUSTICE, *supra* note 152, at 11.

189 URBAN ET AL., *supra* note 187, at 22.

190 *Id.*

191 *QuickFacts: Maricopa County, Arizona*, U.S. CENSUS BUREAU, https://www.census.gov/

concluded in less than a minute, with many only lasting around twenty seconds.[192]

The rapid pace also furthers inequities between parties: Professor Kathryn Sabbeth's research found that "[s]peedy processes not only sacrifice careful analyses and accurate outcomes, but also they increase the bargaining power of plaintiffs[,]. . .carr[y] implications for the out-of-court relationship between parties[,]. . .[and] underscore the role that the state plays in those relationships."[193] The majority of cases are decided in the landlords' favor, even where habitability claims or other legitimate defenses are raised.[194] For example, in a study of Los Angeles court data, 99 percent of unrepresented tenants were displaced.[195]

Fourth, the court issues a judgment and orders a writ of eviction. Failure to appear almost always results in a default judgment against the tenant and often without a hearing, with default rates ranging from 50 to 90 percent across available studies.[196] Typically, tenants do not have an opportunity to seek a hearing after a default judgment. In the few exceptions, the demonstration of evidence required may be prohibitory.[197] For example, the Philadelphia policy states, "If you are late or fail to appear, a default judgment will be entered against you. The court will send you a notice that a default judgment has been entered against you. You may file a petition to open the default judgment . . . You must have a good reason for missing or being late for the trial, must file the petition promptly after learning of the default judgment, and must have a valid, meritorious claim or defense."[198]

Finally, if the judgment is in the landlord's favor, law enforcement or other contracted parties execute the order of eviction.[199] In some jurisdictions, such as Philadelphia, evictions are performed by private armed deputies, who are not required to have law enforcement credentials, to perform the eviction.[200] In Philadelphia, the practice proved life-threatening when a tenant was shot in the head and left in critical condition in March of 2023.[201]

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quickfacts/fact/table/maricopacountyarizona (last visited Aug. 3, 2020).

192 WILLIAM E. MORRIS INST. FOR JUST., INJUSTICE IN NO TIME: THE EXPERIENCE OF TENANTS IN MARICOPA COUNTY JUSTICE COURTS 2 (June 2005).

193 *See* Sabbeth, *supra* note 183, at 378.

194 *See* Lindsey v. Normet, 405 U.S. 56 (1972).

195 *Id.*

196 *See* Sabbeth, *supra* note 183, at 380.

197 *Id.*

198 PHILA. MUN. CT., INFORMATION FOR LANDLORD-TENANT COURT, https://www.courts.phila.gov/pdf/brochures/mc/LANDLORD-TENANT-PAMPHLET.pdf.

199 *COVID-19 Housing Policy*, *supra* note 2.

200 Ryan Briggs, *City Council to Investigate Officer that Executes Court's Evictions, Citing 'Conflicts of Interest'*, WHYY (Sept. 17, 2020), https://whyy.org/articles/city-council-to-investigate-officer-that-executes-courts-evictions-citing-conflicts-of-interest.

201 Kaleah Mcilwain, *Philly Woman Shot in the Head During Eviction Sues Landlord-Tenant Officer*, NBC10 PHILA. (July 25, 2023 7:24 PM), https://www.nbcphiladelphia.com/news/local/philly-woman-shot-in-the-head-during-eviction-sues-landlord-tenant-officer-officials-

Justice Douglas' 1967 description of the eviction process, in his dissent to *Williams v. Shaffer*, holds true today: "Summary eviction proceedings are the order of the day. Default judgments in eviction proceedings are obtained in machinegun rapidity since the indigent cannot afford counsel to defend. Housing laws often have a built-in bias against the poor. Slumlords have a tight hold on the Nation."[202]

The substantial role of the court in facilitating the eviction system is noteworthy. The adjudicator in a forcible entry and detainer case varies by jurisdiction and influences the balance of the proceeding. Adjudicators may be elected officials and there is no restriction against the adjudicator being a property owner or landlord. The qualifications to preside over an eviction court range from a law degree for a judge to a high school diploma for a magistrate.[203] A recent qualitative study of eviction court judges in Georgia and Florida elucidates how courts can cater to landlord expectations and prioritize landlord engagement through a shared understanding of a fast court process: "You have to get them to trust that you're going to keep their cases moving . . ." [204] The study also uncovered heightened sensitivity to how landlords would respond: "[M]y judges were very well versed on how to keep those cases moving in a way that didn't scare off the landlord, for lack of a more lawyerly [sic] to say it."[205] In another example, a judge rejected the notion that they could provide tenants with information about their rights: "It's not my job to say, 'Hey, if you want to stop this, you can file this.' How do I have credibility with my landlords?"[206] The attitude of adjudicators reflects the reality that landlords (and their lawyers) largely drive the eviction process and the court's approach to the process.

Lack of legal representation contributes to the low standard of equity and balance in the eviction system. In 2017, the Legal Services Corporation reported that 86 percent of all civil legal problems for low-income people nationwide receive insufficient help or no help at all.[207] Nationwide, across studies, estimates suggest that only 3 percent of tenants have legal representation in an eviction proceeding, compared to 83 percent of landlords.[208] Without legal representation, tenants are often ill-equipped to navigate complex housing laws and the expedited

call-for-reform/3611606.

202 Williams v. Shaffer, 385 U.S. 1035 (1967) (Douglas, J., dissenting).

203 Research on file with author.

204 Lauren Sudeall, Elora Lee Raymond & Phillip M.E. Garboden, *Disaster Discordance: Local Court Implementation of State and Federal Eviction Prevention Policies During COVID-19*, 30 GEO. J. POVERTY L. & POL'Y 545 (2022).

205 *Id.* at 575.

206 *Id.* at 576.

207 LEG. SERVS. CORP., THE JUSTICE GAP: MEASURING THE UNMET CIVIL LEGAL NEEDS OF LOW-INCOME AMERICANS 6 (2017).

208 *Eviction Representation Statistics for Landlords and Tenants Absent Special Intervention*, NAT'L COAL. FOR THE CIV. RIGHT TO COUNS., http://civilrighttocounsel.org/uploaded_files/280/Landlord_and_tenant_eviction_rep_stats__NCCRC_.pdf (Mar. 2024).

summary judgment proceeding that is designed in favor of landlords' interests.[209] Where tenants are unrepresented, the majority lose their case.[210] Notably, interviews of tenant attorneys in some tenant right to counsel jurisdictions revealed that when tenant representation increased the court process itself shifted, resulting in the court's willingness to grant continuances and postpone hearings to allow tenants to secure counsel.[211]

At the same time, unwritten rules and informal processes leave unrepresented tenants at a disadvantage relative to landlords.[212] A pre-pandemic study of Chicago's eviction court is demonstrative of the system's slant towards landlords.[213] Researchers observed that landlords were rarely required to meet the burden of proof necessary to support an order of possession.[214] Even where testimony is required, parties were sworn in and asked to take an oath to tell the truth in only 8 percent of cases.[215] Although a notice of eviction must comply with procedural due process notice requirements,[216] a judge examined these notices in only 65 percent of cases.[217] Cases should be dismissed if the landlord is not present, but they were only dismissed in 60 percent of cases when a landlord failed to appear.[218] Judges asked tenants if they had a defense[219] in only 27 percent of cases.[220] When asked, tenants offered a legitimate defense in 55 percent of cases, yet all of these tenants were evicted.[221]

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209 Scherer, *supra* note 139; Matthew Desmond, *Tipping the Scales in Housing Court*, N.Y. TIMES (June 29, 2012), https://www.nytimes.com/2012/11/30/opinion/tipping-the-scales-in-housing-court.html; *Unaffordable America*, *supra* note 84.

210 *See, e.g.*, D. James Greiner, Cassandra Wolos Pattanayak & Jonathan Hennessy, *The Limits of Unbundled Legal Assistance: A Randomized Study in a Massachusetts District Court and Prospects for the Future*, 126 HARV. L. REV. 901, 903 (2012).

211 Conclusion drawn from an ongoing study; interview notes are on file with the author.

212 Fleming-Klink, McCabe & Rosen, *supra* note 172; Lauren Sudeall & Daniel Pasciuti, *Praxis and Paradox: Inside the Black Box of Eviction Court*, 74 VAND. L. REV. 1365 (2021) (Court Watch Study in Suburban and Urban Eviction Courts in Georgia).

213 NO TIME FOR JUSTICE, *supra* note 152, at 7 (concluding that the data revealed by the study show that courts are far from achieving the goals of the hearings); *see also* Judith Fox, *The High Cost of Eviction: Struggling to Contain a Growing Social Problem*, 41 MITCHELL HAMLINE L. J. PUB. POL'Y PRAC. 167 (2020).

214 NO TIME FOR JUSTICE, *supra* note 152, at 14.

215 *Id.*

216 Forcible Entry and Detainer Act, 735 ILL. COMP. STAT. 5/9-104 (West 2015); *see* NO TIME FOR JUSTICE, *supra* note 152, at 7; *see also* 735 ILL. COMP. STAT. 5/9-209; CITY OF CHI. ILL., RESIDENTIAL LANDLORD & TENANT ORDINANCE, MUN. CODE CH. 5-12-130 (2015).

217 NO TIME FOR JUSTICE, *supra* note 152, at 6.

218 *Id.* at 17.

219 *See* CITY OF CHI. ILL., RESIDENTIAL LANDLORD & TENANT ORDINANCE, MUN. CODE CH. 5-12-110.

220 NO TIME FOR JUSTICE, *supra* note 152, at 6.

221 *Id.*

These outcomes, which are present in eviction courts across the country,[222] demonstrate that the eviction system is bereft of procedures that could guarantee fairness and justice. The system loses its legitimacy and integrity when landlords are not held to due process standards or required to prove all elements of their prima facie case, or when unrepresented tenants are not made aware of their rights or offered the opportunity to respond. These factors, combined with an apparent bias in favor of the landlord, strips the eviction system of the four crucial components of justice—equality, impartiality, transparency, and the fundamental right to be heard.[223] In this way, the eviction process itself functions as a structural determinant of health inequity that disadvantages tenants in legal forums and negatively impacts health and well-being, as state landlord-tenant laws prioritize the landlord's economic interest over the tenant's rights and housing stability.[224]

C. Eviction Laws and Policies

In the WHO Conceptual SDOH model, eviction laws, policies, practices, and their effects on other basic rights are all examples of the socioeconomic and political elements that perpetuate health inequity and reinforce social hierarchy, discrimination, as well as societal position by race, gender, and class. To further demonstrate how the eviction system operates as a structural and intermediary determinant of health inequity, this section examines the following eviction policies, practices, and effects: (1) "no fault" eviction; (2) extractive management strategies and unenforced habitability standards; (3) serial eviction filing; (4) rent bonds; (5) criminal eviction, crime-free rental properties, and nuisance ordinances; (6) voter suppression; and (7) screening practices.

1. "No Fault" Eviction

Overwhelmingly, state laws permit landlords to terminate the tenancy at the end of the lease term, a standard commonly referred to as "no fault" or "no cause" eviction.[225] The causes of action for an eviction lawsuit are usually based on

222 *See supra* notes 196-202, 223.

223 Lloyd T. Wilson, Jr., *The Beloved Community: The Influence and Legacy of Personalism in the Quest for Housing and Tenants' Rights*, 40 J. MARSHALL L.REV. 513, 530 (2007).

224 RANYA AHMED ET AL., LEG. SERVS. CORP., *A Common Story: The Eviction Process in Shelby County, TN*, *in* THE EFFECT OF STATE AND LOCAL LAWS ON EVICTIONS (2021).

225 *See, e.g.*, Cydney Adams, *How No-fault Evictions Are Contributing to LA's Homeless Crisis*, CBSNEWS (Feb. 24, 2019 7:00 AM) https://www.cbsnews.com/news/no-fault-evictions-priced-out-los-angeles-hidden-homeless-cbsn-originals. As of 2022, only five states had passed "just cause" legislation, which limits the causes for which a landlord can refuse to renew a tenant's lease, thereby promoting housing stability for renters who might otherwise face a no-fault eviction. JADE VASQUEZ & SARAH GALLAGHER, NAT'L LOW INCOME HOUS. COAL., PROMOTING HOUSING STABILITY THROUGH JUST CAUSE EVICTION LEGISLATION 2 (May 17, 2022).

nonpayment of rent, lease violations, holdovers past the lease term, and criminal activity. However, the majority of states allow a landlord to terminate the tenancy without providing a reason ("no fault") at the end of a lease term, or at the appropriate interval in a month-to-month or other periodic tenancy, after adhering to a statutorily prescribed notice period.[226] If the tenant refuses to vacate the unit, the landlord can then formally initiate the eviction process on the basis of a tenant's holdover past the lease term. "No fault" eviction laws not only disrupt housing stability, but they also cement the landlord's authority by providing a mechanism for legally forcing tenants who have complied with lease terms out of the unit. "No fault" evictions can also veil landlord retaliation and discriminatory practices, and circumvent federal and state fair housing laws.[227] As an advocate in Colorado noted, "under the current schema, landlords can refuse to renew leases for unlawful and discriminatory reasons and showing that the landlord's stated lawful reason is pretext is often an impossible battle. Just cause would make it more difficult for landlords to engage in discriminatory and unlawful conduct, or to terminate leases in retaliation for tenants exercising their rights."[228]

"No fault" eviction standards also allow property developers to profit from the displacement of whole communities without recourse. For example, in July 2023, in Chicago, where 1 in 4 evictions are filed after a "no fault" notice of termination, Levav Properties issued notices of "no fault" termination of tenancy to 120 households who resided in their recently acquired South Side Buildings in the Beverly community.[229] The common occurrence was described by Sharonda Whitehead, an 18-year resident of Beverly: "What word comes to mind is displacement. They think that we are disposable . . . we are veterans here. We are working-class people. We are taxpayers. We are voters. We have rights."[230]

During the COVID-19 pandemic, landlords were coached to rely on lease violations and "no fault" terminations of tenancy at the end of lease terms to avoid being subject to the CDC or state eviction moratoria, which typically only halted

226 Abdelhadi, *supra* note 174; Julieta Cuellar, *Effect of "Just Cause" Eviction Ordinances on Eviction in Four California Cities*, PRINCETON U. J. PUB. INT'L AFF. (May 21, 2019); *see also* "*Just Cause" Eviction Policies*, LOC. HOUS. SOLUTIONS, https://www.localhousingsolutions.org/act/housing-policy-library/just-cause-eviction-policies-overview/just-cause-eviction-policies (last visited July 21, 2023).

227 Greenberg et al., *supra* note 39.

228 Letter from the Nat'l Hous. L. Project, members of the Hous. Just. Network & Undersigned Orgs to Sandra Thompson, Fed. Hous. Fin. Agency (July 21, 2023), https://www.nhlp.org/wp-content/uploads/NHLP-Response-to-FHFA-RFI-on-Multifamily-Tenant-Protections.pdf.

229 Ilana Arougheti, *'We're on the Front Lines of Gentrification': Beverly Tenants Protest Mass Eviction in Six-Building Complex*, CHI. TRIB. (last updated July 24, 2023 2:46 PM), https://www.chicagotribune.com/business/ct-biz-beverly-tenants-organize-to-protest-mass-eviction-levav-properties-20230724-ya3wnoj3kjecnedyhpweslozqi-story.html.

230 *Id.*

eviction for nonpayment of rent, rather than other causes of action.[231] While the moratoria were in effect, landlords increasingly evicted tenants based on oftentimes trivial lease violations, which likely would have gone unnoticed prior to the pandemic-era partial bar on eviction, to remove renters with arrears while avoiding rental assistance programs or coverage of the eviction moratoria.[232] In Michigan, "no fault" evictions increased by 61 percent after the state's COVID-19 eviction relief program ("CERA") was adopted. Michigan's "no fault" eviction policy provided a "legal alternative for landlords who elect not to participate in the CERA program (due to program delays or requirements) and provide[d] a loophole for landlords seeking higher paying tenants amid the tightening pandemic-era housing market."[233]

One landlord attorney advised her clients to "pay close attention" to their tenants' behavior: "A lot of nonpaying tenants are also bad actors. They are also not good housekeepers. They have a lot of problems in their life. If they're violent, if there's trash on the balcony, if they moved in their boyfriend, if they've got an unauthorized dog, they're cooking PCP, they made a threat to their landlord, 'Get off my this or that,' that's good grounds."[234] The same attorney noted that "if all else fails," landlords can terminate the tenancy through "no fault" eviction practices by moving a tenant whose lease is expiring to "a month-to-month agreement and then refuse to renew it the following month."[235] She discussed with her landlord clients "as to whether or not they should just put everybody into a month-to-month tenancy so if they stop paying we can terminate the month-to-month tenancy rather than dealing with the CDC order."[236] The landlord attorney noted that, during the pandemic, she had "quite a bit of success" pursuing these kinds of evictions.[237] This example demonstrates how "no fault" eviction standards can become a backdoor for landlords seeking to terminate lease terms for otherwise unlawful reasons, even in times of national public health emergencies.

2. Extractive Management Strategies & Unenforced Habitability Standards

The fact that many renters, particularly those with past interaction with the eviction system, have limited options in the rental market creates an environment conducive to "extractive management strategies." In this method, the landlord

231 Bryce Covert, *Despite the CDC's Eviction Ban, Thousands of Tenants Are Losing Their Homes*, NATION (Nov. 24, 2020), https://www.thenation.com/article/society/evictions-tenants-covid.

232 *Id.*

233 ALEXA EISENBERG & KATLIN BRANTLEY, MICH. POVERTY SOLUTIONS, CRISIS BEFORE THE EMERGENCY: EVICTIONS IN DETROIT BEFORE AND AFTER THE ONSET OF COVID-19 (June 2022)

234 Covert, *supra* note 231.

235 *Id.*

236 *Id.*

237 *Id.*

deliberately disinvests in properties or operates buildings in disrepair by either refusing to respond to tenant reports of infestations, mold, peeling lead paint, and faulty appliances and utilities, or responding with the threat of eviction.[238] Large landlords, who frequently earn millions of dollars in rental income, can absorb housing code fines without affecting profit margins, especially where the housing code is underenforced.[239] In contrast, low-income tenants often lack alternative housing options and are, therefore, reluctant to report violations and forced to endure squalid conditions. These tenants often live paycheck-to-paycheck and sacrifice necessities, such as food or medicine,[240] to pay the rent, which exacerbates health inequity.

The Hoff real estate empire in Milwaukee illustrates the harm of extractive management strategies. Hoff properties included over 700 units that are predominately located in majority Black neighborhoods.[241] Hoff's management practice consisted of ignoring requests for repairs, but filing for eviction as soon as a tenant was late on rental payments. The practice not only fostered housing insecurity and living conditions hazardous to health; it also affected the safety of the property and the neighborhood as a whole, concentrating violent crime and increasing assaults, robberies, and burglaries.[242]

The availability of the eviction system to intimidate and control tenant behavior allows landlords to exploit renters who have no alternatives when choosing where to live by increasing the rent beyond the value of the property, avoiding the cost of repairs, and attaching excess fees to the tenancy.[243] In majority-Black neighborhoods, the practice of inflating prices, especially for necessities like housing, is widespread.[244] According to the Eviction Lab, the "exploitation is often justified by appeals to racist narratives. In the case of housing, this leads to claims that low-income Black tenants are responsible for the dilapidation of their own properties."[245] For example, a landlord in Yonkers, New

238 Henry Gomory & Matthew Desmond, *Extractive Landlord Strategies: How the Private Rental Market Creates Crime Hot Spots*, EVICTION LAB (May 11, 2023) [hereinafter *Extractive Landlord Strategies*], https://evictionlab.org/extractive-landlords-and-crime.

239 *Id.*

240 WHITNEY AIRGOOD OBRYCKI, ALEXANDER HERMANN & SOPHIA WEDEEN, HARV. JOINT CTR. FOR HOUS. STUD., THE RENT EATS FIRST: RENTAL HOUSING UNAFFORDABILITY IN THE US (Jan. 2021).

241 Henry Gomory & Matthew Desmond, *Neighborhoods of Last Resort: How Landlord Strategies Concentrate Violent Crime*, 61 CRIMINOLOGY 270 (2023); Daphne Chen & Cary Spivak, *A Prolific Evictor Left a Profound Mark on Milwaukee. Yet Few in Power Noticed.*, MILWAUKEE J. SENTINEL, https://www.jsonline.com/in-depth/news/investigations/2023/01/11/milwaukee-landlord-curtis-hoffs-anchor-properties-evicted-thousands/69575798007 (last updated Feb. 6, 2024 2:26 PM).

242 *Id.*

243 *Extractive Landlord Strategies*, *supra* note 238.

244 Amber R. Crowell, *Renting Under Racial Capitalism: Residential Segregation and Rent Exploitation in the United States*, 42 SOCIO. SPECTRUM 95 (2022).

245 *Extractive Landlord Strategies*, *supra* note 238; *see* News 12 Staff, *'They Are Causing this*

York, who owns 11 multi-unit properties, blamed the tenants for housing code violations: "They're causing the problem. They're not even cleaning."[246] His strategy is to evict the "bad tenants." In Milwaukee, where Black renters are segregated into dilapidated, high crime neighborhoods, Hoff properties blamed the housing conditions on the tenants: "They were animals," Hoff said.[247]

This blame shifting, which judges often accept, is nearly identical to the justifications proffered to support the segregation of public housing,[248] installment land contracts during Jim Crow,[249] and the adoption of a national lead poisoning policy that allows children, particularly in low-income, predominately Black and Latino neighborhoods, to be poisoned at high rates long after the problem was practically resolved for white children.[250]

3. Serial Eviction Filing

Landlords frequently use the courts to control or influence tenant behavior and increase revenue by transferring costs to tenants.[251] Nearly one-third of households facing eviction are filed against repeatedly at the same address, a practice known as serial eviction filing.[252] For example, in South Carolina, 43 percent of eviction

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Problem.' Yonkers Landlord Blames Bad Tenants for Pest Infestation, Poor Conditions, NEWS12 WESTCHESTER (Dec. 7, 2022 8:35 PM), https://westchester.news12.com/they-are-causing-this-problem-yonkers-landlord-blames-bad-tenants-for-pest; Meta Minton, *Renter Tells Special Magistrate About Nightmare Conditions at Home in The Villages*, VILLAGES-NEWS.COM (Jan. 24, 2023), https://www.villages-news.com/2023/01/24/renter-tells-special-magistrate-about-nightmare-conditions-at-home-in-the-villages; Meta Minton, *Landlord in the Villages Blames Tenants in Dispute Over Derelict Homes*, VILLAGES-NEWS.COM (Feb. 28, 2023), https://www.villages-news.com/2023/02/28/landlord-in-the-villages-blames-tenants-in-dispute-over-derelict-homes.

246 News 12 Staff, *supra* note 245.

247 *Extractive Landlord Strategies*, *supra* note 238.

248 *See infra* Section V.B.

249 RICHARD ROTHSTEIN, THE COLOR OF LAW: A FORGOTTEN HISTORY OF HOW OUR GOVERNMENT SEGREGATED AMERICA (2017).

250 Emily A. Benfer, *Contaminated Childhood: How the United States Failed to Prevent the Chronic Lead Poisoning of Low-Income Children and Communities of Color*, 41 HARV. ENV. L. REV. 493 (2017) ("'[M]ost of the cases are in [Black] and Puerto Rican families, and how . . . does one tackle that job? . . . Until we can find a means to (a) get rid of our slums and (b) educate the relatively ineducable parent, the problem will continue to plague us.'" (quoting Manfred Bowditch, Lead Industry Association Congressional Testimony 1956)).

251 Philip Garboden & Eva Rosen, *Serial Filing: How Landlords Use the Threat of Eviction*, 18 CITY & COMM. 638 (2019); Adam Porton et al., *Inaccuracies in Eviction Records: Implications for Renters and Researchers*, 31 HOUS. POL'Y DEBATE 377, 380 (2021).

252 Lillian Leung et al., *Serial Eviction Filing: Civil Courts, Property Management, and the Threat of Displacement*, 100 SOC. FORCES 316 (2021) [hereinafter *Serial Eviction Filing: Civil Courts*]; Lillian Leung, Peter Hepburn & Matthew Desmond, *Serial Eviction Filings: How Landlords Use the Courts to Collect Rent*, EVICTION LAB (Sept. 15, 2020), https://evictionlab.org/serial-eviction-filings.

cases are serial in nature.[253] In one study of serial eviction filing in three cities, researchers concluded that "landlords generally try to avoid costly evictions, instead relying on the serial *threat* of eviction . . . . By redefining renters as debtors, filing assists in rent collection by leveraging the state to materially and symbolically support the landlord's debt collection."[254] Serial filing is a property-management approach most commonly used by corporate landlords[255] that disproportionately affects Black renter households, with 14.7 percent of Black households receiving repeated filings at the same address, compared to 9.7 percent of white households.[256] Serial eviction filings affect tenants' credit rating and ability to secure future rental housing. Since the practice increases housing costs by 20 percent due to fines and fees, every time a new case is filed, it is likely to decrease the tenant's ability to pay other bills or result in deferred payments—thereby further negatively influencing material circumstances and, in turn, health inequity.[257]

4. Rent Bonds

Despite the democratic principle in the U.S. legal system that both parties have the right to present arguments and evidence, tenants do not always have the automatic right to be heard in eviction lawsuits.[258] In multiple states, tenants do not have access to either a hearing or an appeal of an eviction judgment unless they pay a "rent bond," typically an amount equivalent to one month's rent or the amount alleged due by the landlord or more, to the court.[259] For example, in Florida, if a tenant is unable to pay the rent bond to the court, the case is automatically decided in the landlord's favor, even though the tenant has yet to be heard and even if the tenant has defenses, such as unlawful landlord behavior.[260] Other states require tenants to pay the rent to the court before they can raise counterclaims. For example, in Oregon, "If the tenant does not comply with an order to pay rent into the court . . . , the tenant shall not be permitted to assert a counterclaim in the action for possession."[261] In Dallas County, Texas, the state appellate rent bond statute was recently ruled unconstitutional, though housing

253 Porton et al., *supra* note 251.

254 Garboden & Rosen, *supra* note 251, at 638.

255 *Serial Eviction Filing: Civil Courts*, *supra* note 252.

256 Hepburn, Louis & Desmond, *supra* note 37.

257 *Serial Eviction Filing: Civil Courts*, *supra* note 252.

258 Emily A. Benfer et al., Opinion, *The Eviction Moratorium Limbo Laid Bare the System's Extreme Dysfunction*, WASH. POST (August 12, 2021), https://www.washingtonpost.com/opinions/2021/08/12/eviction-moratorium-court-cdc-congress; Sabbeth, *supra* note 157.

259 *See* spreadsheet on file with author.

260 Sabbeth, *supra* note 183, at 381.

261 OR. REV. STAT. § 90.370 (2023).

attorneys are uncertain whether the rule will be followed locally, further demonstrating the court's discretion and the system's slant toward landlords.[262] When the right to participate in the legal process hinges on a tenant's ability to pay a bond into court, eviction policy operates as a structural determinant of health inequity that influences power structures, establishes the hierarchy of litigants, and undermines the tenant's ability to prevent an eviction and its negative consequences to health and well-being.

5. Criminal Eviction, Crime Free Rental Properties, and Nuisance Ordinances

In numerous jurisdictions, local law allows, and even directs, landlords to target vulnerable populations and historically marginalized groups with extreme penalties, including the loss of personal freedom and a criminal record. In Arkansas, renters who are late on rent payments can be charged with a misdemeanor and sentenced to jail time, despite the Eighth Amendment prohibition against cruel and unusual punishment and the prohibition on debtors' prison.[263] The 122-year-old law allows landlords to initiate the criminal action and has resulted in over 1,000 criminal eviction cases between 2018 and 2020 alone.[264] The law disproportionately impacts Black female, low-income renters: 62 percent of criminal eviction cases filed in Little Rock in 2012 were filed against Black women, who represent 20 percent of the population.[265] Landlords are supportive of the law and have a record of lobbying to prevent repeal: The president of the Hot Springs Landlord Association said, "We're not about turning someone into a criminal because they didn't pay their rent, but we do want a simple, easy to use law that's inexpensive." Similarly, the president of the Greene County Landlord Association explained: "I don't want to label anyone a criminal by no means. But, you know, we need a good way to evict people."

Equally harmful, "Crime Free" rental properties and nuisance ordinances use third parties (the landlord) to control behavior (of the tenant) by requiring property owners to evict a tenant who makes frequent calls to 911.[266] These laws

262 Jacob Vaughn, *A New Dallas County Court Ruling Might Make It Easier for Some Tenants to Appeal Evictions*, DALLAS OBSERVER (Sept. 22, 2022), https://www.dallasobserver.com/news/some-tenants-may-have-an-easier-time-appealing-evictions-after-dallas-county-court-ruling-14869449 ("'This is a county court of law in Dallas County that ruled it unconstitutional. Whether people decide to ignore that or not is a different question,' said Mark Melton, the attorney who argued the case.")

263 ARK. CODE ANN. § 18-16-101 (2021); *see also* Maya Miller & Ellis Simani, *When Falling Behind on Rent Leads to Jail Time*, PROPUBLICA (Oct. 26, 2020), https://www.propublica.org/article/when-falling-behind-on-rent-leads-to-jail-time.

264 Miller & Simani, *supra* note 263.

265 *Id.* (citing University of Arkansas at Little Rock Law Professor Emerita Lynn Foster).

266 *Health Justice*, *supra* note 21.

disproportionately impact domestic violence victims and women of color. In one study analyzing nuisance citations where domestic violence was present, 50 percent of cases resulted in a landlord formally or informally evicting the tenants. In 83 percent of cases studied, property owners relied on either eviction or the threat of eviction to block future police calls, thereby depriving vulnerable renters of safety and the protection of law enforcement.[267] Renters in Black neighborhoods were much more likely to receive nuisance citations with a rate of 1 in 16 eligible properties receiving a citation compared to 1 in 41 eligible properties in white neighborhoods.[268] Out of all nuisance citations, 40 percent of cases resulted in a formal eviction and 78 percent resulted in a landlord-initiated forced move.[269] As Professor Deborah Archer has concluded, "crime-free housing ordinances enable racial segregation by importing the racial biases, racial logics, and racial disparities of the criminal legal system into private housing markets."[270]

Where eviction laws and policies allow landlords to harness the bias and intimidation of the criminal justice system against the tenant, they reinforce a culture of subordination and disempowerment—key elements of structural determinants of health inequity.

6. Voter Suppression

Eviction is also associated with challenges in exercising the fundamental right to vote. A recent study found that eviction depressed voter turnout in the 2016 election, regardless of whether the communities in question were urban or rural and whether they had high or low rates of eviction.[271] In the aftermath of an eviction, displaced renters may not be able to demonstrate a current address in the district or may be forced to move to a new county, which typically would require the advanced submission of a change of address form in order to vote.[272] Where a recently evicted renter does attempt to vote without updating their voter registration, they may open themselves up to criminal charges for voter fraud.[273]

267 Matthew Desmond & Nicol Valdez, *Unpolicing the Urban Poor: Consequences of Third-Party Policing for Inner-City Women*, 17 AM. SOC. REV. 117 (2012).

268 *Id.*

269 *Id.*

270 Debora N. Archer, *The New Housing Segregation: The Jim Crow Effects of Crime-Free Housing Ordinances*, 118 MICH. L. REV. 173 (2019).

271 Gillian Slee & Matthew Desmond, *Eviction and Voter Turnout: The Political Consequences of Housing Instability*, 51 POL. & SOC. 3 (2023).

272 *See, e.g.*, ARK. CODE ANN. § 108-00-07 (2007); ALA. CODE §§ 17-3-50, 17-3-56 (2006).

273 52 U.S.C. § 10307(c). Though there have not been any cases of an individual being charged with voter fraud following an eviction, in 2022 five Wisconsin citizens were charged with voter fraud following their registration at the incorrect address, including one unhoused individual. Scott Bauer, *Trump Backer, 4 Others Charged with Voter Fraud in Wisconsin*, ASSOCIATED PRESS (Feb. 10, 2022), https://apnews.com/article/business-donald-trump-wisconsin-presidential-elections-elections-

The effects were greater in areas with new voter restrictions and less in places that allowed registration and voting on the day of the election.[274] While many of the states with strict voter ID requirements have exceptions—such as natural disaster (TX), confidential listings due to domestic violence, sexual assault, or stalking (WI), or religious objections to being photographed (IN, KS, MS, SC, TN, TX and WI)—no state expressly includes exceptions for people who were recently evicted and are unable to demonstrate a current address.[275] "As eviction disproportionately affects low-income, majority Black and Latino communities, it is likely diminishing the power of low income, Black and Latino voters."[276] As a result, eviction likely affected past election results.[277] Researchers estimated that "reducing the residential eviction rate by 1 percentage point would have increased voter turnout in 2016 by 2.73 percentage points." The significance of deterred political participation is poignant: "In the 2016 presidential election, six states were decided by less than 2 percentage points, including Michigan, Pennsylvania, and Florida."[278] Housing security and political participation and representation—and the ability to disrupt structural barriers to health equity—are deeply intertwined.

7. Screening Practices

Screening practices that rely on past interaction with the eviction system influence intermediary determinants of health by restricting a tenant's ability to obtain future housing. Eviction screening practices disproportionately exclude Black renters, and Black women in particular.[279] The negative effects of eviction begin to attach at the moment of an eviction filing; eviction creates a permanent and public record—a "Scarlet E"—that can affect a tenant's economic and housing security for years.[280] Approximately 85 percent of landlords run an eviction report on all rental housing applicants and 90 percent of landlords run a credit and

f7e490e5a73b54110e077c824c4e3bb3?utm_source=copy&utm_medium=share.

274 Slee & Desmond, *supra* note 271.

275 *Voter ID Laws*, NAT'L CONF. STATE LEGISLATURES, https://www.ncsl.org/elections-and-campaigns/voter-id (last updated Feb. 2, 2024).

276 Gillian Slee, *Eviction Depressed Voter Turnout in the 2016 Presidential Election*, EVICTION LAB (Nov. 8, 2021), https://evictionlab.org/eviction-voter-turnout.

277 Slee & Desmond, *supra* note 271.

278 *Id.*

279 Sandra Park*, Unfair Eviction Screening Policies Are Disproportionately Blacklisting Black Women,* ACLU (March 30, 2017), https://www.aclu.org/blog/womens-rights/violence-against-women/unfair-eviction-screening-policies-are-disproportionately.

280 Lauren Kirchner, *Data Brokers May Report COVID-19–Related Evictions for Years*, MARKUP, https://themarkup.org/locked-out/2020/08/04/covid-evictions-renter-background-reports (last updated August 7, 2020, 1:54 PM).

criminal background check on rental housing applicants.[281] Nine out of ten landlords, and the majority of large landlords, rely on third-party tenant screening companies to compile these reports.[282] The screening always includes a search for past eviction records, which are typically categorized as an automatic strike against the tenant, even if the applicant was not the leaseholder or the tenant filed the case affirmatively to enforce rights.[283] In court records, it can also appear as though the landlord prevailed when a stipulated judgment is filed with the court, even though a settlement was reached, or the tenant repaid all rental arrears.[284] Where tenants were subjected to serial eviction filings,[285] they will have multiple records affecting their report. Screening reports may not even rely on correct information, since court records are frequently inaccurate and include misinformation due to clerical errors, file management, and other issues. In one study, a review of over 3.6 million administrative court records from 12 states found that "22 percent of eviction records contain ambiguous information on how the case was resolved or falsely represent a tenant's eviction history."[286]

Typically, the existence of any eviction record will be a complete bar to approving a rental housing application and/or the basis for charging the tenant a higher security deposit.[287] These judgments are made even if the eviction case was dismissed and even if there is no way to verify that the identity of the tenant matches that in the eviction record. For example, in Chicago, Hunter Properties, Inc., which manages 2,500 apartments, maintains a policy to categorically reject any applicant that has any prior interaction with the eviction system.[288] This policy applies even if the court case was decided in the tenant's favor, even if the tenant proactively filed the case, and even if it was a frivolous lawsuit.[289] There are no exceptions to the policy and the tenant's ability to pay the rent or comply with the

281 Shannon Price, *Stay at Home: Rethinking Rental Housing Law in an Era of Pandemic*, 28 GEO. J. POVERTY L. & POL'Y 1, 302 (2020); *TransUnion Independent Landlord Survey Insights*, TRANSUNION SMARTMOVE (Aug.7, 2017), https://www.mysmartmove.com/SmartMove/blog/landlord-rental-market-survey-insights-infographic.page.

282 Lauren Kirchner & Matthew Goldstein, *How Automated Background Checks Freeze Out Renters*, N.Y. TIMES (May 28, 2020), https://www.nytimes.com/2020/05/28/business/renters-background-checks.html.

283 Valerie Schneider, *Locked Out by Big Data: How Big Data, Algorithms and Machine Learning May Undermine Housing Justice*, 52 COLUM. HUM. RTS. L. REV. 251, 268–70 (2020).

284 *Id.* at 279.

285 *Serial Eviction Filing: Civil Courts*, *supra* note 252.

286 Porton et al., *supra* note 251.

287 Wonyoung So, *Which Information Matters? Measuring Landlord Assessment of Tenant Screening Reports*, 33 HOUS. POL'Y DEBATES 1484, 1502 (2023).

288 Legal Aid Chicago v. Hunter Properties, Inc., No. 1:23-cv-4809 (N.D. Ill., filed Jul. 25, 2023).

289 *Id.*

lease terms are not relevant to the determination.[290] In Chicago, consistent with national statistics, this policy disproportionately harms Black renters, who represent 33 percent of the Cook County renter population and 56 percent of renters who received an eviction filing between September 2010 to March 2023.[291] Notably, Black women represented 33 percent of people filed against during the same timeframe, significantly increasing barriers to future housing opportunities.[292]

Tenant screening companies and credit reporting agencies are barred from reporting eviction records beyond seven years, pursuant to the Fair Credit Reporting Act. However, even after that time, the record continues to exist and many landlords continue to report evictions to credit agencies and screening companies.[293] Unless it is sealed, the record is also always available to landlords through independent court record searches.

In practice, most of the tenant screening companies offer products that judge or score the applicant and provide a "yes" or "no" recommendation to the landlord about whether to accept the applicant, rather than provide public record information and allow landlords to make an independent determination. The reports do not consider mitigating circumstances[294] or false positives. Further, where Artificial Intelligence ("AI") made the determination and only provides a recommendation (yes or no) or a score, there is no information about why the applicant was rejected.[295]

Landlords, particularly large landlords, will rely on systematized screening software algorithms designed by companies[296] to determine whether to lease to a prospective tenant. As one study found, reliance on the screening company's evaluation allows property owners "to make systematic decisions that protect them from fair housing lawsuits."[297] Since AI is making the decision, the tenant screening companies often promote the tool as a way to eliminate bias, but research

290 *Id.*

291 *Id.*

292 *Id.*

293 CONSUMER FINANCIAL PROT. BUREAU, MARKET SNAPSHOT: BACKGROUND SCREENING REPORTS (2019), https://files.consumerfinance.gov/f/documents/201909_cfpb_market-snapshot-background-screening_report.pdf.

294 Schneider, *supra* note 283, at 254.

295 ARIEL NELSON, NAT'L CONSUMER L. CTR., BROKEN RECORDS REDUX: HOW ERRORS BY CRIMINAL BACKGROUND CHECK COMPANIES CONTINUE TO HARM CONSUMERS SEEKING JOBS AND HOUSING 15–17 (2019), https://www.nclc.org/images/pdf/criminal-justice/report-broken-records-redux.pdf.

296 *See, e.g.*, Corelogic, LeaseRunner; RealPage; Online Rental Exchange.

297 Eva Rosen, Philip M.E. Garboden & Jennifer E. Cosyleon, *Racial Discrimination in Housing: How Landlords Use Algorithms and Home Visits to Screen Tenants*, 86 AMER. SOC. REV. 787, 801 (2021).

has shown that they may instead increase housing discrimination.[298] Algorithms "use historical data as input to produce a rule that is applied to a current situation," and therefore, "[t]o the extent that historical data reflects the results of de jure segregation, Jim Crow laws, redlining, restrictive covenants, white flight, and other explicitly and implicitly racist, laws, policies, and actions, any given algorithmic 'rule' is likely to produce racist results, including when those patterns reflect past discrimination."[299] These algorithms are intended to be "race-blind," but they rely on criteria—such as income, eviction history, criminal history, and credit score—that are correlated with structural racism and racial marginalization. The flawed screening product harms millions of renters' housing stability and errors have even resulted in homelessness, which is associated with numerous comorbidities.[300] The U.S. District Court for the District of Connecticut found that the tenant screening company transforms the records review process into a "yes/no switch" and eliminates the possibility of a full assessment of an applicant to avoid eliminating tenants who do not pose any risk.[301]

Tenant screening companies reportedly use incorrect or unqualified information and include information based on mistaken identity.[302] Screening companies often only require a partial match of the letters in a tenant's name to include negative history in the screening.[303] Thus, the tenant screening may include an eviction or criminal record that does not belong to the applicant due to the error-prone tool, as well as the inability of companies to verify court data with date of birth, Social Security Numbers, or other identifying information.[304] In a 2021 Compliance Bulletin, the CFPB stated it is "particularly concerned" that "the procedures that some tenant-screening companies use to match public records . . . to specific consumers may create a high risk that inaccurate data will be included in tenant-screening reports" and that the "risk of mismatching" may fall heaviest on "Hispanic, Black, and Asian individuals because there is less surname diversity than among the white population."[305] Third-party tenant screening companies are

298 Wonyoung So, *supra* note 287, at 1502, 1504–05.

299 Schneider, *supra* note 283.

300 MICHELE GILMAN, DATA & SOC., POVERTY LAWGORITHMS: A POVERTY LAWYER'S GUIDE TO FIGHTING AUTOMATED DECISION-MAKING HARMS ON LOW-INCOME COMMUNITIES 30–33 (2020).

301 Connecticut Fair Hous. Ctr. v. CoreLogic Rental Prop. Sols., LLC, 478 F. Supp. 3d 259, 273, 279 (D. Conn. 2020).

302 Kirchner & Goldstein, *supra* note 282.

303 *Id.*

304 *Id.*; *see also* Schneider, *supra* note 283; *Connecticut Fair Hous. Ctr.*, 478 F. Supp. 3d at 259.

305 CFPB, ENFORCEMENT COMPLIANCE BULLETIN AND POLICY GUIDANCE: CONSUMER REPORTING OF RENTAL INFORMATION, BULLETIN 2021-03 (July 31, 2021), https://files.consumerfinance.gov/f/documents/cfpb_consumer-reporting-rental-information_bulletin-2021-03_2021-07.pdf.

considered specialty consumer reporting agencies under the Fair Credit Reporting Act ("FCRA"). The FRCA requires that screeners "follow reasonable procedures to assure maximum possible accuracy."[306] However, unlike credit scores, federal regulators do not review tenant scoring models or the underlying algorithms to ensure the process is predictive or statistically sound.

Racial discrimination in the screening process is more overt among small size property landlords. A study led by Drs. Eva Rosen and Philip Garboden found that "landlords distinguish between tenants based on the degree to which their behavior conforms to insidious cultural narratives at the intersection of race, gender, and class."[307] Small size landlords are less likely to rely on screening companies and instead "make decisions based on informal mechanisms such as 'gut feelings,' home visits, and the presentation of children."[308] In these instances, a tenant with a history of interaction with the eviction system need not apply, or can expect to face far worse conditions than in prior housing.[309]

The disproportionate and negative effect of tenant screening policies and practices, and the lack of regulation, on historically underrepresented and marginalized groups demonstrates how a policy, practice, or entrenched norm increases subordination and disempowerment. (Figure 1) These structural determinants of health inequity decrease housing access and negatively impact health equity and well-being.

The whole of the eviction system—from the laws and policies that determine whether a tenant can stay housed to landlord practices that determine who has access to safe, decent, and affordable or substandard housing—bestows power upon the landlord, deteriorates tenants' material circumstances, and perpetuates health inequity among historically marginalized people. With structural determinants driving the system, eviction deepens longstanding patterns of economic and housing instability in historically marginalized communities and negatively affects health outcomes. Figure 5 provides a partial snapshot of the

306 15 U.S.C. § 1681e(b) (2018).

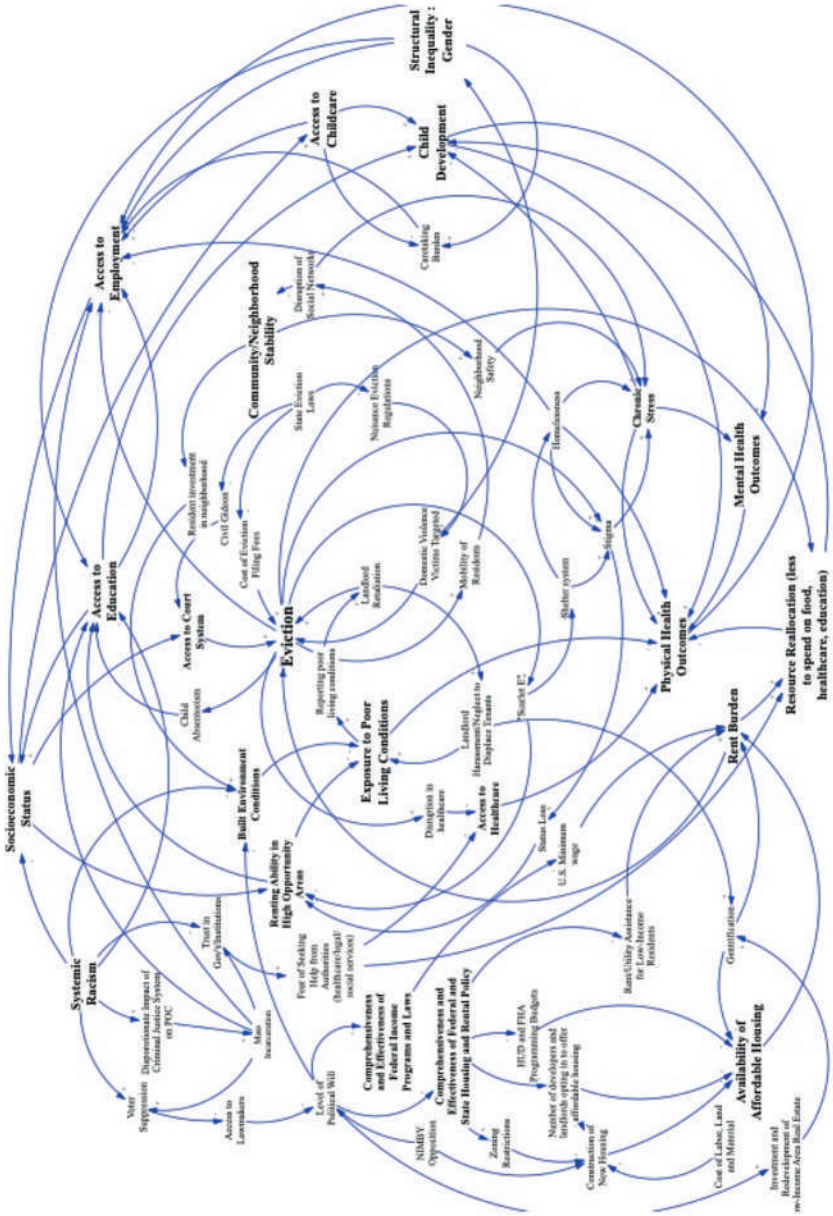
307 Rosen, Garboden & Cosyleon, *supra* note 297.

308 *Id.*

309 *See Eviction and the Reproduction of Urban Poverty*, *supra* note 37 ("When evicted tenants do find subsequent housing, they often must accept conditions far worse than those of their previous dwelling. Because many landlords reject applicants with recent evictions, evicted tenants are pushed to the very bottom of the rental market and often are forced to move into run-down properties.").

complex network of causal loops and health outcomes within the eviction system.

Figure 5. The Eviction System: Causal Loops and Health Outcomes[310]



310 Marissa Y. Long & Emily A. Benfer, *The Eviction System: Causal Loops and Health Outcomes* (2021), simplified for print.

V. APPLYING THE HEALTH JUSTICE FRAMEWORK TO THE U.S. EVICTION SYSTEM

As described in this Article, eviction operates as a structural determinant of health inequity that negatively influences material circumstances and shapes health status among historically marginalized groups, with Black people experiencing eviction and its harms at the highest rates. Examining the eviction system in the context of the WHO Conceptual SDOH model reveals the roots of inequity in eviction law and policy, and pathways from those root causes to stark differences in health and well-being by race. Preventing the devastating and intergenerational health effects of eviction requires directly confronting the structural and intermediary determinants of health inequity embedded in, and resulting from, the American eviction system. Efforts to address structural determinants of health inequity in eviction will be most effective where they abide by the key commitments of health justice outlined in the framework. (Figure 2) The Health Justice Framework collectively identifies and addresses drivers of health inequity, and includes (at least) four overarching principles that can be engaged simultaneously to address and prevent health inequity:[311]

1. *Community Empowerment*[312] *and Community-Driven Structural Change*: Engage and "cultivate the political capacity of people who are disproportionately harmed by health inequity"[313] as leaders in the decision making, development, and implementation of community-driven structural change, including protective and corrective laws and policies.
2. *Truth and Reconciliation*: Investigate the historical mechanisms of structural racism underlying health inequity and offer reconciliation opportunities.
3. *Law and Policy*: Address the structural determinants of health inequity, including the social, political, and legal mechanisms of subordination.
4. *Support and Protect*: Provide supports and legal protections to transition material and environmental circumstances from negative to positive determinants of health.

311 *See supra* notes 21-35.

312 Where this article uses the term "empowerment" or "elevate the power" of historically marginalized communities, the health justice focus on empowerment rejects the concept of empowerment that suggests a favored group granting power to another. Rather, the "health justice framework seeks the outcome of power among race-class subjugated communities (and should not contemplate the idea of an outside actor bestowing power)." *Post-Pandemic Clinic*, *supra* note 24, at 47 n.4 (2021). *See, e.g.*, Harris & Pamukcu, *supra* note 24; *Health Justice Strategies*, *supra* note 23.

313 Michener, *supra* note 17.

The following sections provide examples of how each health justice principle can be applied to the U.S. eviction system to confront and eliminate the structural determinants of health inequity.

A. Prioritize Empowerment of Race-Class Subjugated Communities and Prioritize Community-Driven Structural Change

Among the core tenets of the Health Justice Framework is building power among people burdened by structural racism and health inequity to ensure that any structural changes are driven by the communities most affected. Community power and the act of working to increase power are both linked to improved health outcomes, including lower infant mortality, reduced cardiovascular risk, disease reduction, emotional well-being, and environmental improvement, among other benefits.[314] Building power requires engaging and "cultivat[ing] the political capacity of people who are disproportionately harmed by health inequity"[315] as leaders in the decision making, development, and implementation of community-driven structural change.

Dr. Jamila Michener's theory of power in health justice posits:

> Since historical and contemporary alignments of power have produced and perpetuated the status quo of health inequity, altering this trajectory will involve struggles for power. Such struggle can take (at least) two forms: 1) building power among those who are most affected by health inequity 2) breaking the power of interests that undermine health equity.[316]

Mechanisms for power building among race-class subjugated communities include "community organizing, coalition and social movement seeding and development and strategic institutional negation."[317] In turn, power breaking addresses the imbalance of power that "undergirds health inequity through 1) minimizing profit; 2) administrative regulation and enforcement; and 3) strategic institutional negotiation."[318] In the context of eviction, the need to apply power shifting methods to unequal power dynamics is clear in the landlord's, property owner's, and investor's ability to unequivocally control and manipulate the tenant's access to safe and decent housing and, therein, their survival.[319]

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314 Anthony Iton, Robert K. Ross & Pritpal S. Tamber, *Building Community Power to Dismantle Policy-Based Structural Inequity in Population Health*, 41 HEALTH AFFS. 1763 (2022).

315 Michener, *supra* note 17.

316 *Id.*

317 *Id.*

318 *Id.*

319 *See* Javins v. First Nat'l Realty Corp., 428 F.2d 1071, 1079 (D.C. Cir. 1970) ("The

A critical component of power shifting to address the structural racism of eviction is community-led and -centered structural change:

> "Communities that have been disenfranchised by racism, poverty, and other forms of subordination must be recognized, engaged, respected, and empowered as leaders in the development and implementation of interventions to eliminate health inequities and realize health justice . . . the processes created to develop, evaluate, and reform laws and policies that shape health must incorporate mechanisms for combatting existing power imbalance and subordination, by centering community decision making and control."[320]

Community-led structural change requires that community members have the authority and resources (financial and otherwise) to meaningfully inform the development of protective and corrective laws and policies, including the prioritization of interventions. Communities and individuals affected by health inequity are "best positioned to identify the major challenges to overcoming inequity and to evaluate the viability of proposed solutions"[321] and know better than anyone how laws and policies will play out in their lives. Any policy changes must be centered around community knowledge, experience, and goals. Increased power should include the ability to direct and control resources in their own community—an approach that has been implemented in other public health contexts, such as efforts to improve the built environment, food and nutrition security, and immunization.[322]

Recent research demonstrates that tenant organizing and power building, indeed, reduces eviction: for every ten new tenant organizations, there is a 10 percent reduction in eviction filings.[323] The COVID-19 pandemic serves as an example of the positive effects of increasing tenant power. During the pandemic,

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inequality in bargaining power between landlord and tenant has been well documented."); Jamila Michener, *Civil Justice, Local Organizations, and Democracy*, 122 COLUM. L. REV. 1389, 1397 (2022); *supra* Section IV.C.

320 *What is Health Justice?*, *supra* note 24.

321 *Health Justice*, *supra* note 21, at 346.

322 CTR. FOR DISEASE CONTROL AND PREVENTION, GETTING FURTHER FASTER COMMUNITY PROGRAM, https://www.cdc.gov/chronicdisease/healthequity/sdoh-and-chronic-disease/nccdphps-programs-to-address-social-determinants-of-health/getting-further-faster.htm (last visited Mar. 25, 2024) (Partnered with 42 communities to implement SDOH interventions); *Policy Solutions to End Hunger in America*, DREXEL UNI. CTR. FOR HUNGER-FREE COMMS., https://drexel.edu/hunger-free-center/research/briefs-and-reports/policy-solutions-to-end-hunger (last visited Mar. 25, 2024) (Framework created for Biden Administration's Conference on Hunger, Nutrition and Health); UNICEF, HUMAN-CENTERED DESIGN FIELD GUIDE, https://www.hcd4health.org/resources.

323 Andrew Messamore, *The Effect of Community Organizing on Landlords' Use of Eviction Filing: Evidence from U.S. Cities*, 70 SOC. PROB. 809 (2023).

community organizing and the development of tenant associations and organizations grew nationwide. This empowerment and had an immediate impact on federal, state, and local policymakers who introduced model legislation to advance housing stability and health equity.[324] Landlord behavior also changed. In response to tenant-led direct actions and protests that negated systems, shutdown courthouses, or blocked evictions,[325] landlords "halted eviction proceedings and instead negotiated terms with tenants that kept them in their homes."[326]

As predicted in Dr. Michener's theory of power in health justice, the development of citywide tenant unions and organizations gave renters bargaining power and access to rights in the landlord-tenant relationship. These local efforts were enhanced by coalition building with local and national organizations that amplified messages, drew resources, and centered tenants in the movement for housing stability during and beyond the pandemic. These efforts increased the ability of tenants to participate in the policy process and drew the attention of the state, local, and federal government, including an audience with the Biden-Harris Administration. The shift in tenant power and the increased attention to tenant voices is likely responsible for an unprecedented number of housing-related bills during and after the pandemic, including the White House Renter Bill of Rights and HUD dedicating $10 million in funding for tenant education, outreach, and organizing in certain federally assisted housing.[327] The investment in capacity building among tenants is critical and should be replicated and extended to private market renters. Ultimately, health justice empowerment and engagement allow harmed or high-risk individuals to direct the dismantling of structural determinants

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324 Erika Rickard & Natasha Khwaja, *State Policymakers Are Working to Change How Courts Handle Eviction Cases*, PEW (Aug. 26, 2021), https://www.pewtrusts.org/en/research-and-analysis/articles/2021/08/26/state-policymakers-are-working-to-change-how-courts-handle-eviction-cases.

325 Michelle Conlin, *'This is Not Justice.' Tenant Activists Upend U.S. Eviction Courts*, REUTERS (Feb. 8, 2021 2:09 PM), https://www.reuters.com/article/us-health-coronavirus-usa-evictions-insi/this-is-not-justice-tenant-activists-upend-u-s-eviction-courts-idUSKBN2A8112.

326 Jamila Michener & Mallory SoRelle, *Politics, Power, and Precarity: How Tenant Organizations Transform Local Political Life*, 11 INT. GRPS. & ADVOC. 209 (2022).

327 Rickard & Khwaja, *supra* note 324; Press Release, U.S. Dep't of Hous. & Urb. Dev., *HUD Affirms Renter Protections and Releases $10 Million Funding Opportunity for Tenant Education and Outreach* (July 27, 2023), https://www.hud.gov/press/press_releases_media_advisories/HUD_No_23_150; Press Release; Exec. Off. of the President, Readout of White House Meeting on Tenant Protections and Rental Affordability (Nov. 15, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/11/15/readout-of-white-house-meeting-on-tenant-protections-and-rental-affordability; *see also* Press Release, Exec. Off. of the President, FACT SHEET: Biden-Harris Administration Announces New Actions to Protect Renters and Promote Rental Affordability (Jan. 25, 2023), https://www.whitehouse.gov/briefing-room/statements-releases/2023/01/25/fact-sheet-biden-harris-administration-announces-new-actions-to-protect-renters-and-promote-rental-affordability.

of health inequity and the housing policies that negatively affect their well-being.[328]

B. Acknowledge the Historical and Modern-Day Mechanisms of Structural Discrimination and Racism Underlying Health Inequity & Offer Reconciliation Opportunities

Dr. Martin Luther King, Jr. said, "I do not see how we will ever solve the turbulent problem of race confronting our nation, until there is an honest confrontation with it and a willing search for the truth and a willingness to admit the truth when we discover it."[329] Similarly, this principle of health justice confronts subordination and disempowerment by uncovering and publicly documenting the historical mechanisms of structural racism, including their effect on historically marginalized groups, and offering harmed individuals an opportunity for reconciliation. In the SDOH Framework developed by Professor Ruqaiijah Yearby, any attempts to address structural discrimination must also implement a "truth and reconciliation process that acknowledges the existence of structural discrimination and offers individuals from less privileged groups a mechanism to recover from the trauma of experiencing structural discrimination."[330]

It is well-documented that Black people and majority-Black communities have a heightened risk of facing housing instability and disproportionately experience eviction.[331] In a health justice approach, federal, state, and local governments inquire into the factors that led to racial disparity in housing access, stability, affordability, and conditions. Remediating structural determinants of health inequity requires documenting the United States' sordid history of subordination and racially discriminatory housing and landlord-tenant laws at the national and local levels. Namely, the disproportionate impact of eviction on historically underrepresented and marginalized groups is intertwined with the United States' history of racial discrimination at the community and local level that prohibited land and home ownership;[332] exploited Black families through "on

328 *See* PUB. HEALTH LEADERSHIP SOC'Y, PRINCIPLES OF THE ETHICAL PRACTICE OF PUBLIC HEALTH 2–3 (2002), https://www.apha.org//media/files/pdf/membergroups/ethics/ethics_brochure.ashx.

329 Martin Luther King Jr., The Other America: Speech Given at Grosse Point South High School (Mar. 14, 1968).

330 *See* Yearby, *supra* note 35.

331 *See supra* Section II.A.

332 *See* ROTHSTEIN, *supra* note 249; KENNETH T. JACKSON, CRABGRASS FRONTIER: THE SUBURBANIZATION OF THE UNITED STATES 196–98 (1985); Julian Bond, *Historical Perspectives on Fair Housing*, 29 MARSHALL L. REV. 315, 317 (1996).

contract" home purchases that drained assets;[333] segregated neighborhoods;[334] seized land and displaced, or physically divided, entire neighborhoods in the name of post-war era "slum clearance" or "urban renewal;"[335] required discriminatory lending and zoning practices;[336] pushed communities of color into "undesirable" and unhealthy areas near industry;[337] cleared thriving majority-Black communities to develop interstate highways;[338] and repeatedly infringed on the rights of communities of color.[339]

These policies are all examples of structural discrimination and racism that advantaged white Americans in home ownership, income, education, and health while relegating Black Americans to racially segregated neighborhoods that became the target of profit for real estate and industry alike.[340] Today, racially segregated neighborhoods that are predominately Black are subjected to substandard and unaffordable housing conditions and have less economic investment and fewer community resources, which increases eviction risk and exacerbates poor health, especially among Black women.[341]

These neighborhoods also have more pollution, noise, environmental and health hazards, substandard housing stock, and overcrowding, and are typically far removed from city resources—all of which are social determinants of poor health.[342] During the pandemic, these disparities resulted in a life-or-death reality: communities of color were more susceptible to contracting viruses, at high risk of

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333 BERYL SATTER, FAMILY PROPERTIES: HOW THE STRUGGLE OVER RACE AND REAL ESTATE TRANSFORMED CHICAGO AND URBAN AMERICA (2009).

334 *See* ROTHSTEIN, *supra* note 249.

335 *See generally* Housing Act of 1949, 42 U.S.C. ch. 8A; *see also* Marc A. Weiss, *The Origins and Legacy of Urban Renewal, in* FEDERAL HOUSING POLICY AND PROGRAMS: PAST AND PRESENT 253 (J. Paul Mitchell ed., 1985).

336 *See* ROTHSTEIN, *supra* note 249.

337 EMILY COFFEY ET AL., SHRIVER CTR. ON POVERTY L. & EARTH JUST., POISONOUS HOMES (2020), https://www.povertylaw.org/wp-content/uploads/2020/06/environmental_justice_report_final.pdf.

338 Deborah Archer, *Transportation Policy and the Underdevelopment of Black Communities*, 106 IOWA L. REV. 2125 (2021).

339 *Id.*

340 *Id.*

341 Lee Mobley et al., *Environment, Obesity, and Cardiovascular Disease Risk in Low-Income Women,* 30 AM J. PREVENTATIVE MED. 327, 327 (2006).

342 Renee E. Walker et al., *Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature,* 16 HEALTH & PLACE 881, 876–84 (2010); Nicole I. Larson et al., *Neighborhood Environments: Disparities in Access to Healthy Foods in the U.S.,* 36 AM. J. PREVENTATIVE MED. 74, 74–81 (2009); Lavonna Blair Lewis et al., *African Americans Access to Healthy Food Options in South Los Angeles Restaurants*, 95 AM. J. PUB. HEALTH 672, 668–73 (2005); Ingrid Gould Ellen et al., *Neighborhood Effects on Health: Exploring the Links and Assessing the Evidence*, 23 J. URB. AFFS. 393, 391–408 (2001); A.V. Diez Roux, *Investigating Neighborhood and Area Effects on Health,* 91 AM. J. PUB. HEALTH 1783, 1786 (2001).

COVID-19 complications or death due to comorbidities precipitated by structural discrimination, and at heightened risk of eviction and homelessness.[343] Similarly, the lack of infrastructure and access to transportation common in low-income communities creates physical barriers to justice that contribute to the high default rate seen in eviction proceedings today.[344] In a study of Philadelphia and Harris County, Texas, researchers determined that equalizing the travel time to court across all tenants would have reduced the number of default judgment orders of eviction by 4,000 to 9,000 over the study period.[345]

Historical and longstanding discriminatory practices are responsible for the entrenched segregation, disinvestment, crumbling infrastructure, environmental injustice,[346] poverty,[347] lack of wealth accumulation, and health inequity in majority-Black and Latino neighborhoods.[348] For example, in 1934, the New Deal authorized the Public Works Administration to build the country's first federally funded public housing units.[349] During the mid-to-late 1930s, Congress held several public hearings on the topic of housing in the United States. The testimony provides a snapshot of the culture of racism that permeated decision-making:

> If you could keep these people within confines, put up a little Chinese Wall around them, and keep them all in Harlem, all in New York City, or New York State, and did not have the children wandering all over the country, taking their low standards of living, their health conditions, their conditions of life along with them, you might say it is a local problem, but those things are spreading out throughout the entire country. (Mrs. Roscoe Conklin Bruce, Manager Paul Dunbar Apartments, Congressional Testimony, 1937.)[350]
>
> I would say they are a shiftless race. (Harry Winters, Council of

343 *Health Justice Strategies*, *supra* note 23.

344 David A. Hoffman & Anton Strezhnev, *Longer Trips to Court Cause Evictions*, 120 PROCEEDINGS NAT'L ACAD. SCI. e2210467120 (2023).

345 *Id.*

346 Jamie Smith Hopkins, *The Invisible Hazard Afflicting Thousands of Schools.* CTR. FOR PUB. INTEGRITY (Feb. 17, 2017), https://publicintegrity.org/environment/the-invisible-hazard-afflicting-thousands-of-schools.

347 *Health Justice*, *supra* note 21, at 325.

348 *Id.*

349 The country's first public housing was created by the New York City Housing Authority in 1935. *About NYCHA,* N.Y.C. HOUS. AUTH., https://www.nyc.gov/site/nycha/about/about-nycha.page# (last visited Jan. 24, 2024).

350 *To Create a United States Housing Authority: Hearing Before the H. Comm. On Banking and Currency*, 75th Cong. 200 (1937).

Real Estate Association, Congressional Testimony, 1937.)[351]

The Neighborhood Composition Rule of 1939 reflected the overarching culture of subordination and required the racial composition of public housing developments to reflect the racial composition of the surrounding neighborhoods.[352] It was national policy to firmly maintain residential segregation. Even after the rule was invalidated in 1949, by which time over 170,400 units of public housing were already built, public housing continued to be sited in segregated communities of color.[353] By 1980, more than one million public housing units were built in highly segregated areas of the United States that were and continue to be disproportionately exposed to substandard conditions and environmental hazards.[354]

The harm was compounded by the federal Urban Renewal Program, instituted under the Housing Act of 1949, that authorized the use of eminent domain powers to seize and sell land in "blighted" areas to developers.[355] "Approximately one million people were displaced in 2,500 projects carried out in 993 American cities; 75% of those displaced were people of color."[356] Forced displacement policies, including urban renewal and interstate highway development practices, displaced communities without compensation, replacement housing, or relocation assistance. It decimated neighborhoods, businesses, and personal assets; dramatically reduced the supply of affordable and decent housing; and "broke social networks, destroyed nascent political organization, and spread diseases and violence."[357]

Today, the median wealth of a white family is nearly twelve times that of a Black family.[358] Even homeownership gains among Black families over the last fifty years were lost due to predatory lending practices in the early 2000s and the

351 *Id.*

352 Secretary of the Interior Harold Ickes, who managed the public housing program at the time the Rule was approved, had a foundation of combatting discrimination and promoting integration. Despite this foundation, he "caved to the politics of the time" and likely approved of this Rule to "avoid clashes with segregationists" and appease a wary public. Betsey Martens, Elizabeth Glenn & Tiffany Mangum, *Race, Equity and Housing: The Early Years*, J. HOUS. & CMTY. DEV. (Oct. 9, 2020), https://www.nahro.org/journal_article/race-equity-and-housing-the-early-years.

353 COFFEY ET AL., *supra* note 337.

354 *Id.*; *see also* ROTHSTEIN, *supra* note 249.

355 Mindy Thompson Fullilove & Rodrick Wallace, *Serial Forced Displacement in American Cities, 1916–2010*, 88 J. URB. HEALTH 381 (2011).

356 *Id.*

357 *Id.* at 382–83.

358 Janelle Jones, *The Racial Wealth Gap: How African-Americans Have Been Shortchanged Out of the Materials to Build Wealth*, ECON. POL'Y INST.: WORKING ECON. BLOG (Feb. 13, 2017), https://www.epi.org/blog/the-racial-wealth-gap-how-african-americans-have-been-shortchanged-out-of-the-materials-to-build-wealth.

subsequent foreclosure crisis, thereby increasing the Black renter population.[359]

Pandemic-era research offers important insights into the necessity of addressing past harms to ensure the success of future interventions. In a study of renter experiences with pandemic-era state level eviction moratoria, the effects of past discrimination had a chilling effect on renter access to eviction protections, as described in the following excerpts:

> For example, Ashton, a Black college student in Florida, was aware of the moratoriums but expressed concern that these policies would be applied in a discriminatory way . . . and would not protect him from his landlord's eviction threats . . . "Mentally, of course, I'll just start thinking . . . that I'm Black and maybe these people are kind of not really considering Blacks for assistance or help in this case." . . . .
>
> Dre, a Black Florida resident, also expressed concerns that racially discriminatory implementation of the moratoriums might undermine the policies' protections . . . "For me, I was denied. But for them [a White neighbor], their application was accepted and that's just a classic example of how this system is rigged against [non-White people]." These experiences made him question the ability of the moratoriums to protect him as a Black renter . . . .
>
> [P]articipants described how racial discrimination deterred them from seeking other eviction-prevention resources . . . . Ian, another Black Florida renter, noted, "I felt probably I wouldn't get any help—and considering, like, I'm Black—so I thought I'd be discriminated on . . . so that's why I didn't, like, bother trying to get some help."[360]

Especially as federal, state, and local governments seek to address the dual crises of affordable housing and eviction, there remains an urgent need to uncover this type of history and its consequences, and to offer opportunities for affected populations to share experiences that can inform solutions. This type of exploration is critical to accountability, building trust, developing an accurate problem statement, and healing past and ongoing trauma due to structural racism. Professor Yearby recommends the adoption of a truth and reconciliation process, like the one developed in Providence, Rhode Island, a state that passed a ballot to remove "Providence Plantations" from its official name in 2020. The city developed a plan

359 *See* Yearby, *supra* note 35.
360 Keene et al., *supra* note 9.

to share the "state's role throughout history in the institution of slavery, genocide of Indigenous people, forced assimilation and seizure of land; followed by city leaders reviewing laws and policies that resulted in discrimination against Black and Indigenous people; and concluded with community discussion about the state's history and the ways in which historical injustices and systemic discrimination continue to affect society today."[361]

C. Design Laws and Policies to Address the Structural Determinants of Health Inequity & Provide Supports and Legal Protections

The U.S. eviction system is among the most egregious representations of structural determinants of health inequity, determining the trajectory of a person's health and well-being in mere minutes and reinforcing race-class subjugation. The final principles enumerated in the Health Justice Framework offer mechanisms for supplanting the current eviction system with one that facilitates access to the supports necessary to avoid eviction, and ultimately addresses the structural determinants of health inequity through protective and corrective laws and policies. The third principle of the Health Justice Framework directs that law and policy must address the social determinants that threaten historically marginalized people's health, financial, and social well-being. The fourth principle adds that laws and policies must be accompanied by legal protections, social supports, and necessary accommodations. This section will apply these complementary principles jointly to the socioeconomic and political contexts in the eviction system.

As described in Part I, III, and IV, the structural determinants include the socioeconomic and political contexts that result in discriminatory policies and lead to intermediary determinants of poor health, including reduced material circumstances. The structural determinants include: (1) governance processes (legislative, administrative, and judicial), (2) laws and policies, (3) budgets, and (4) enforcement processes, among others. In the third principle of the Health Justice Framework, each of these four contexts must be evaluated and redesigned to prioritize and ensure health equity. At the same time, the fourth principle of the Health Justice Framework requires that supportive measures (e.g., rental assistance and housing subsidies) and legal protections (e.g., against retaliation for reporting conditions violations) be adopted to support positive health outcomes and to address immediate needs. The descriptions that follow provide non-exhaustive examples of how prioritizing health justice within the socioeconomic and political contexts can support policymakers and courts in the effort to increase housing stability and health equity.

361 *Id.*

1. Governance Process and Court-based Procedures

While many courts continue to see landlords as their primary stakeholder,[362] numerous courts adopted strategies that increased housing stability, primarily during the COVID-19 pandemic, including eviction diversion, pre-eviction outreach, increased filings fees, evidentiary standards, and tenant right to counsel. This list is by no means comprehensive, and courts and policymakers are directed to the 2022 American Bar Association Resolution on Ten Guidelines for Residential Eviction Laws and the National Center for State Courts for additional interventions.[363]

Eviction Diversion

Eviction diversion programs are aimed at keeping renters in their homes and resolving any disputes between landlords and tenants outside the eviction court system. This approach connects parties to support and, where implemented pre-filing, prevents the initial formation of the eviction record and the subsequent "Scarlet E." The necessary components to a successful eviction diversion program include access to an attorney or advocate, an alternative to the court process, and assistance—such as supportive services, financial assistance, debt forgiveness, housing counseling, and case management. It is critical that all three prongs of diversion are offered in tandem. Programs that implement mediation alone risk replicating the power imbalance and inequitable outcomes present in the eviction system. The pre-filing, mandatory eviction diversion program in Philadelphia offers a model: tenants have access to an advocate, rental assistance, and the opportunity to enter into a facilitated alternative to housing court, including mediation and legal services consultation.[364] Similarly, after demonstrating the return on investment in multiple cities, Michigan expanded to a statewide diversion program that included state court rule changes to encourage greater participation in the program.[365] Across all eviction diversion programs that have been studied,

362 Sudeall & Pasciuti, *supra* note 212.

363 *ABA Ten Guidelines for Residential Eviction Laws*, AM. BAR ASSOC. (Mar. 14, 2022), https://www.americanbar.org/groups/legal_aid_indigent_defense/sclaid-task-force-on-eviction—housing-stability—and-equity/guidelines-eviction.

364 *City of Philadelphia's Eviction Diversion Program: About Page*, CITY OF PHILA. DEPT. OF PLAN. & DEV., https://eviction-diversion.phila.gov/#/About (last visited Jul. 31, 2023); Aidan Gardiner, *How Philadelphia Kept Thousands of Tenants from Being Evicted*, N.Y. TIMES (July 13, 2023), https://www.nytimes.com/2023/07/13/headway/philadelphia-tenants-eviction.html?smid=url-share; *see also Eviction Diversion Program in Jackson County, MI*, EVICTION INNOVATIONS (May 27, 2020), https://evictioninnovation.org/2020/05/27/diversion-jackson-co.

365 Press Release, Exec. Off. of the President, FACT SHEET: White House Summit on Building Lasting Eviction Prevention Reform (Aug. 2, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/02/fact-sheet-white-house-summit-on-building-lasting-eviction-

67 to 95 percent of participating tenants stayed housed.[366]

Pre-Eviction Outreach to High-Risk Renters

Courts, local government, and community-based organizations can partner to use data patterns and machine learning tools to identify tenants who are at risk of possible eviction, following examples from New York, Los Angeles, and Washington, D.C. For example, in D.C., the Children's Law Center partnered with a local hospital system and the Department of Housing to identify communities at high risk of asthma due to substandard housing conditions, allowing directed outreach and code enforcement. Early intervention in housing conditions cases also serves to prevent eviction, as retaliatory evictions frequently occur after a tenant reports a landlord for code violations. During the pandemic, tenant organizations in jurisdictions across the country frequently accessed court filing records and proactively conducted outreach to tenants facing eviction to link tenants to legal assistance, rights education, and resources. In Los Angeles, SAGE-Strategic Action for a Just Economy developed a tool to analyze displacement risk by mapping distressed properties, ownership patterns, and eviction history, among other risk factors. Through these strategies, tenants are identified and provided social supports and legal assistance to prevent or proactively address landlord harassment, eviction, and poor housing conditions prior to displacement.

Increased Filing Fees

Low filing fees allow landlords to use the court to collect rent, control or intimidate tenants, and promote serial eviction filing practices. Increased filing fee costs can motivative landlords to amicably work out a solution with tenants to avoid such cost. Multiple studies have found that increasing the cost of filing an eviction significantly reduces eviction rates.[367] For example, in an Eviction Lab study, researchers determined that an increase in the filing fee of $100 would reduce the eviction filing rate by 2.25 percentage points.[368] The researchers explained the implications: "For context, the eviction filing rate in the median

prevention-reform.

366 EVICTION DIVERSION AND PREVENTION PROGRAMS, NETWORK FOR PUB. HEALTH L. (May 19, 2021), https://www.networkforphl.org/wp-content/uploads/2021/05/Fact-Sheet-Eviction-Diversion.pdf.

367 Henry Gomory et al., *The Racially Disparate Influence of Filing Fees on Eviction Rates*, 33 HOUS. POL'Y DEBATE 1463 (2023); *see also* Ashley C. Bradford & David W. Bradford, *The Effect of State and Local Housing Policies on County-Level Eviction Rates in the United States, 2004-2016* (2021), https://dx.doi.org/10.2139/ssrn.3623318.

368 Henry Gomory et al., *When it's Cheap to File an Eviction Case, Tenants Pay the Price*, EVICTION LAB (June 6, 2023), https://evictionlab.org/tenants-pay-for-cheap-evictions.

neighborhood in our sample is 3.3 percent. That $100 increase to the filing fee would more than halve its number of eviction cases. It would also drive down the eviction judgment rate by 0.64 percentage points, directly helping to keep tenants in their homes."[369] However, tenant protections must be adopted to prevent landlords from passing the cost of filing and other fees onto tenants. Jurisdictions can prohibit the practice of adding court costs, including the judgment amount, to rental fees, or withholding it from the security deposit.

Evidentiary Standards

A common strategy during the Great Recession was to require that landlords demonstrate an evidentiary basis for their claim, providing full documentation of notices and other documents, before being allowed to file an eviction. New York requires similar production of evidence prior to filing a debt collection case to ensure there is sufficient grounds for the case and to prevent improper service of process and other due process issues.[370] This practice prevents the abuse of the court system and filters out unmeritorious claims. During the pandemic, numerous courts demonstrated their ability to require documentation by requiring a landlord affidavit certifying the property is not covered by the state, local, or federal moratoriums.[371] Similar evidentiary standards can be permanently adopted.

Right to Counsel

Tenant right to counsel programs address the imbalance of power in eviction proceedings and are credited with redressing disparities in the eviction system by reducing eviction filings, orders of eviction, and involuntary moves, among other positive outcomes for tenants.[372] A study of Los Angeles reviewed publicly available eviction court data and determined that 97 percent of tenants were unrepresented and out of the unrepresented tenants, 99 percent likely experienced displacement.[373] In analyzing the case information for local legal aid providers, the study found that tenants who are represented are able to avoid disruptive

369 *Id.*

370 James C. McKinnley, Jr., *Top State Judge Tightens Rules on Debt Collection*, N.Y. TIMES (May 1, 2014), https://w ww.nytimes.com/2014/05/01/nyregion/top-state-judge-tightens-rules-on-debt-collection.html.

371 *See, e.g.*, *CARES Act Affidavit*, MO. CTS. (May 13, 2020), https://www.courts.mo.gov/file.jsp?id=156716.

372 *See generally Eviction Right to Counsel Resource Center*, STOUT, https://www.stout.com/en/services/transformative-change-consulting/eviction-right-to-counsel-resources (last visited July 28, 2023).

373 STOUT, COST-BENEFIT ANALYSIS OF PROVIDING A RIGHT TO COUNSEL TO TENANTS IN EVICTION PROCEEDINGS 10 (2019).

displacement 95 percent of the time.[374] After Cleveland adopted the right to counsel, tenants avoided judgment or an involuntary move in 93 percent of cases.[375] Right to counsel also appears to decrease filing rates, thereby changing landlord behavior.[376] In response to the heightened risk of eviction during the COVID-19 pandemic and at the urging of tenants and advocacy organizations, tenant right to counsel was adopted in a record number of jurisdictions. As of May 2024, seventeen cities, five states, and one county have legislatively adopted the tenant right to counsel.[377] While the intervention has yet to be comprehensively studied—especially in jurisdictions with limited notice requirements, rent bonds, or punitive eviction practices[378]—to ensure the right to counsel provides the greatest benefit, it is critical to engage tenants in the development of the right and as advisors throughout its existence, avoid rigid eligibility criteria (e.g., familial status) and processes, provide the right to all tenants, partner with community-based organizations and tenant groups to educate and inform tenants about their rights and how to access the benefit, and fully fund the right to prevent it from lapsing into a short-term benefit that only occurs when policymakers are motivated to include it in the budget. Shifts in the court process, such as postponing hearings to allow tenants to access the right and bench cards (e.g., Washington state) that allow or require judges to inform tenants about right to counsel, are also critical to the success of the right to counsel.

2. Laws and Policies

Federal, state, and local governments must consider the impact of their eviction and housing laws and policies on the health and well-being of historically marginalized people and communities. Because the social determinants of health are affected by government decision-making, it is imperative that states and localities take a health justice approach to housing policy development that redresses the historical and root causes of structural racism and anticipates possible negative health consequences, especially for the people at highest risk of housing

374 *Id.*

375 CLEVELAND EVICTION RIGHT TO COUNSEL ANNUAL INDEPENDENT EVALUATION: JANUARY 1, 2022 TO DECEMBER 31, 2022, STOUT (Jan. 31, 2023), https://freeevictionhelpresults.org/wp-content/uploads/2023/01/UPDATED-Stouts-2022-Independent-Evaluation-FINAL_2023.01.31.pdf.

376 *Id.*; *see also* NYC HUM. RESOURCES ADMIN., UNIVERSAL ACCESS TO LEGAL SERVICES: A REPORT ON YEAR FOUR OF IMPLEMENTATION IN NEW YORK CITY 3 (2021).

377 *The Right to Counsel for Tenants Facing Eviction: Enacted Legislation*, NAT'L COAL. FOR A CIV. RIGHT TO COUNSEL, http://civilrighttocounsel.org/uploaded_files/283/RTC_Enacted_Legislation_in_Eviction_Proceedings_FINAL.pdf (last modified Nov. 2023).

378 *See supra* Section IV.C; *see also LSC Eviction Laws Database*, LEG. SERV. CORP. (2021), https://www.lsc.gov/initiatives/effect-state-local-laws-evictions/lsc-eviction-laws-database.

displacement (households with children, women, and Black people). Policymakers must monitor legislation and amend or repeal laws that could negatively impact low-income and minority populations by: "(1) evaluat[ing] how a law might be applied, intentionally or inadvertently, to the disadvantage of marginalized individuals; and (2) examin[ing] the potential health effects on the entire population, paying special attention to marginalized individuals."[379] Laws and policies must affirmatively and aggressively address past and current drivers of health inequity and promote positive health outcomes among low-income and historically marginalized populations. Health justice principles—such as the truth and reconciliation process, community empowerment, and community driven-structural change described herein, as well as tools that include the Environmental Impact Assessment, Health Equity Impact Assessment, or the Child Impact Assessment—can be used to identify deleterious health effects of eviction and housing policy that disproportionately impact people and communities of color and develop health protective laws and policies.[380] Equally critical, state laws that constrain or preempt local efforts to address eviction and increase health and housing equity must be addressed.[381] Failure to address barriers and take these collective precautions will most certainly result in policies that either maintain the status quo and perpetuate poor health or create new health hazards, both of which reinforce patterns of structural racism and health inequity.

Multiple immediate measures can be taken to improve laws and policies governing eviction, including the following non-exhaustive first steps toward health justice and equity. The 2023 White House Blueprint for a Renters Bill of Rights offers additional, critical interventions that can be adopted at the federal, state, and local levels.[382]

Clean Hands and Just Cause Eviction Requirements

Landlords should be required to verify compliance with rental ordinances,

379 *Health Justice*, *supra* note 21, at 341.

380 KIDSIMPACT: ADVOCATES FOR CHILDREN, https://kidsimpact.org (last visited Mar. 8, 2020); *HIAs and Other Resources to Advance Health-Informed Decisions: A Toolkit to Promote Healthier Communities Through Cross-Sector Collaboration*, PEW, https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/hia-map?sortBy=relevance&sortOrder=asc&page=1 (last updated Feb. 2023).

381 *See generally* THE LOCAL POWER AND POLITICS REVIEW 10 (2022), https://static1.squarespace.com/static/5ce4377caeb1ce00013a02fd/t/621ef122d42c703ace74086b/1646194985581/LPPR-VolumeII-2022.pdf; *see also* Nestor M. Davidson, *The Dilemma of Localism in an Era of Polarization*, 128 YALE L.J. 954 (2019); Joshua S. Sellers & Erin A. Scharff, *Preempting Politics: State Power and Local Democracy*, 72 STAN. L. REV. 1361 (2020).

382 THE DOMESTIC POL'Y COUNCIL & NAT'L ECON. COUNCIL, THE WHITE HOUSE BLUEPRINT FOR A RENTERS BILL OF RIGHTS (2023), https://www.whitehouse.gov/wp-content/uploads/2023/01/White-House-Blueprint-for-a-Renters-Bill-of-Rights.pdf.

housing quality standards, and continuous, reasonable access ("clean hands"). The need for adoption and enforcement of clean hands laws was apparent during the COVID-19 eviction crisis: 90 percent of eviction cases filed in Detroit were filed by landlords whose properties were not in compliance with the city's rental ordinance.[383] In Cleveland, the Housing Court exercised its authority to adopt a clean hands rule.[384] The court conducts routine reviews of the eviction docket and requires any property owner with an outstanding warrant for code violations to appear and enter a plea in the criminal case before the eviction action can proceed.[385] New York state proposed a Clean Hands bill[386] that would make it unlawful for a landlord to file an eviction action where the property has outstanding charges of building code violations. Philadelphia plans to mitigate this issue by creating a publicly available database of landlords and information about their properties.[387]

In addition, policymakers must address the harmful loophole created by "no fault" eviction laws. To date, at least eight states have formally adopted "just cause" eviction standards.[388] In a "just cause" jurisdiction, landlords can only file for eviction against a tenant for a limited number of causes of action. This approach is likely to prevent the discrimination and abuse that occurs in "no fault" jurisdictions and to reduce serial eviction filing. Early research demonstrates that cities that implemented just cause eviction laws experienced lower eviction (by 0.808 percentage points) and eviction filing rates (by 0.780 percentage points) than those that did not.[389] These policies should be adopted across Low Income Housing Tax Credit ("LIHTC"), federally assisted, and private market housing.[390]

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383 EISENBERG & BRANTLEY, *supra* note 233.

384 *See* URBAN ET AL., *supra* note 187; RAYMOND L. PIANKA, CLEVELAND HOUSING COURT—A PROBLEM-SOLVING COURT ADAPTS TO NEW CHANGES, TRENDS IN STATE COURTS (2012); Robert Jaquay, *Cleveland's Housing Court*, SHELTERFORCE (May 1, 2005), www.nhi.org/online/issues/141/housingcourt.html.

385 *See* PIANKA, *supra* note 384.

386 A.1853, 2023–2024 Leg. Sess. (N.Y. 2023).

387 *Mayor's Taskforce on Eviction Prevention and Response*, CITY OF PHILA. (June 2018), https://www.phila.gov/documents/mayors-task-force-on-eviction-prevention-and-response-final-report.

388 Sophie Quinton, *Blue States Pass 'Good Cause' Eviction Laws,* PLURIBUS NEWS (Apr. 30, 2024), https://pluribusnews.com/news-and-events/blue-states-pass-good-cause-eviction-laws/; NADA HUSSEIN & SARAH GALLAGHER, NAT'L LOW INCOME HOUS. COAL., THE STATE OF STATEWIDE TENANT PROTECTIONS (May 2023), https://nlihc.org/sites/default/files/state-statewide-tenant-protections.pdf.

389 Cuellar, *supra* note 226.

390 *See generally* Florence Wagman Roisman, *The Right to Remain: Common Law Protections for Security of Tenure*, 86 N.C. L. REV. 817 (2008); Letter from the Nat'l Hous. L. Project, *supra* note 228.

Providing Legal Defenses to Eviction and the Right to Be Heard (Eliminating Rent Bonds)

Courts should implement methods for educating tenants about their rights and provide tenants with an opportunity to assert defenses to an eviction, such as a landlord's breach of the warranty of habitability, self-help eviction attempts, or retaliation. Automating appeal rights can also assist unrepresented tenants in exercising rights and increase fairness and equity in proceedings. At the same time, the elimination of rent bond requirements is necessary to ensure that all tenants can have the ability to exercise their right to be heard or to appeal a decision, regardless of their ability to pay into the court or the landlord's claims of rental arrears.

Right to Cure, Grace Period, Redemption Rights

States and localities should mandate that landlords offer tenants a reasonable payment plan that gives tenants additional time to pay rent or the ability to pay in installments (e.g., according to their income over multiple months). In the District of Columbia, some landlords have adopted a credit system, wherein every on time rental payment is also credited toward rental debt forgiveness. To address rental arrears, jurisdictions must require the landlord to support the tenant's application for, and accept, rental assistance. HUD strongly supports the use of repayment plans, recommending that the monthly retroactive rent payment plus the amount of rent the tenant pays at the time the repayment agreement is executed should not exceed 40 percent of the family's monthly adjusted income.[391] During the pandemic, some states, including Connecticut, Oregon, and North Carolina instituted mandatory or upon request grace periods to pay rent.[392] The Oregon law created a grace period of six months for tenants following the close of the emergency period to repay their arrearages.[393] The tenants were required, however, to give the landlord notification that they plan to utilize the grace period.[394] Landlords could not charge tenants a late fee for using this grace period and paying late[395] and had the voluntary option of offering tenants an alternative repayment plan to the grace period..[396] Research on the effect of moratoria during the pandemic demonstrated that additional time was helpful to tenants and allowed

391 REPAYMENT AGREEMENT GUIDANCE, U.S. DEP'T HOUS. & URB. DEV., https://www.hud.gov/sites/dfiles/PIH/documents/Attachment4_Repayment_Agreement_Guidance.pdf (last visited July 28, 2023).

392 Conn. Exec. Order No. 7X (May 10, 2020); H.B. 4213, 80th Leg. Assemb., 1st Spec. Sess. (Or. 2020); N.C. Exec. Order No. 142 (May 30, 2020).

393 H.B. 4213, 80th Leg. Assemb., 1st Spec. Sess. (Or. 2020)

394 *Id.*

395 *Id.*

396 *Id.*

them to gather resources and avoid eviction.[397]

Late Fee Bans and Limits

Policymakers can implement late fee bans or limits and create a buffer period following the rent due date, in which tenants can pay rent without being charged a late fee or being in violation of the lease. Multiple states successfully prohibited late fees during the pandemic.[398]

Record Sealing and Regulating the Use of Eviction Records

Avenues for addressing the "Scarlet E" precipitated by an eviction filing include two broad categories: (1) regulating private actors' use of eviction records; and (2) altering courts' creation and storage of such records to prevent access.[399] Record sealing prevents landlords from using a tenant's prior rental history against them when they apply for new housing. Multiple states have attempted to prevent the long-term negative consequences of eviction records by limiting public access to eviction records (e.g., record sealing or expungement), prohibiting the denial of an application for tenancy based on eviction records, and limiting the types of evictions that appear on tenant screening reports.[400] Numerous states, including California, Colorado, Florida, Illinois, and Minnesota,[401] among others, have adopted mandatory or discretionary record sealing laws.[402] In addition, during the COVID-19 pandemic policymakers introduced 31 eviction record sealing bills[403] and the American Bar Association passed a resolution urging federal, state, and local government to prohibit tenant screening practices that include nonpayment of rent evictions that occurred during the pandemic, indicating an understanding of the importance of the policy to public health.[404]

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397 *See, e.g.*, Keene et al., *supra* note 9, at 445–46.

398 *See* Ryan P. Sullivan, *Survey of State Laws Governing Fees Associated with Late Payment of Rent*, 24 CITYSCAPE 269 (2022); *see, e.g.*, H.B. 4213, 80th Leg. Assemb., 1st Spec. Sess. (Or. 2020).

399 Esme Caramello & Nora Mahlberg, *Combating Tenant Blacklisting Based on Housing Court Records: A Survey of Approaches*, SHRIVER NAT'L CTR. ON POVERTY L.: CLEARINGHOUSE COMMUNITY (Sept. 2017), https://perma.cc/PZX2-9HJE.

400 Jaboa Lake & Leni Tupper, *Eviction Record Expungement Can Remove Barriers to Stable Housing,* CTR. FOR AM. PROGRESS (Sept. 30, 2021), https://www.americanprogress.org/issues/poverty/reports/2021/09/30/504373/eviction-record-expungement-can-remove-barriers-stable-housing.

401 *See* CAL. CIV. PRO. CODE § 1161.2; COLO. REV. STAT. § 13-40-110.5; FLA. STAT. § 83.626; 735 ILL. COMP. STAT. § 5/9-121; MINN. STAT. § 84.014.

402 Lake & Tupper, *supra* note 400.

403 Rickard & Khwaja, *supra* note 324.

404 AM. BAR ASS'N., RESOLUTION 10H: PREVENTING AN EVICTION CRISIS AND FURTHER HOUSING INSECURITY FOLLOWING THE COVID-19 PANDEMIC (2020), https://www.americanbar.org/

The federal government is also called to respond to the deleterious effect of eviction records. Members of Congress have introduced multiple bills that included provisions on eviction record sealing or tenant screening practices.[405] HUD should issue guidance interpreting the Fair Housing Act to require individualized assessments (as opposed to reliance on tenant screening reports) before applicants can be denied housing admission due to a prior eviction. This guidance should make it clear that the automatic denial of applicants with prior eviction filings against them is a violation of the Fair Housing Act due to the disparate impact on Black and Hispanic households, women, and families.[406] HUD should also require public housing authorities that evict tenants through the formal court process to petition the court to seal any eviction record from public housing.

The Consumer Financial Protection Bureau ("CFPB") issued an advisory opinion that addresses tenant screening practices, including a directive that background reports should not contain records that have been "expunged, sealed, or otherwise legally restricted from public access."[407] The CFPB and Federal Trade Commission can also issue an opinion interpreting the subject matter regulated under section 15 U.S.C. § 1681c(a) of the Fair Credit Reporting Act to afford states greater freedom to restrict the reporting of eviction records that are unfair or that contravene public policy objectives. To demonstrate the need for state and federal action, CFPB could conduct and publish a market report on landlords' use of tenant screening reports and the effect on renters, like it has with employers' use of criminal background checks.[408]

3. Budgets

Federal, state, and local budgets operate as structural determinants of health inequity. The recommendations enumerated throughout this article cannot be possible, and health equity cannot be achieved, unless substantial investments are directed to eviction prevention, affordable housing, community development, home ownership, and supports that help historically marginalized people and communities recover from over a century of insidious interpersonal, systemic, and structural racism. Robust action by federal and state governments to direct funds toward eliminating historical, structural, and institutional discrimination—

content/dam/aba/administrative/news/2020/08/2020-am-resolutions/10h.pdf.

405 Eviction Crisis Act of 2021, S. 2182, 117th Cong. (2021).

406 *See* 24 C.F.R. § 100.500(a).

407 ROHIT CHOPRA, CONSUMER FINANCIAL PROT. BUREAU ADVISORY OPINION (2024), https://files.consumerfinance.gov/f/documents/cfpb_fair-credi-reporting-background-screening_2024-01.pdf.

408 CONSUMER FINANCIAL PROT. BUREAU, MARKET SNAPSHOT: BACKGROUND SCREENING REPORTS (2019), https://files.consumerfinance.gov/f/documents/201909_cfpb_market-snapshot-background-screening_report.pdf.

following the direction of affected populations—is paramount.

First, policymakers at every level of government must invest in affordable, safe, and decent housing and provide equitable access to thriving communities and areas of opportunity to ensure that a person's health is no longer determined by zip code. The American Rescue Plan Act ("ARPA") State and Local Fiscal Recovery program marked the first-time communities across the nation made significant investments in affordable housing, eviction prevention, and homelessness prevention.[409] The Biden Administration's 2023 and 2024 Budgets included historic investments in housing, amounting to over $175 billion in 2023 that included building and preserving affordable housing, providing assistance to first-generation homebuyers who were excluded from generational wealth building, and adopting pandemic-era interventions in eviction prevention, eviction diversion, and rental assistance.[410] The budget proposals recognized the effects of racially discriminatory laws and policies and represents the most comprehensive approach to addressing housing inequity in recent history. Regrettably, it has yet to pass in entirety, and few state and local budgets have even partially matched the ARPA investments.

Market Interventions and Rent Subsidies

Pursuant to health justice principles, the United States must invest in race-class subjugated communities, including historically marginalized communities, through market interventions that include rental subsidies and new construction or rehabilitation that will increase long-term affordable housing.[411] Rental subsidies are necessary to address the increasing costs of housing and should be combined with complementary market interventions, such as rent regulation systems, to prevent displacement, especially among low-income renters.[412] At the same time,

409 *Local Government ARPA Investment Tracker*, BROOKINGS, https://www.brookings.edu/articles/arpa-investment-tracker/ (last updated Mar. 15, 2024); American Rescue Plan Act of 2021, P.L. 117-2 (2021).

410 Press Release, Exec. Off. of the President, FACT SHEET: President Biden's Budget Lowers Housing Costs and Expands Access to Affordable Rent and Home Ownership (Mar. 9, 2023), https://www.whitehouse.gov/omb/briefing-room/2023/03/09/fact-sheet-president-bidens-budget-lowers-housing-costs-and-expands-access-to-affordable-rent-and-home-ownership; *see also* Press Release, Exec. Off. of the President, President Biden Announces New Actions to Ease the Burden of Housing Costs (May 16, 2023), https://www.whitehouse.gov/briefing-room/statements-releases/2022/05/16/president-biden-announces-new-actions-to-ease-the-burden-of-housing-costs.

411 THE DOMESTIC POLICY COUNCIL AND NATIONAL ECONOMIC COUNCIL, THE WHITE HOUSE BLUEPRINT FOR A RENTERS BILL OF RIGHTS (2023), https://www.whitehouse.gov/wp-content/uploads/2023/01/White-House-Blueprint-for-a-Renters-Bill-of-Rights.pdf.

412 NYU Furman Ctr., Rent Regulation for the 21st Century: Pairing Antigouging with Targeted Subsidies (Apr. 2021), https://furmancenter.org/files/Rent_Regulation_for_the_21st_Century.pdf.

Government-Sponsored Enterprises ("GSE") must remedy the current market conditions that can be traced to racially discriminatory lending policies. To accomplish this, GSEs must address disparities in asset accumulation, the racially dual home mortgage lending market (in which Black people receive FHA loans), the persistence of mortgage lending discrimination, and the siting of homes, as detailed herein. (*See* Section V.B.)

Financial Supports

Unemployment insurance,[413] the pandemic-era Child Tax Credit,[414] safety net programs (e.g., Temporary Assistance to Needy Families and Supplemental Nutrition Assistance Program), and rental assistance or housing payments all increase the affordability of housing and are demonstrated to prevent eviction. Yet, safety net programs are drastically underfunded and difficult to access, and Congress allowed the Child Tax Credit expansion to lapse despite its record of reducing child poverty by more than 40 percent.[415] Other than the American Recovery and Reinvestment Act of 2009, which distributed $741 million in rental assistance to about 336,000 households across three years, the United States had no history of a large-scale, nationwide federal program dedicated to short-term emergency rental assistance until the COVID-19 pandemic.[416] Prior to the pandemic, just over forty rental assistance programs existed nationally.[417] Early programs were underfunded, depleted in a few hours,[418] and covered a fraction of

413 Ryan Nunn et al., *Incomes Have Crashed. How Much Has Unemployment Insurance Helped?*, BROOKINGS INST. (May 13, 2020), https://www.brookings.edu/blog/up-front/2020/05/13/incomes-have-crashed-how-much-has-unemployment-insurance-helped.

414 *Id.*

415 Chuck Marr, Kris Cox & Sarah Calame, *Any Year-End Tax Legislation Should Expand Child Tax Credit to Cut Child Poverty*, CTR. BUDGET & POL'Y PRIORITIES (Nov. 7, 2023), https://www.cbpp.org/research/federal-tax/any-year-end-tax-legislation-should-expand-child-tax-credit-to-cut-child; Zachary Parolin et al., *Monthly Poverty Rates Among Children After the Expansion of the Child Tax Credit*, 5 POVERTY & SOC. POL'Y BRIEF 1 (2021), https://www.povertycenter.columbia.edu/news-internal/monthly-poverty-july-2021.

416 THE WHITE HOUSE, ADVANCING EQUITY THROUGH THE AMERICAN RESCUE PLAN 161 (2022), https://www.whitehouse.gov/wp-content/uploads/2022/05/Advancing-Equity-Through-The-American-Rescue-Plan.pdf.

417 Solomon Greene & Samantha Batko, *What Can We Learn from New State and Local Assistance Programs for Renters Affected by COVID-19?*, URB. INST. (May 6, 2020), https://housingmatters.urban.org/articles/what-can-we-learn-new-state-and-local-assistance-programs-renters-affected-covid-19. This included some private programs; at the "outset of the pandemic, only a few dozen jurisdictions operated [public] rental assistance programs or eviction diversion programs." Jacob Leibenluft, *Emergency Rental Assistance: Supporting Renting Families, Driving Lasting Reform*, U.S. DEP'T OF THE TREAS. (Mar. 22, 2023).

418 *See, e.g.*, Michelle Homer & Doug Delony, *All Funds for Houston Rental Assistance Program are Already Gone and Site is Now Closed*, KHOU (May 13, 2020), https://www.khou.com/article/news/health/coronavirus/rental-assistancefor-houstonians-

the rental debt (limited to one to three months of assistance)[419] or were capped at a few hundred dollars.[420] The pandemic-era CARES Act appropriated up to $4 billion to states and localities that could be used to create or expand rental assistance programs. However, the funding fell far short of the national need and, according to the National Low Income Housing Coalition, the programs were heterogeneous, had limited funding, and often required onerous documentation, including proof of COVID-19 hardship, which led to the denial of high-risk tenants or deterred applications altogether.[421]

Emergency Rental Assistance and Eviction Court Reform

Federal, state, and local governments should permanently establish Emergency Rental Assistance ("ERA") programs and the eviction court reform that the federal ARPA ERA prompted. The ARPA ERA program established, for the first time, a national framework for preventing tenant interactions with the eviction system. In response to the pandemic eviction crisis, Congress created the ERA program, dedicating a historic $46.5 billion in rental and utility assistance to state, local and tribal grantees[422] to prevent eviction and utility shut-offs due to non-payment.[423] The ERA program, and the Biden Administration's guidance to support grantees in establishing over 700 programs across the country, is credited with keeping eviction filings well below pre-pandemic historical averages during the height of and throughout the pandemic for the first time since eviction data

deadline/285-55a97aa7-a7ce-46ef-91e0-44574bc1adb9.

419 *See, e.g.*, Gabriella Nuñez, *City of Kissimmee to provide foreclosure, rental assistance for those impacted by COVID-19*, CLICK ORLANDO (Mar. 31, 2020), https://www.clickorlando.com/news/local/2020/03/31/city-of-kissimmee-to-provide-foreclosure-rental-assistance-for-those-impacted-by-covid-19.

420 *See, e.g.*, MTN News, *Whitefish Housing Authority Establishes Emergency Rental Assistance Fund*, KPAX (Mar. 27, 2020 5:06 PM), https://www.kpax.com/news/local-news/flathead-county/whitefish-housing-authority-establishes-emergency-rental-assistance-fund.

421 Vincent Reina et al., COVID-19 Emergency Rental Assistance: Analysis of a National Survey of Programs (Jan. 2021), https://nlihc.org/sites/default/files/HIP_NLIHC_Furman_Brief_FINAL.pdf.

422 *ERA Eligible Units of Local Governments*, U.S. DEPT. OF THE TREAS., https://home.treasury.gov/system/files/136/ERA-List-of-Eligible-Local-Governments-Final.pdf (last visited July 29, 2023); *Emergency Rental Assistance Program: Payments to Tribes and Tribally Designated Housing Entities (TDHE)*, U.S. DEPT. OF THE TREAS. (Feb. 26, 2021), https://home.treasury.gov/system/files/136/Payments-to-Tribes-and-TDHEs.pdf.

423 In January 2021, the Consolidated Appropriations Act provided $25 billion for rental and utility assistance, establishing the Emergency Rental Assistance (ERA) program. Consolidated Appropriations Act of 2021, 15 U.S.C. § 9058a; GRANT A. DRIESSEN, MAGGIE MCCARTY & LIBBY PERL, CONG. RSCH. SERV., R46688, PANDEMIC RELIEF: THE EMERGENCY RENTAL ASSISTANCE PROGRAM (2023). A second round of ERA funding—$21.55 billion—was included in Section 3201 of the American Rescue Plan Act of 2021. *See* 15 U.S.C. § 9058c.

became available.[424] Critically, the U.S. Department of the Treasury's and ARPA Implementation Team's approach to ERA, led by White House ARPA Coordinator and Senior Advisor to the President Gene Sperling, emphasized equitable access and urged on-the-ground outreach and application assistance in the highest risk communities. As a result, and as the data demonstrates, ERA was equitably distributed: over 80 percent of ERA was delivered to very low-income households earning 50 percent of Area Median Income. In addition, people who disproportionately face eviction received the majority of ERA funds: over 40 percent of applicants receiving assistance self-identified as Black; over 20 percent of applicants receiving assistance self-identified as Latino; and female-headed households made up to almost two-thirds of ERA beneficiaries.[425] This distribution is in line with the rates at which Black, Latino, and female-headed households had faced eviction filings earlier in the pandemic, according to research by the Eviction Lab.[426]

These unprecedented results are due to the Biden Administration's adoption of best practices in the administration of ARPA and ERA, including the issuance of guidance[427] that:

- strongly encouraged partnership with courts to actively prevent evictions and develop eviction diversion programs, and allowed housing stability funds to be used for both diversion and legal services;
- helped families experiencing homelessness gain access to assistance by creating a commitment letter process for those who lacked a current rental obligation;
- removed cultural and language barriers and encouraged partnership with community-based organizations and trusted community leaders to increase access and awareness;
- allowed (and even encouraged) the use of self-attestation in documenting each aspect of a household's eligibility for ERA (financial hardship, risk of homelessness or housing instability, income) in order to simplify the process and disburse funds quickly;

424 Peter Hepburn et al., *Preliminary Analysis: Eviction Filing Patterns in 2021*, EVICTION LAB (Mar. 8, 2022), https://evictionlab.org/us-eviction-filing-patterns-2021; Peter Hepburn et al., *COVID-Era Policies Cut Eviction Filings by More Than Half*, EVICTION LAB (May 3, 2023), https://evictionlab.org/covid-era-policies-cut-eviction-filings-by-more-than-half; Peter Hepburn et al., *U.S. Eviction Filing Patterns in 2020*, 7 SOCIUS 23780231211009983 (2021) [hereinafter *Filing Patterns in 2020*].

425 Press Release, U.S. Dep't of the Treas., New Treasury Data Shows Over 80% of Emergency Rental Assistance Delivered to Lowest-Income Households (Feb. 24, 2022).

426 *Filing Patterns in 2020*, *supra* note 424; THE WHITE HOUSE, *supra* note 416, at 35; U.S. Dep't of the Treas., *supra* note 425.

427 Emergency Rental Assistance: Frequently Asked Questions, U.S. DEPT. OF THE TREAS. (June 24, 2021).

- ∞ allowed grantees to provide an advance on expected assistance to large landlords and utility providers while the application process was being completed;
- ∞ allowed grantees to partner with community-trusted nonprofits to deliver advance assistance to households at risk of eviction in the community while applications were processed;
- ∞ allowed grantees to make additional payments to incentivize landlords to enter into a lease with "hard-to-house" households that would otherwise not qualify under screening policies;
- ∞ allowed grantees to provide ERA to cover past arrears at a prior address, at a tenant's request, to remove future barriers to housing stability related to outstanding debts; and
- ∞ addressed the issue of rent bonds by allowing ERA programs to cover them as an eligible "other expense" to ensure tenants had a right to raise defenses in rent bond jurisdictions, among other model interventions.

The combined result of adopting these evidence-based best practices was the rapid distribution of billions of dollars in ERA to the households that needed it most. By the end of 2021, nearly one in four grantees had spent all of their initial ERA allocation.[428] In addition to allowing landlords to recoup lost rental income and protecting tenants from eviction by covering both prospective rent and rental arrears, ERA also led to the piloting of tenant right to counsel programs and the establishment or improvement of court-based or court-adjacent eviction diversion programs. The introduction of ERA even shifted court practices, prompting judges to order the deferral of cases in order to allow parties to apply for ERA and resolve the case equitably. These model pandemic-era programs nearly eliminated eviction during the pandemic. Their permanent adoption could drastically improve health equity and housing stability among race-class subjugated communities and the most vulnerable families.

Low and No Barrier Services

As the flexibilities of ERA demonstrated, it is critical to reduce administrative burdens to ensure tenants can access any supportive services and material supports. Administrative burdens—such as eligibility determinations, documentation requirements, and lengthy application processes—block access to critical public benefits and often deter participation or result in health harms, such as increased

428 U.S. Gov't Accountability Off., GAO-22-105490, Emergency Rental Assistance: Additional Grantee Monitoring Needed to Manage Known Risks (2022).

stress and anxiety.[429] In a study of tenant experiences with state eviction moratoria, a tenant described how past experiences with administrative burdens deterred her from accessing the eviction protections afforded by the moratorium, despite eligibility: "It's never easy. I feel like sometimes it's like more trouble than it's worth, even when you really, really need it. Even having dealt with, you know, like, just getting assistance from the county over the years as far as food stamps or child-care vouchers. So, it's just always just a headache."[430] As described herein, in the effort to expedite the delivery of ARPA ERA funds, the Biden Administration issued guidance permitting and encouraged state and local grantees to adopt flexibilities in the application process, including allowing self-attestation for all areas of eligibility. Shortly after, the speed of ERA distribution rapidly increased, even in spite of some authorities' and landlords' attempts to undermine it.[431] The types of flexibility adopted during the pandemic should be applied to supportive benefits and legal protections to ensure access.

Federally Assisted Housing

In addition to the safety net of rental assistance, tenant-based and building or unit-based rental assistance programs are among the primary approaches to increasing the long-term affordability of housing and can also increase health equity. Housing Choice Vouchers ("vouchers") require tenants to pay 30 percent of their adjusted monthly gross income in rent in private market housing.[432] HUD has found that vouchers reduce homelessness, increase independent housing, increase the average number of rooms per household member, and increase household expenditures on food.[433] The study conducted by HUD also found vouchers had a significant impact on housing location:[434] vouchers were found to decrease the number of moves and result in better residential housing locations than the tenant would otherwise experience without the voucher, among other

429 Pamela Herd & Donald Moynihan, *How Administrative Burdens Can Harm Health*, HEALTH AFFS. (Oct. 2, 2020), https://www.healthaffairs.org/do/10.1377/hpb20200904.405159.

430 Keene et al., *supra* note 9, at 442.

431 *See* Will Parker, *Why Some Landlords Don't Want Any of the $50 Billion in Rent Assistance*, WALL ST. J. (Mar. 19, 2021) https://www.wsj.com/articles/why-some-landlords-dont-want-any-of-the-50-billion-in-rent-assistance-11616155203 ("In Houston, a nonprofit charged with administering pandemic rental assistance last year said more than 5,600 households who applied for money had a landlord who refused to take it"); Arthur Delaney, *Some Landlords Would Rather Evict Tenants Than Accept Federal Rental Aid*, HUFFPOST (Sep. 17, 2021), https://www.huffpost.com/entry/emergency-rental-assistance-program-landlords_n_61439bdce4b0d808bf26967e.

432 *Housing Choice Vouchers Fact Sheet*, U.S. DEP'T OF HOUS. & URBAN DEV., https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/about/fact_sheet (last visited Jul. 30, 2023).

433 Gregory Mills et al., U.S. Dep't of Hous. & Urb. Dev., Effects of Housing Vouchers on Welfare Families (2006).

434 *Id.*

positive outcomes.[435] Despite the advantages of vouchers, studies have identified varied rates of housing search success, due to source of income discrimination and other barriers.[436] HUD also reported that local housing authorities often fail to use all of the vouchers designated to them in a given year.[437] The study recommends prohibiting source of income discrimination as a method for ensuring that low-income households have the ability to use the vouchers to obtain housing.[438] Since the Fair Housing Act ("FHA") does not include source of income discrimination, a practice in which landlords discriminate against low-income renters who use subsidies like housing vouchers and other forms of public assistance, it is upon states to prohibit source of income discrimination. As of May 2023, twenty-one states have done so.[439]

Public housing and project-based programs are another important source of affordable housing that provides low-cost housing to tenants in a range of single family homes to high rise apartment buildings managed by local public housing authorities.[440] However, these units are typically located in highly segregated and resource deprived neighborhoods, are frequently cited for substandard conditions,[441] which housing authorities typically blame on lack of investment in the national Housing Trust Fund, and have a high rate of eviction and serial eviction filings.[442] These failings must be addressed to protect the 1.2 million

435 *Id.*; see Eva Rosen, *Rigging the Rules of the Game: How Landlords Geographically Sort Low–Income Renters*, 13 CITY & CMTY. 310 (2014).

436 HUD found that at least 20 percent of housing searches using vouchers are unsuccessful. DEP'T OF HOUS. & URBAN DEV., THE IMPACT OF SOURCE OF INCOME ON VOUCHER UTILIZATION AND LOCATIONAL OUTCOMES vii (2011). In another study, the median success rate was 61% after a 180-day search and ranged from less than 25% (very rare) to 100% (slightly less rare, but still uncommon). INGRID GOULD ELLEN, KATHERINE O'REGAN & SARAH STROCHAK, USING HUD ADMINISTRATIVE DATA TO ESTIMATE SUCCESS RATES AND SEARCH DURATIONS FOR NEW VOUCHER RECIPIENTS 7 (2021), https://www.huduser.gov/portal/sites/default/files/pdf/Voucher-Success_Rates.pdf.

437 Id.

438 *Id.* at 23.

439 HUSSEIN & GALLAGHER, *supra* note 388.

440 *HUD's Public Housing Program,* U.S. DEP'T OF HOUS. & URBAN DEV., https://www.hud.gov/topics/rental_assistance/phprog (last visited July 30, 2023); CONG. RSCH.SERV., INTRODUCTION TO PUBLIC HOUSING (last updated Feb. 13, 2014).

441 *See, e.g.*, Press Release, U.S. Atty's Off/ SDNY, U.S. Attorney Announces Application Process for Second Term Of NYCHA Monitorship (May 24, 2023); CREATING A TRULY INDEPENDENT DC HOUSING AUTHORITY: INCREASING POLITICAL INSULATION TO IMPROVE OUTCOMES AT DCHA, D.C. OFF. OF THE ATT'Y GEN. (2022), https://oag.dc.gov/sites/default/files/2022-12/DCHA-Report-final-.pdf.

442 Danya E Keene & Kim M Blankenship, *The Affordable Rental Housing Crisis and Population Health Equity: A Multidimensional and Multilevel Framework*, 100 J. URB. HEALTH 1212 (2023); GROMIS, ET AL., *supra* note 99; Lillian Leung et al., *No Safe Harbor: Eviction Filing in Public Housing*, 97 SOC. SERV. REV. 456 (2023).

households living in public housing, as estimated by HUD.[443] At the same time, HUD should increase its housing conditions standards for the HCV program and require that pre-rental lead paint inspections and risk assessments occur before a child is exposed and develops permanent brain damage.[444] In order for these programs to be effective, they must be examined to identify policies that reinforce structural racism and health inequity, including admission screening practices, eviction policies, and the high risk of exposure to health harms due to insufficient inspection standards and historic siting of complexes in areas of high environmental contamination.[445]

Low-Income Housing Tax Credits & Affordable Housing Development

LIHTC and other federal, state, and local affordable housing development programs provide funding for the development of long-term affordable housing. LIHTC, which provides funding for tax credits for the acquisition, rehabilitation, or new construction of rental housing reserved for lower-income households, has already supported the creation of more than two million housing units, helping to alleviate the housing shortage.[446] The Internal Revenue Service should use its regulatory authority to require stronger tenant protections and eviction deterrents in LIHTC housing, including "just cause" eviction standards. LIHTC and additional federal programs for the development of affordable housing, including Community Development Block Grants and HOME Investment Partnerships Program,[447] should be expanded and further funded.[448] On the state and local level, programs have included housing trust funds, state and local tax credits for affordable housing, and inclusionary zoning.[449] Affordable housing development,

443 *Public Housing*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/program_offices/public_indian_housing/programs/ph (last visited July 30, 2023).

444 Benfer et al., *supra* note 258.

445 *See* s*upra* Section II.B; *see also* Ann Cammett, *Confronting Race and Collateral Consequences in Public Housing,* 39 SEATTLE U. L. REV. 1123 (2016); Jeffrey Fagan et al., *Race and Selective Enforcement in Public Housing*, 9 J. EMPIRICAL LEG. STUD. 697 (2012).

446 *Low-Income Housing Tax Credits*, NAT'L HOUS. L. PROJECT, https://www.nhlp.org/resource-center/low-income-housing-tax-credits (last visited July 30, 2023).

447 For general information on these programs, see *Community Development Block Grant Program*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/program_offices/comm_planning/cdbg (last updated Jan. 17, 2024); *Home Investment Partnerships Program*, U.S. DEP'T OF HOUS. & URB. DEV., https://www.hud.gov/program_offices/comm_planning/home (last updated Dec. 22, 2022).

448 G. Thomas Kingsley, *Trends in Housing Problems and Federal Housing Assistance*, URBAN INST. (Oct. 2017), https://www.urban.org/sites/default/files/publication/94146/trends-in-housing-problems-and-federal-housing-assistance.pdf.

449 Solomon Greene & Aaron Shroyer, *How States Can Support Shared Prosperity in Cities by Promoting Affordable Rental Housing,* URBAN INST. (Mar. 26, 2020), https://www.urban.org/research/publication/how-states-can-support-shared-prosperity-cities-

land banking, and major reforms to zoning and land use could provide opportunities for development of more affordable housing. Research has shown that there is a strong correlation between zoning strictness and high housing prices.[450] All of these approaches must be well-funded and reviewed for structural determinants of health inequity in order to be successful.[451]

Community Development

Community Development also offers a model for community investment and outreach.[452] The strategy includes efforts to "improve the physical, economic, and social environment by promoting affordable housing, small-business development, job creation, and social cohesion."[453] Without such assistance, homes deteriorate, causing hazardous conditions that harm residents and the wider community.[454] Greater investment in low-income communities, and historically marginalized communities, can lead to eviction reduction, increased housing stability, less strain on families, and lower levels of violence—outcomes that increase health equity.[455] Any community development program must emphasize health justice principles that prioritize community-centered and -led problem solving to address the structural determinants of health inequity.

Human Right to Housing

Ultimately, the United States must redress the structural racism in eviction by creating the right to safe and decent housing and achieve "the goal of a decent

through-affordable-rental-housing.

450 Edward L. Glaeser & Joseph Gyourko, Harvard Inst. of Econ. Rsch., The Impact of Zoning on Housing Affordability 20 (2002).

451 For documentation of exclusionary zoning, see Matt Mleczko & Matthew Desmond, *To Reform Exclusionary Zoning, We First Need to Document It. Now We Have a Tool for That*, EVICTION LAB (Mar. 17, 2023), https://evictionlab.org/zoning-restrictiveness-index.

452 Amanda Cassidy, *Community Development and Health*, HEALTH AFFS. (Nov. 10, 2011), https:// www.healthaffairs.org/do/10.1377/hpb20111110.912687/full/healthpolicybrief_56.pdf.

453 Id.; see generally Alexander von Hoffman, The Past, Present, and Future of Community Development in the United States: Investing in What Works for America's Communities, HARV. UNIV. JOINT CTR. FOR HOUS. STUDY, Paper No. W12-6 (2012), https://www.jchs.harvard.edu/sites/default/files/w12-6_von_hoffman.pdf.

454 HARV. UNIV. JOINT CTR. FOR HOUS. STUDS., THE US HOUSING STOCK: READY FOR RENEWAL, IMPROVING AMERICA'S HOUSING 2013 at 7 (2013), https://www.jchs.harvard.edu /sites/default/files/harvard_jchs_remodeling_report_2013_0.pdf.

455 Alistair Woodward & Ichiro Kawachi, *Why Reduce Health Inequalities?*, 54 J. EPIDEMIOLOGY & CMTY. HEALTH 923, 924 (2000); *Health Justice*, *supra* note 21, at 347; Kevin Park, *Good Home Improvers Make Good Neighbors*, HARV. UNIV. JOINT CTR. FOR HOUS. STUDY, Paper No. W08-2 1, 19 (2008), https://www.jchs.harvard.edu/sites/default/fil es/w08-2_park.pdf.

home and a suitable living environment for every American family."[456] Decision makers have advanced a right to housing in both national and international stages. In 1944, Franklin Roosevelt declared that the United States had a second bill of rights, the Economic Bill of Rights, that included the right to housing, stating "We cannot be content, no matter how high that general standard of living may be, if some fraction of our people — whether it be one-third or one-fifth or one-tenth — is ill-fed, ill-clothed, ill-housed, and insecure."[457] In 1948, the United States signed the Universal Declaration of Human Rights, which recognizes the right to adequate housing as a human right.[458] The United States also ratified the International Covenant on Civil and Political Rights (1992)[459] and the International Convention on the Elimination of All Forms of Racial Discrimination (1994).[460] These covenants recognize the right to be free from discrimination, including in housing, and stress the need for the adoption of equitable policies that address historical discrimination.[461] As the National Homelessness Law Center has documented, France, Scotland, South Africa, and several other countries have adopted a right to housing in their constitutions or legislation, leading to improved housing access and conditions.[462] The United States has a duty to address the structural determinants of health inequity by dedicating the resources to ensure permanent housing stability for historically marginalized people and communities who have been denied these rights at great cost, including at the expense of their health and well-being.

4. Enforcement Processes

Finally, to reverse the pattern of structural racism, states and localities must adopt penalties and enforcement mechanisms that deter discrimination and the economic exploitation of communities of color. This requires investing in the

456 U.S. Housing Act of 1949, Pub. L. 81-171 (Sec. 2) (Jul. 15, 1949).

457 Franklin D. Roosevelt, Economic Bill of Rights: The 1944 Annual Message to Congress (Jan. 11, 1944), *in* THE PUBLIC PAPERS AND ADDRESSES OF FRANKLIN D. ROOSEVELT, 40–42 (Samuel Rosenman ed., 1950).

458 The Universal Declaration of Human Rights is nonbinding and was codified in the International Covenant on Economic, Social, Political and Cultural Rights (ICESCR), which the U.S. has signed but not ratified. *See* ERIC TARS, NAT'L HOMELESSNESS L. CTR., HOUSING AS A HUMAN RIGHT (2020), https://nlihc.org/sites/default/files/AG-2021/01-06_Housing-Human-Right.pdf.

459 G.A. Res. 2200A (XXI) (drafted Dec. 16, 1966) (entry into force Mar. 23, 1976).

460 G.A. Res. 2106 (XX) (Dec. 21, 1965) (entry into force Jan. 4, 1969).

461 ERIC TARS, NAT'L HOMELESSNESS L. CTR., HOUSING AS A HUMAN RIGHT (2020), https://nlihc.org/sites/default/files/AG-2021/01-06_Housing-Human-Right.pdf.

462 *Id.*; Eric Tars, Julia Lum & E. Kieran Paul, *The Champagne of Housing Rights: France's Enforceable Right to Housing and Lessons for U.S. Advocates*, 4 NE . L.J. 429 (2012); SOUTH AFRICAN HUMAN RTS. COMM'N, THE RIGHT TO ADEQUATE HOUSING: FACT SHEET, https://www.sahrc.org.za/home/21/files/Fact%20Sheet%20on%20the%20right%20to%20adequate%20housing.pdf (last accessed Jul. 28, 2023).

development of pathways for historically marginalized groups to safely report violations, without fear of retaliation, as well as increased enforcement activities to address persistent discrimination. Common approaches include penalties for unlawful evictions, illegal lease clauses, and frivolous or retaliatory eviction filings, as well as upholding fair housing protections. These interventions can help to build trust and prevent further abuse of tenants' rights.

Statutory Damages and Penalties for Unlawful Evictions

States and localities can impose criminal penalties against landlords who evict tenants through unlawful means. New York allows for criminal prosecution of landlords, who can be charged with a Class A misdemeanor for taking such action.[463] New York also allows civil remedies for affected renters. The landlord can face a civil penalty of $1,000–$10,000 for each violation and can also be fined each day they refuse to allow the renter re-entry.[464] Connecticut increased landlord fines to $2,000 for housing code violations.[465] The Minnesota Attorney General prosecuted multiple landlords for "self-help" evictions early in the pandemic to send a clear message of compliance expectations,[466] and the Rhode Island Attorney General issued a statement warning landlords that self-help evictions would be prosecuted.[467] While not all evictions were prevented, these strong actions on the part of Attorneys General had a chilling effect on extrajudicial attempts to coerce tenants out of their homes.

Prohibition of and Statutory Damages for Leases that Waive Tenant Rights

Each state should adopt a tenant bill of rights that includes statutory causes of action for tenants to file against landlords who use illegal clauses or waive tenant rights (e.g., excessive late fees) in the lease. For example, Colorado prohibits rental agreements from including waivers that limit a renter's legal recourse, as well as fee-shifting clauses that only benefit the landlord.[468]

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463 *Illegal Eviction Law*, N.Y. COURTS, https://www.nycourts.gov/courts/nyc/housing/illegal.shtml (last updated Mar. 6, 2020).

464 Id.

465 S.B. No. 998, Reg. Sess. (Conn. 2023).

466 Press Release, Off. of the Att'y Gen. M.N., Attorney General Ellison's Office Wins Halt to Illegal Removal of Tenants During Emergency (Apr. 7, 2020), https://www.ag.state.mn.us/Office/Communications/2020/04/07_Mostad.asp.

467 *Guidance for Law Enforcement Officials*, OFF. OF THE ATT'Y GEN. OF R.I. (Apr. 6, 2020), http://www.riag.ri.gov/documents/RIAGGuidanceonSelf-HelpEvictions.pdf.

468 H.R. 23-1120, 74th Gen. Assemb., Reg. Sess. (Colo. 2023).

Fair Housing Protections

State and local governments should enact and consistently enforce state and local fair housing laws that explicitly offer eviction protections for vulnerable populations, including families and Black renters. The FHA provides statutory protections against discrimination in rental housing, sale of housing, and mortgage lending.[469] In 2017, more than 28,000 housing discrimination complaints were filed.[470] Since the FHA's passage, HUD has conducted studies about every ten years to monitor trends in racial discrimination in housing.[471] The 2012 study found that, although the most blatant forms of housing discrimination (e.g., refusing to meet with minority home seekers) have declined, other forms (e.g., providing less information about the home offering) have remained.[472] The persistent discrimination and lack of proactive efforts to address fair housing concerns on the local level demonstrates the need for the recently reinstated Affirmatively Further Fair Housing ("AFFH") Rule. The AFFH Rule was instituted under the Obama Administration,[473] terminated in 2020 by the Trump administration for being "complicated, costly, and ineffective,"[474] and reinstated in 2023 by the Biden Administration with new provisions designed to strengthen community engagement and encourage public participation in the design of Equity Plans.[475]

CONCLUSION

Philosopher Amartya Sen posits that "health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to value . . . Equity in the achievement and distribution of health gets, thus, incorporated and embedded in a larger understanding of justice."[476] Yet, for millions of Black people and historically marginalized groups, the U.S. eviction system operates as a major driver and structural determinant of health inequity. The system, thereby, undermines justice and thwarts efforts to achieve the housing stability so fundamental to one's capability and thriving at the individual and community level.

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469 42 U.S.C. § 3601 (2018).

470 *Fair Housing Act Overview and Challenges*, *supra* note 150.

471 U.S. Dep't Of Hous. & Urban Dev., Housing Discrimination Against Racial And Ethnic Minorities 2012 (2013).

472 Id.

473 24 C.F.R. §§ 5.150–5.167-5.180 (2023).

474 Press Release, U.S. DEP'T OF HOUS. & URBAN DEV., *Secretary Carson Terminates 2015 AFFH Rule* (July 23, 2020).

475 Press Release, U.S. DEP'T OF HOUS. & URBAN DEV., *HUD Announces New Proposed "Affirmatively Furthering Fair Housing" Rule, Taking a Major Step Towards Rooting Out Longstanding Inequities in Housing and Fostering Inclusive Communities* (Jan. 19, 2023).

476 Amartya Sen, *Why Health Equity?*, 11 HEALTH ECON. 659, 663 (2002).

With the COVID-19 pandemic as the only exception, the nation has never made a concerted effort to confront the eviction system as a structural determinant of health inequity or to address its disproportionate and harmful impact on historically marginalized people, especially Black families. During the COVID-19 pandemic, when it was widely understood that health is inseparable from housing,[477] policy makers prioritized health equity and eviction prevention. The result was unprecedented: eviction courts halted proceedings, filing rates dropped to *all time* historical lows, and new financial resources that were equitably distributed increased housing stability among the estimated tens of millions of renters who were at heightened risk of eviction. The United States achieved what was once dismissed as impossible when it appropriately treated the eviction crisis as a public health crisis and prioritized health equity and housing stability.

Today, as the vast majority of pandemic-era interventions have lapsed and eviction increasingly threatens the health and stability of historically marginalized communities, the country is called to act. The pandemic should serve as a catalyst to prioritize health justice in the U.S. eviction system as a major public health commitment. Without swift intervention at the federal, state and local levels, the predictable result will be a bolstered eviction system and return to the pre-pandemic norm where millions of renter households face eviction each year and we wittingly strip young children and infants of their homes at the highest rates. Especially after successfully preventing the COVID-19 eviction crisis, there can be no conscionable justification for allowing the eviction system to operate unchanged. Inaction and complacency as the country returns to the status quo—or worse—guarantees the perpetuation of health inequity among historically marginalized groups, especially Black women, families, and children.

Policymakers and courts can immediately employ the Health Justice Framework to address the structural and intermediary determinants of health inequity inherent in the U.S. eviction system. The Framework demonstrates how to effectively supplant harmful laws, policies, and practices with equitable, protective, and supportive ones. It requires an investigation into the historic and modern day causes of health inequity and their dismantling. It emphasizes that structural change is only possible if people facing obstacles to equity and justice have the power to drive that change. Ultimately, the achievement of health justice and equity demands that every individual in America has uninhibited access to stable, safe, decent, and affordable housing free of the threat of eviction and its devastating consequences. It is this America—a place where housing and health equity are ensured—that we must all demand.

477 Benfer et al., *supra* note 258.

Aggregating Liability for Medical Malpractice

Omer Pelled*

Abstract:

Some injurers, such as large medical facilities, are involved in many accidents, even when they act reasonably. Under prevailing law, these injurers are liable only for the harm they cause by failing to take reasonable care. To reach a finding of liability, courts must review every incident to determine whether the injurer was negligent and, if so, whether the negligent conduct was the but-for cause of the injury. However, it is often easier and more accurate to determine whether an injurer negligently caused unreasonable harm to some (unknown) victims, based on outcomes, than to examine the injurer's conduct in each incident. For example, suppose a court determines that it is reasonable for 100 patients to contract an infection during hospitalization. In that case, it can surmise that when 150 patients have contracted an infection, the hospital or its employees negligently caused harm to 50 patients. In light of this informational advantage, this article examines an aggregated liability regime that, like a strict liability regime, depends solely on outcomes. However, this aggregated regime requires the injurer to pay only for harm that could reasonably have been avoided, like under a negligence regime. This article shows that when applied to medical facilities, the proposed regime increases the chances that negligent hospitals will compensate victims while significantly decreasing the direct and indirect costs of investigating suspected malpractice cases individually. Last, the article shows that aggregated liability can be applied to other tortfeasors, such as polluting factories and product manufacturers, and that it offers significant advantages when applied to manufacturers of smart devices and other AI products.

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INTRODUCTION

Negligence law holds injurers accountable only if they fail to conform to the applicable standard of care and if their victims can establish that the injurer's conduct caused the victim's harm. The structure of negligence law makes sense if we understand tort liability as significantly directed at providing appropriate incentives for risk reduction. Negligence liability deters injurers by requiring them to pay for the harm caused by their actions when they fail to take reasonable care.[1]

Tort law's emphasis on the injurer's conduct is attributed to the fact that potential injurers are rarely personally involved in accidents, even when they are negligent. For example, while reckless driving increases the risk of road accidents, most reckless drivers will arrive at their destination without incident.[2] In these paradigmatic cases, the outcome of the behavior——the occurrence of a road accident——provides little information about the injurer's conduct.

Some injurers are routinely involved in many adverse events, even when taking adequate care. For these injurers, the harm they cause over time offers valuable information about their conduct that is currently ignored. This information about long-term results could prove especially valuable in cases where determining the injurer's conduct in each incident requires a costly inquiry. Consider the following example.

> Example 1. *Hospital-acquired infection*. Alex was admitted to the hospital due to a spinal injury that required simple surgery and a short hospital stay. Other than the spinal injury, Alex was generally healthy. While hospitalized, Alex developed an infection that caused permanent harm. Should Alex be

1 *See* RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW § 6.1 (9th ed. 2014) (explaining that reasonable care, under negligence liability law, is defined by a marginal cost–benefit analysis, inducing injurers to optimally invest in care).

2 2021 statistics imply that, on average, a vehicle is involved in an accident resulting in bodily injury once every 175 years. In 2021, the United States recorded a total of 302,722,000 registered vehicles covering a distance of 3,132 billion miles. On average, each vehicle traveled 10,346 miles throughout the year. *See* NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., FATALITY ANALYSIS REPORTING SYSTEM (2021), https://www-fars.nhtsa.dot.gov/Main/index.aspx (last visited February 5, 2023). The year also saw 1,727,608 car crashes resulting in injuries, indicating one injury-causing crash for every 1,812,911 miles traveled. With cars averaging 10,346 miles annually, a vehicle is involved in a crash once in 175 years. For data on car crashes, *see* NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., FATALITY AND INJURY REPORTING SYSTEM TOOL (FIRST) (2021), https://cdan.dot.gov/query (last visited February 5, 2023). Many car crashes involve reckless drivers. Out of the 42,939 car crash fatalities, 13,384 fatalities (31%) were from drunk-driving crashes. *See* NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., DRUNK DRIVING, https://www.nhtsa.gov/risky-driving/drunk-driving (last visited February 5, 2023)

compensated for the harm?[3]

The situation in Example 1 is prevalent and often preventable.[4] Medical personnel can take simple measures, such as washing their hands before approaching a patient's bed or removing their ties and bracelets, to reduce the risk of infection.[5]

Prevailing tort law is supposed to offer a remedy to any patient who contracts an infection because the medical staff fails to take one of these simple measures. Since the cost of these preventative measures is much lower than the risk they prevent, failing to take them is considered negligent.[6] Even so, most patients suffering from a hospital-acquired infection will not try to sue their physician or medical facility for medical malpractice, and if they do, they will likely lose.

Consider, for example, the case of *Gahm v. Thomas Jefferson Univ. Hosp.*, on which Example 1 is based.[7] Mr Gahm underwent back surgery. During recovery, he developed a severe infection, resulting in two months of hospitalization and long-lasting bodily harm. During the trial, Gahm presented expert reports from several physicians stating that since he developed a hospital-acquired infection, it stood to reason that the hospital had breached its duty to maintain safe and adequate facilities. Nevertheless, the court granted the hospital's motion to dismiss since Gahm did not present evidence that the hospital deviated from the standard of care.[8] The problems Gahm faced in proving his case are shared by most patients in a similar position.

First, proving that the hospital's personnel failed to take reasonable measures may be difficult. Infections in hospitals are common, so the occurrence of infection

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3 The example is based on the case of Gahm v. Thomas Jefferson Univ. Hosp., 2000 U.S. Dist. LEXIS 2072 (E.D. Pa. Feb. 29, 2000).

4 Patchen Dellinger et al., *Hospitals Collaborate to Decrease Surgical Site Infections*, 190 AM. J. SURGERY 9 (2005) (stating that many hospitals underutilize simple procedures that are known to reduce surgical-site infections. Hospitals participating in the study implemented several practices and reported a 27% decrease in infection rate).

5 *See*, *e.g.*, John M Boyce & Didier Pittet, *Guideline for Hand Hygiene in Healthcare Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/ APIC/IDSA Hand Hygiene Task Force*, 30 AM. J. INFECTION CONTROL 1 (2002) (recommending that medical staff be obliged to wash their hands thoroughly before each contact with a patient); Graham Jacob, *Uniforms and Workwear: An Evidence Base for Developing Local Policy*, NHS DEPARTMENT HEALTH POLICY (2007), available at https://data.parliament.uk/DepositedPapers/Files/DEP2009-0656/DEP2009-0656.pdf (neckties and hand jewelry should not be worn in any care activity which involves patient contact, since they might harbor pathogens and increase the risk of infections).

6 *See infra* note 40 and accompanying text.

7 *See supra* note 3.

8 *Id*. at *8 ("There is no basis for finding that the hospital deviated from an appropriate standard of care . . . or that the hospital's services, or lack of them, increased the chances of plaintiff's infection.").

is insufficient to shift the burden of proof.[9] Evidence regarding preventative measures in each case might be challenging to obtain. For example, hand-washing before approaching a patient may be considered the standard of care,[10] but most patients do not observe the healthcare staff's hand-washing practices or cannot obtain evidence of this behavior.[11] In addition, proving causation presents another significant barrier to compensation. The plaintiff must demonstrate that the harm suffered could have been prevented if the medical personnel had taken appropriate measures. Given the substantial risk of infection even under optimal conditions, the inherent risk of infection complicates the attribution of causation to specific instances of negligence.[12]

This article proposes a new liability regime that aggregates the information about accidents the injurer was involved in over time.[13] Injurers that tend to be involved in numerous accidents, such as hospitals, will be liable only for the harm they cause in excess of the harm they would have caused had they (consistently) conformed to the standard of reasonable care. This liability regime shifts the focus from the injurer's conduct in each incident to the outcome of their behavior over time. Much like a strict liability regime, a regime that assigns liability only for excessive harm does not require an inquiry into the injurer's conduct in each incident. Instead, liability is determined by comparing the actual harm from accidents to the expected harm given reasonable care. However, under this suggested regime, the injurer is liable only for the harm that could have been reasonably prevented, similar to a negligence regime. We, therefore, call it strict liability for unreasonable harm (SLUH*)*.

For example, assume that 150 patients contract a hospital-acquired infection.

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9 Courts have declined shifting the burden of proof in case of a hospital-acquired infection, stating that infections ordinarily occur in the absence of negligence. *See* Bars v. Palo Verde Hosp., 2005 Cal. App. Unpub. LEXIS 9326 (Oct. 12, 2005).

10 Hand hygiene is one of the main strategies for reducing the incidence of healthcare-associated infections, and thus is included in national guidelines. Despite the universal acceptance of this inexpensive infection-preventative measure, hospitals consistently battle low levels of compliance among healthcare workers. *See, e.g.*, L. Kingstone, et al., *Hand Hygiene-Related Clinical Trials Reported Since 2010: A Systematic Review*, 92 J. HOSPITAL INFECTIONS 309 (2016).

11 *But see* Knight v. West Paces Ferry Hosp., Inc., 585 S.E.2d 104 (2003) (a directed verdict for the defendant was reversed on appeal, since the testimonies of the plaintiff and her husband regarding nurses' hand-washing practices were sufficient evidence for the jury to consider).

12 *See*, *e.g.*, Jelinek v. Casas, 328 S.W.3d 526 (Tx. Sup. 2010) (hospital was negligent in not treating the patient with antibiotics following a surgery, but patient's family could not establish that the patient would have suffered less from the infection she contracted if antibiotics had been administered sooner).

13 Scholars have previously considered a variety of other aggregating solutions to informational challenges in tort and other law. *See, e.g.*, Lee Ann Fennel, *Accidents and Aggregates,* 59 WILLIAM & MARY L. REV. 2371 (2018); Saul Levmore, *Conjunction and Aggregation*, 99 MICH. L. REV. 723 (2001); Ariel Porat & Eric A. Posner, *Aggregation and Law*, 122 YALE L. J. 2 (2012); *see also id.* at 9 n.8 (citing other sources touching on aggregation issues).

Applying SLUH, a court would have to determine if and by how much these infections exceed the number of infections that would have occurred had the hospital taken reasonable infection-preventing measures. By using data on the risk of infections from studies and from other hospitals, the court can determine the reasonable level of harm is 100 infections (i.e., given the patients admitted to the hospital, only 100 patients should have contracted an infection, assuming the hospital implemented reasonable practices). Under SLUH, the court should hold the hospital liable for the harm of 50 patients, without examining the risk-reducing practices of the hospital's personnel in each incident.[14]

SLUH follows the same structure as scientific inquiry into conduct and causation. In a case of hospital-acquired infection, no scientist should be comfortable stating with any conviction that a particular patient would have fared better if they had received different care.[15] However, it is possible to ascertain, with some level of certainty, that more patients contracted infections than is generally the case when reasonable infection-preventing measures are taken.[16]

Using SLUH as an alternative to the current liability regime for medical facilities solves most of the shortcomings plaguing the current system. As hospitals' liability under SLUH is not dependent on the availability of evidence regarding conduct, hospitals and their employees will have no incentive to adopt defensive practices or hide information about errors to reduce liability risk. SLUH is also likely to save hospitals and patients money because the procedural costs of the liability system are much lower, per incident, than the current regime.

Analyzing SLUH as an alternative to current medical malpractice law is not merely a theoretical exercise. Several medical associations, such as the American Heart Association (AHA) and the American College of Surgeons (ACS), have used similar systems to detect avoidable risks and advise hospitals about managing

14 For a discussion about the distribution of compensation among victims, *see infra* Part II.A.

15 Determining causation, as a scientific endeavor, requires overcoming a missing data problem—for any person examined in the study we know only the outcome that materialized for the received treatment, but we cannot know what would have been the outcome for that same person given the control treatment. Thus, science can only infer average causal effects for many individuals. *See* GUIDO W. IMBENS & DONALD B. RUBIN, CAUSAL INFERENCE FOR STATISTICS, SOCIAL, AND BIOMEDICAL SCIENCES—AN INTRODUCTION 14 (2015) (explaining that "the problem of causal inference is . . . a *missing data problem*: given any treatment assigned to an individual unit, the potential outcome associated with any alternate treatment is missing").

16 For example, if given reasonable care, patients have a 5% average risk of suffering from an infection, then we can reasonably reject the hypothesis that all patients received reasonable care given a rate of patients who contract an infection exceeding 5% by a large enough margin. *See* L. David Hillis et al., *2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines*, 124 CIRCULATION 652, § 5 (2011) (presenting the data on adverse clinical outcomes of surgery patients and risk-assessment models that estimate the rates at which these various adverse events occur). A comprehensive liability regime should consider all the risks associated with the treatment together. *See infra* Part II.A.

them.[17] By collecting information from various hospitals and studies about patients' characteristics, ailments, treatments, and outcomes, these organizations assess how many patients should be expected to suffer complications if the hospital treats all patients adequately. Comparing this anticipated rate of complications with the hospital's outcomes shows which hospital is not taking adequate risk-reducing measures. The SLUH regime uses similar data to assign liability.

The SLUH system represents one of several proposed alternatives to the current liability system, including enterprise liability, proportional liability, and no-fault systems. The SLUH system has some commonalities with each of these alternatives, but it surpasses them when implemented in large medical facilities.

The first alternative, enterprise liability, posits that medical facilities should bear direct responsibility for any negligent treatment their patients endure, rather than assigning liability to individual physicians.[18] Similarly, SLUH assigns liability to the medical facility. In contrast, under SLUH, victims are not required to prove they received negligent treatment nor to establish factual causation.

A second alternative, proportional liability, allows victims of negligent treatment to receive partial compensation discounted by the probability that the negligent care caused the injury.[19] Similarly, SLUH provides partial compensation to patients who have experienced an adverse outcome during medical care, with the amount determined by the proportion of excessive harm in relation to the total harm to patients. Unlike proportional liability, SLUH does not require patients to prove negligence. Furthermore, as an aggregative system, SLUH utilizes data to evaluate liability across all cases objectively,[20] rather than relying on subjective probability assessments, as in proportional liability.

A third alternative, the no-fault compensation system, provides financial compensation to patients who have suffered medical harm, regardless of whether the medical care they received was adequate or not. The no-fault system may be structured around mandatory first-party insurance or social insurance.[21] A no-fault system compensates victims without assigning blame, eliminating the incentives for defensive medicine. However, it can also eliminate liability for hospitals, reducing investment in reasonable care.[22] Combining SLUH with first-party

17 *See infra* Part II.C.

18 *See infra* Part I.A.1.

19 *See infra* Part II.

20 Courts may utilize statistical evidence to establish a prima facie case of negligence under the doctrine of *res ipsa loquitur*. *See* RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL HARM § 17 (2010); ARIEL PORAT & ALEX STEIN, TORT LIABILITY UNDER UNCERTAINTY 87–92 (2001) (discussing the use of statistical evidence as part of the *res ipsa loquitur* doctrine).

21 *See infra* notes 88–89 and accompanying text.

22 A social security system that covers injuries without assigning liability can lead to the underdeterrence of injurers. *See* Gary T. Schwartz, *Ethics and the Economics of Tort Liability Insurance*, 75 CORNELL L. REV. 312, 337–45 (1990).

insurance or social insurance that covers only reasonable harm can maintain incentives for reasonable care while also eliminating incentives for defensive medicine and ensuring compensation to patients who have suffered medical harm.[23]

The Article continues as follows. Part I describes several shortcomings of negligence law, focusing on medical malpractice. Tort liability might encourage physicians to adopt defensive practices, such as performing unnecessary tests and procedures to reduce liability risk, and might discourage hospitals from mitigating the risk of future errors following an incident. In addition, the administrative costs of the medical malpractice regime are extremely high relative to the damages paid out to victims. Lastly, because negligence is difficult and expensive to prove, only a small fraction of patients with valid claims are compensated, resulting in underdeterrence.

Part II considers the application of SLUH to medical facilities. It shows that when a medical facility treats enough patients, applying SLUH reduces the incentives to practice defensive medicine and increases enforcement without adding administrative costs. It also shows how courts can deal with the risk of error in assigning liability. Lastly, it shows that factfinders can utilize existing data regarding various risks of complications from medical care for implementing SLUH.

Part III discusses four objections and limitations of SLUH. The first objection is that victims of medical malpractice are unidentified and undercompensated. While the criticism is valid, currently most victims receive no compensation. Furthermore, SLUH can be supplemented with insurance to ensure full compensation. A second objection to SLUH is that it discourages long-term investments in care. However, liability under SLUH could be adjusted to avoid distorted incentives. A third objection is that other alternatives to the current medical malpractice law might be superior to SLUH. These alternatives are also considered. The last objection is that the new liability regime requires extensive legislation and may face strong opposition from healthcare providers and the plaintiffs' bar, making it politically unfeasible. The concerns of various stakeholders are examined and addressed.

Part IV suggests other typical cases where SLUH can be used. It shows that SLUH is warranted whenever three conditions are met: (i) the total harm across cases is verifiable; (ii) it is possible to determine the reasonable harm for the injurer across time; and (iii) the injurer causes enough harm to justify a statistical inference. Typical injurers that meet these conditions include, for example, product manufacturers, car fleets, and polluters. Applied to these types of injurers, SLUH can create better incentives to take reasonable actions and decide on whether to

23 *See infra,* Part II.D.1.

participate in a risky activity than negligence or strict liability regimes. Part IV further shows that SLUH might be especially beneficial when applied to artificial intelligence (AI) devices and products which, despite reducing accident rates, are involved in accidents that reasonable humans would avoid.

The conclusion ends the discussion.

I. THE CHALLENGES OF A NEGLIGENCE REGIME

The example that opened this article illustrates a case of hospital-acquired infection. Unfortunately, infections in hospitals are common and very often preventable.[24] Every year, one in every twenty hospitalized patients contracts an infection, resulting in some 100,000 deaths annually.[25] Medical errors generally, including adverse drug events,[26] diagnostic errors,[27] wrong-site surgery,[28] and foreign objects left inside a patient during surgery,[29] contribute to approximately 100,000 more preventable deaths annually.

Theoretically, negligence law should encourage hospitals to reduce the risk of accidents to the optimal level and compensate the victims when they fail to do so.[30]

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24 The Centers for Disease Control and Prevention (CDC) considers healthcare-associated infections as one of the "winnable battles," defined as a public health risk with large-scale impact on health and proven strategies that can substantially ameliorate it. *See* Centers for Disease Control and Prevention, *Healthcare-Associated Infections (HAIs)*, CDC WINNABLE BATTLES FINAL REPORT (November 2016), https://stacks.cdc.gov/view/cdc/43072 (hereinafter WINNABLE BATTLES REPORT). According to the CDC it is possible to prevent up to 70% of healthcare-associated infections. For an analysis of prevention efforts in hospitals, *see* E. Patchen Dellinger et al., *Hospitals Collaborate to Decrease Surgical Site Infections*, 190 AM. J. SURGERY 9 (2005) (states that many hospitals underutilize simple procedures that are known to reduce surgical-site infections. Hospitals that participated in the study implemented several practices and reported 27% decrease in infection rate).

25 *See* Sarah L. Krein et al., *Preventing Hospital-Acquired Infections: A National Survey of Practices Reported by U.S. Hospitals in 2005 and 2009*, 27 J. GENERAL INTERNAL MED. 773, 773 (2012) (citing several studies reporting that the rate of hospitals-acquired infections is 5–10%, resulting in approximately 99,000 deaths in 2002); *see also*, WINNABLE BATTLES REPORT, *supra* note 24, at 9 (same).

26 *See, e.g.*, Brian J. Kopp et al., *Medication Errors and Adverse Drug Events in an Intensive Care Unit: Direct Observation Approach for Detection*, 34 CRITICAL CARE MED. 415 (2006) (revealing that adverse drug events commonly occur in hospitalized patients and are frequently associated with human error).

27 *See, e.g.*, David E. Newman-Toker & Peter J. Pronovost, *Diagnostic Errors—The Next Frontier for Patient Safety*, 301 JAMA 1060 (2009) (overviewing current studies about the scope of medical adverse events due to diagnostic errors).

28 *See, e.g.*, Richard S. Yoon et al., *Using 'Near Misses' Analysis to Prevent Wrong-Site Surgery*, 37 J. HEALTHCARE Q. 126 (2015) (noting that wrong-site procedures in the United States, including surgeries, occur at least forty times a week.).

29 *See, e.g.*, Verna C. Gibbs et al., *Preventable Errors in the Operating Room: Retained Foreign Bodies After Surgery—Part I*, 44 CURRENT PROBS. SURGERY 281 (2007) (discussing the large scope of adverse medical outcomes due to retained surgical items in the United States).

30 The analysis assumes that hospitals can be directly or indirectly liable for patients, and indeed

However, the current medical malpractice system does not promote efficiency or safety. While the United States leads in health expenditures per capita,[31] it has a high annual rate of treatable mortality cases relative to other countries.[32] Preventable medical error is estimated to be the third leading cause of death in the United States.[33] The current system also fails to adequately compensate victims, with the vast majority of victims receiving either partial or no compensation for their injuries.[34]

The relationship between medical malpractice liability and the cost and safety of medical care is complex. There are several ways in which the current legal regime affects the incentives of physicians and hospitals to invest in risk-reducing practices, for example by prioritizing attention to health risks that are more likely to trigger litigation over others that are seldom followed by a lawsuit. Furthermore, the current system requires extensive evidence of conduct and causation, making

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that is the case. When a hospital fails to adopt reasonable practices, it can be directly liable via corporate negligence doctrine, which does not require the plaintiff to establish the negligence of a third party. *See* Thompson v. Nason Hosp., 527 Pa. 330, 339 (1991). Furthermore, hospitals are vicariously liable for the negligent practices of members of the medical staff. *See* Johns v. Jarrard, 927 F.2d 551, 556 (11th Cir. 1991) (hospitals are vicariously liable for the malpractice of its emergency room physicians); Atwood v. UC Health, 2018 U.S. Dist. LEXIS 146817 (S.D. Ohio Aug. 29, 2018) (same). Last, hospitals may even be liable for the negligence of an independent, private attending physician, if it creates the impression that the physician acts on behalf of the hospital. *See* I.M. v. United States, 362 F. Supp. 3d 161, 199 (2019) ("vicarious liability for the malpractice of a private attending may also be imposed upon on a hospital under a theory of apparent or ostensible agency").

31 According to the OECD, in 2022 the U.S. spent 16.6% of its GDP on healthcare, significantly higher than the second-highest spender, Germany, which spent only 12.7% of its GDP. When measured in dollars per capita, the difference is even more pronounced. In the U.S., the average per capita spending on healthcare reached $12,555, which is around 57% higher than the average spending in Germany and Switzerland, the next highest spenders, where per capita spending was only around $8,000. *See* OECD, *Health at a Glance 2023: OECD Indicators*, available at https://doi.org/10.1787/7a7afb35-en.

32 Treatable mortality cases are deaths that can be avoided through timely and effective healthcare interventions. According to the OECD, all western European countries, as well as Chile, Israel, Slovenia, Canada, Australia, New Zealand, and Korea have a lower rate of treatable mortality than the United States. Data on treatable mortality are drawn from the WHO Mortality Database, available at https://platform.who.int/mortality.

33 See John T. James, *A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care*, 9 J. PATIENT SAFETY, 122 (2013) (estimating that more than 200,000 people die annually in the United States due to medical error); John T. James, *Deaths from Preventable Adverse Events Originating in Hospitals*, 26 BMJ QUALITY & SAFETY 692, 692–93 (2017) (same); Martin A. Makary & Michael Daniel, *Medical Error—The Third Leading Cause of Death in the US*, 353 BMJ (2016) (same); Kaveh G. Shojania & Mary Dixon-Woods, *Estimating Deaths Due to Medical Error: The Ongoing Controversy and Why It Matters*, 26 BMJ 423 (2017) (claiming that a quarter-million deaths per year is likely an underestimation).

34 Paul C. Weiler, *Reforming Medical Malpractice in a Radically Moderate—and Ethical—Fashion*, 54 DEPAUL L. REV. 205, 215 (2005) ("[T]here is just one paid malpractice claim for every twenty-one negligent medical injuries").

it extremely expensive. Since filing a medical malpractice claim is expensive, very few victims sue.[35]

There is an extensive empirical debate over the severity of these problems, and this Article is not the place to resolve them.[36] Instead, this Part analyzes the main shortcomings of the current liability system, namely how it distorts incentives, creates substantial costs, and undercompensates victims. The following Part will show how SLUH can encourage better safety practices and adequately compensate victims.

A. Distorted Incentives

Negligence law encourages injurers to take reasonable care, provided the courts can clearly define the standard of care, and observe what safety measures the injurer has taken. When the standard of care is unclear or there is a lack of evidence regarding the healthcare's risk-reducing measures, healthcare providers may prefer measures that reduce liability over measures that reduce actual risk to the patient. There are three typical ways in which a negligence regime can distort incentives: by encouraging hospitals to (i) reduce risks that might trigger a lawsuit while ignoring other risks that are less often the focus of litigation; (ii) perform tests and procedures that produce evidence of due care, even when they are not medically justified; and (iii) discourage physicians from engaging in conduct that is beneficial for patients but may be used as evidence of negligence.

1. Prioritizing Measures That Are Part of the Negligence Inquiry

For negligence law to successfully serve as a deterrent, courts must define a clear standard of care, accounting for all risk-reducing measures and their costs and benefits. However, introducing more risk-reducing measures into the inquiry is costly. Courts must therefore choose the level of abstraction at which fault will be determined.

Consider the following example.

> Example 2. *Foreign object*. Masha underwent stomach surgery. During the procedure, the surgeon used several sponges. Two nurses in the operating room independently counted every sponge

35 The tendency of medical malpractice victims not to sue also makes medical malpractice law a poor deterrent. *See* TOM BECKER, THE MEDICAL MALPRACTICE MYTH, 22–44 (2005) (claiming that "the real problem is too little litigation and too many incidents of medical malpractice").

36 For an evidence-based examination of the challenges of the medical malpractice system, as well as critical analysis of the effects of tort reforms on outcomes and medical costs, *see* BERNARD BLACK ET AL., MEDICAL MALPRACTICE LITIGATION: HOW IT WORKS, WHY TORT REFORM HASN'T HELPED (2021).

> used and counted the sponges again at the end of the surgery. Both nurses miscounted, and one sponge was left inside Masha's stomach and caused her harm.[37]

When courts examine such a case, they might focus on the surgeon's actions and deem any surgeon who forgets a sponge inside a patient during surgery negligent, considering that it is obviously standard practice to remove them. However, these accidents are usually caused by lapses in attention, and there will always be at least some unavoidable lapses.[38] As errors are inevitable, we might broaden the scope of the negligence inquiry, moving away from the particular conduct (leaving the sponge) and basing the standard of care on the surgeon's measures to reduce the risk of errors, such as counting the sponges during the surgery.[39] Basing liability on practices designed to reduce errors means that surgeons will be considered negligent if they fail to take precautions that can reduce the risk of patient harm and are economically justifiable, given the probability and magnitude of the harm.[40] In Example 2, the surgical team included two nurses tasked with reducing the risk of leaving a foreign object behind during surgery. Tasking a third nurse with triple-checking the number of sponges used at the start and end of every surgery might reduce the risk even further, but the cost of hiring a third nurse might outweigh the benefit of doing so. Even if having a third nurse is justified, we can further ask about a fourth, fifth, and so forth. At some point, which we label the standard of care,[41] further precautions are unjustified, even though some medical errors will still occur.

Focusing solely on error-reducing precautions may not be sufficient in

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37 The example is loosely based on the facts in Cefaratti v. Aranow, 138 A.3d 837 (Conn. 2016).

38 ALAN MERRY & ALEXANDER MCCALL SMITH, ERRORS, MEDICINE AND THE LAW, 72–97, 127–51 (2006) (discussing common reasons for medical negligence, suggesting that most medical errors are a result of a momentary lapse in attention).

39 Indeed, not every medical error is considered a result of negligence. *See*, *e.g.*, Schueler v. Strelinger, 43 N.J. 330, 334 (1964) ("if the doctor has brought the requisite degree of care and skill to his patient, he is not liable simply because of failure to cure or for bad results that may follow. Nor in such case is he liable for an honest mistake in diagnosis or in judgment"). For a model of negligence that accommodates lapses in attention to the negligence inquiry, *see* Robert D. Cooter & Ariel Porat, *Lapses of Attention in Medical Malpractice and Road Accidents*, 15 THEORETICAL INQ. L. 329, 348–50 (2014) (distinguishing between first-order precautions that affect the probability of an accident and second-order precautions that change the probability distribution of the former acts).

40 This is the standard conception of the Learned Hand rule. *See* U.S. v. Carroll Towing Co., 159 F. 2d 169 (1947); Richard A. Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29, 29–34 (1972). For a comparison of negligence and strict liability, *see* Steven Shavell, *Strict Liability versus Negligence*, 9 J. LEGAL STUD. 1 (1980).

41 For an economic analysis of the standard of care, *see* STEVEN SHAVELL, FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW 180–89 (2004); ROBERT COOTER & THOMAS ULEN, LAW & ECONOMICS 205–08, 211–17 (6th ed. 2016).

mitigating medical errors. Various factors contributing to the risk of medical error are beyond the physician's control but can be mitigated by the hospital. One way to expand the negligence inquiry is to look beyond a physician's decision-making and consider the circumstances they face in the workplace. For example, a high patient load increases the risk of error.[42] If a physician must treat several patients, any time added to the treatment of one patient reduces the risk of error for that patient but increases the risk for others. Sleep deprivation is another factor that aggravates the risk of error and might be beyond the physician's control. Medical residents often work 80 hours per week, which limits their free time and ability to rest properly.[43] Hospitals can alleviate the risk of medical errors from excessive workload and insufficient rest by hiring additional staff. Thus, we can reach a further level of abstraction of the negligence inquiry, from the treating physician to the hospital's investment in personnel and other error-reducing investments.[44]

Such a shift in focus from medical personnel to the institutional level has been promoted, to some extent, by proposals to adopt "hospital enterprise liability", which places sole responsibility on the hospital for failure to provide reasonable care for its patients. However, patients still must prove either negligence by the physician or nurse, or that the hospital failed to ensure a proper standard of medical care.[45] Thus, even suggestions to adopt enterprise liability focus on the treatment, and not on the hospital's investment in personnel. Focusing on the treatment simplifies the determination of negligence. However, such simplification is not a

42 *See* C. A. Bond et al., *Medication Errors in United States Hospitals*, 21 PHARMACOTHERAPY: J. HUM. PHARMACOLOGY & DRUG THERAPY 1023, 1031–32 (2001) (showing that the risk of medication errors increases substantially with workload); Jack Needleman et al., *Nurse-Staffing Levels and the Quality of Care in Hospitals*, 346 NEW ENG. J. MED. 1715, 1719–20 (2002) (more time spent on patient care reduces lengths of stay and lowers rates of complications); Pascale Carayon & Ayşe P. Gürses, *A Human Factors Engineering Conceptual Framework of Nursing Workload and Patient Safety in Intensive Care Units*, 21 INTENSIVE & CRITICAL CARE NURSING 284 (2005) (increase in nursing workload is associated with adverse patient outcomes).

43 *See, e.g.*, Sigrid Veasey et al., *Sleep Loss and Fatigue in Residency Training: A Reappraisal*, 288 JAMA 1116, 1122–23 (2002) (sleep deprivation negatively affects residents' performance over time); Teodor P. Grantcharov et al., *Laparoscopic Performance After One Night on Call in a Surgical Department: Prospective Study*, 323 BMJ 1222, 1223 (2001) (surgical residents after a night on call have higher complication rates, longer operative times, and higher error rate); Steven W. Lockley, *Effect of Reducing Interns' Weekly Work Hours on Sleep and Attentional Failures*, 351 NEW ENG. J. MED. 1829, 1835 (2004) (demonstrating that "[t]he acute and chronic sleep deprivation inherent in the traditional schedule caused a significant increase in attentional failures in interns working at night").

44 A hospital's negligence inquiry should also take into account investment in equipment. For instance, in the case of Candler General Hospital, Inc. v. MnNorrill, 354 S.E.2d 872 (Ga. Ct. App. 1987), the plaintiff alleged that the hospital is directly liable for his injury due to the inadequacy of the equipment provided in the emergency room. *See also* Washington v. Wash. Hosp. Ctr., 579 A.2d 177, 180 (D.C. 1990) (hospital was directly liable for failing to provide a device which allows early detection of insufficient oxygen in time to prevent brain injury).

45 *See*, *e.g.*, Thompson v. Nason Hosp., 527 Pa. 330, 339 (1991).

feature of the negligence regime, which considers the costs and benefits of any risk-reducing measure. Still, it reduces litigation costs in an overly complex system.[46]

Courts simplify the problem of defining the standard of care in two ways. First, they reduce the level of abstraction, focusing on the medical staff's decisions but not reviewing the decision-making process.[47] Second, courts can reduce complexity by including only a subset of the precautionary measures and risks in their negligence inquiry and ignoring other measures.[48]

Focusing on some risks while ignoring others distorts healthcare facilities' incentives. In Example 2, think, for example, about the risks of leaving sponges behind as opposed to the risks of prolonging the surgery. Assume that while counting the sponges during the procedure reduces the risk of leaving any behind, it prolongs the procedure, increasing the risks posed by extended surgery.[49] If complications from prolonged surgery are not factored into the negligence inquiry, hospitals might overinvest in care measures intended to reduce the risk of leaving a foreign object in a patient while underinvesting in care measures that reduce complications from prolonged surgeries. The tradeoff between setting the optimal standard of care and simplifying the negligence inquiry means that negligence law cannot create optimal incentives. Focusing the inquiry on particular risks and preventative measures incentivizes injurers to invest in measures that reduce liability, not necessarily those that are socially desirable.

The gap between risk-reducing and liability-reducing measures might explain why studies find that hospitals underinvest in preventing hospital-acquired infections.[50] If the risk of infection mostly falls outside the scope of the negligence

46 *See* Giuseppe Dari-Mattiaci, *On the Optimal Scope of Negligence*, 1 REV. L. & ECON. 331 (2005) (arguing that an increase in administrative costs reduces the number of precautionary measures that courts will review for establishing negligence); Joshua C. Teitelbaum, *Computational Complexity and Tort Deterrence*, 51 J. LEGAL STUD. 249 (2022) (showing that when a choice set of precautionary measures is large enough, it might be mathematically impossible to detect the standard of care).

47 In corporate law the business judgment rule requires courts to examine the decision-making process instead of the concrete decision. *See, e.g.*, Kenneth B. Davis Jr., *Once More, the Business Judgment Rule*, 2000 WIS. L. REV. 573, 575–76 (2000) ("[T]he focus is not on what the hypothetical reasonable director would have done . . . [I]t serves as an objective confirmation of the critical, but entirely subjective, requirement that the directors have a good faith belief that their decision is in the corporation's best interest").

48 *See* Dari-Mattiacci, *supra* note 46, at 350–51 (the optimal scope of negligence balances the advantages of a broader scope, in terms of better incentives, with its administrative costs).

49 There are risks associated with longer procedure time, such as the risk of surgical-site infection or other complications. *See, e.g.*, Eiko Imai et al., *Surgical Site Infection Risk Factors Identified by Multivariate Analysis for Patient Undergoing Laparoscopic, Open Colon, and Gastric Surgery*, 36 J. INFECTION CONTROL 727 (identifying extended duration of surgery as an independent risk factor for surgical-site infections).

50 *See supra* notes 4-5.

inquiry, hospitals may choose to save costs or invest in measures that reduce other risks.

2. Encouraging Defensive Medicine

A second problem of basing medical malpractice liability on the medical staff's conduct is that it encourages practicing defensive medicine—medically unwarranted treatments and diagnostic tests, performed solely to reduce liability.[51]

For example, suppose that doctors are concerned about the possibility of being held liable for not administering a costly prenatal test that can detect a congenital disorder while administering an unnecessary test carries no liability risk. In this case, they may overprescribe the test to avoid liability. Many physicians believe "defensive medicine is widespread and practiced the world over, with serious consequences for patients, doctors, and healthcare costs."[52] Some empirical evidence supports this claim, showing that tort reform, intended to reduce liability risk, has reduced medical expenditure and treatment intensity while not affecting patient outcomes, suggesting that physicians perform some procedures and tests to mitigate liability and not to treat patients.[53]

Defensive practices do not have to be expensive. Physicians might opt for a

51 *See* Steve Boccara, *Medical Malpractice*, *in* TORT LAW AND ECONOMICS 341, § 12.4.4 (Michael Faure ed., 2009) (reviewing the law and economic literature on defensive medicine both from a theoretical and an empirical perspective); Mitchell Polinsky & Steven Shavell, *Punitive Damages: An Economic Analysis*, 111 HARV. L. REV. 869, 879–80 (1998) (considering the case of excessive spending on precautions and defensive behaviors in cases where damages exceed harm); Ariel Porat, *Offsetting Risks*, 106 MICH. L. REV. 243, 264 (2007) ("One of the most undesirable outcomes of medical malpractice liability is defensive medicine . . . When a doctor must choose between two courses of action and cannot be sure which one is more reasonable or which one a court will find reasonable in the event that the patient sues, he will choose the action that is the least risky for him").

52 *See* Sandro Vento et al., *Defensive Medicine: It Is Time to Finally Slow Down an Epidemic*, 6 WORLD J. CLIN. CASES 406, 406 (2008). Most claims about the spread and costs of defensive medicine are based on questionnaires. *See* Nicholas Summerton, *Positive and Negative Factors in Defensive Medicine: A Questionnaire Study of General Practitioners,* 310 BMJ 27 (1995) (98% of 300 practitioners that answered the survey reported some defensive practices). Since doctors have a financial incentive to warn about defensive practices, there is always a fear that reports of defensive medicine are exaggerated. *See* BECKER, *supra* note 35 (claiming that there is no convincing evidence of defensive medicine).

53 *See* Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 QUART. J. ECON. 353 (1996) (malpractice reforms lead to reductions of 5% to 9% in medical expenditure without substantial effects on mortality or medical complications among elderly Medicare beneficiaries); Ronen Avraham & Max Schanzenbach, *The Impact of Tort Reform on Intensity of Treatment: Evidence from Heart Patients*, 39 J. HEALTH ECON 278 (2015) (caps on damages reduced the use of bypass surgery without affecting patients' outcomes). *But see* Frank A. Sloan & John H. Shadle, *Is There Empirical Evidence for 'Defensive Medicine'? A Reassessment*, 28 J. HEALTH ECON. 481 (2009) (finding that tort reform did not affect medical expenses or patients' outcomes).

treatment that burdens the patient if it reduces liability risk. For example, a physician might recommend surgical delivery (C-section), which reduces risks for the newborn but causes more harm to the mother because surgical delivery reduces liability risk. Physicians are sued for not recommending surgery when it would have prevented harm to the baby, while they are rarely sued for recommending surgery as a safer alternative.[54]

Defensive medicine effectively reduces liability because current medical malpractice law focuses on conduct. If courts do not examine their conduct, physicians and hospitals will not be encouraged to invest in producing evidence attesting to their reasonableness.

3. Discouraging Risk-Reducing Practices

A third, seldom-discussed concern is that physicians can reduce liability by avoiding actions that produce evidence of fault after an accident has occurred.[55] This may increase the risk of harm to other patients or may further harm patients who have already suffered an accident. Consider the following example.

> Example 3. *Falling patient*. Edmond underwent surgery. During the procedure, Edmond's body was not secured to the surgical table, and he fell, resulting in harm to his shoulder. Nassima, Edmond's surgeon, considers how to communicate the incident to Edmond and others in general.[56]

Example 3 illustrates how liability risk might affect the decision to engage in conduct that, while beneficial, can increase liability risk. Open communication between doctor and patient is essential for continued care when a medical error

54 Evidence suggests that obstetrics over-recommend surgical delivery to reduce liability risk. *See* Joshua D. Dahlke et al., *Evidence-Based Surgery for Cesarean Delivery: An Updated Systematic Review*, 209 AM. J. OBSTETRICS & GYNECOLOGY 308 (2013) (suggesting that the increase on the rate of cesarean delivery causes an increase in maternal morbidity and mortality); Tony Y. Yang et al., *Relationship Between Malpractice Litigation Pressure and Rates of Cesarean Section and Vaginal Birth After Cesarean Section*, 47(2) MED. CARE 234 (2009) (suggesting that liability environment influences the delivery method recommended or chosen by obstetrics).

55 For a general discussion on the effects of evidentiary concerns on primary behavior, *see* Gideon Parchomovsky & Alex Stein, *The Distortionary Effect of Evidence on Primary Behavior*, 124 HARV. L. REV. 518, 524–28 (2010) (maintaining that "[e]ach actor has a strong incentive to behave in a way that generates evidence favorable to her case in court. This evidentiary motivation will often undermine substantive law's efforts to minimize harm at the lowest possible cost."); Michael S. Pardo, *Some Remarks on the Importance of Evidence outside of Trials*, 36 REV. LITIG. 443, 466–47 (2016) (same).

56 For a case where plaintiff alleges the physician failed to take adequate care measures, resulting in the patient's body falling from the table during surgery, *see* Locklear v. Cummings, 262 N.C. App. 588 (2018).

occurs.[57] For instance, Nassima may wish to apologize to Edmond for what happened during the procedure. Nevertheless, the hospital's legal counsel might instruct Nassima to limit communication and especially refrain from apologizing, fearing that an apology would later be viewed as an admission of fault.

Nassima might also be discouraged from informing others about what happened in the operating room. While it is necessary to report accidents to increase patient safety, accident reports can be used as evidence of fault.[58] In addition, the purchase of new equipment in the wake of an accident may be viewed as an admission that the old equipment was sub-par, so the hospital might forgo such a purchase in order to reduce its liability risk, even though it needs the new equipment to reduce a known risk for future patients.[59]

Patient safety is also promoted by sharing information with others. For example, electronic health records (EHRs) promote documentation and easy access to patient information, thus improving communication between doctors. Transfer of information between physicians is a known source of errors, so simplifying communication should promote patient safety.[60] Using EHRs also allows doctors to use clinical decision support systems, which may further reduce medical errors.[61] However, EHRs also create discoverable evidence, especially metadata, which can later be used to prove liability.[62] While efficiency would

57 *See* Aaron Lazare, *The Healing Forces or Apology in Medical Practice and Beyond*, 57 DEPAUL L. REV. 251(2007).

58 *See* Makary & Daniel, *supra* note 33 (noting that "[c]urrently, deaths caused by errors are unmeasured and discussions about prevention occur in limited and confidential forums" and that "[t]hese forums review only a fraction of detected adverse events and the lessons learnt are not disseminated beyond the institution or department"); Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEXAS L. REV. 1595, 1602 (2002) (hospitals and practitioners object to implementing reporting systems that gather information about errors for fear that such reports are not insulated from legal discovery during medical malpractice proceedings).

59 Federal rules of evidence prohibit plaintiffs from presenting evidence of actions the defendant took after the accident to prevent similar accidents as proving fault. *See* FED. R. EVID. 407 ("When measures are taken that would have made an earlier injury or harm less likely to occur, evidence of the subsequent measures is not admissible to prove: negligence . . . ").

60 Communication between physicians, especially during transfers between units and shifts, is strongly connected to patient safety. EHRs ameliorate the risk of errors due to miscommunication. *See* Martin Muller et al., *Impact of the Communication and Patient Hand-off Tool SBAR on Patient Safety: A Systematic Review*, 8 BMJ OPEN 1 (2018) (meta-analysis showing evidence that communicational tools helped improve patient outcomes); M. Leonard et al., *The Human Factor: The Critical Importance of Effective Teamwork and Communication in Providing Safe Care*, 13 QUAL. & SAF. HEALTH CARE 85 (2004) (effective communication between health care professionals is one of the common causes for medical errors and patient harm).

61 *See, e.g.*, Mohamed Ramadan & Khalid Al-Saleh, *Development of an Expert System for Reducing Medical Errors*, 4 INT'L J. SOFTWARE ENGINEERING & APPLICATIONS 29 (2013) (describing a method for developing a support system that should reduce medical errors).

62 Thomas R. McLean et al., *Electronic Medical Record Metadata: Uses and Liability*, 206 J.

require physicians to adopt EHRs based only on the system's costs and outcomes, physicians also consider the liability risks of implementing EHRs.

One way to overcome the disincentive to adopt risk-reducing practices is to prohibit plaintiffs from presenting evidence of them in court. For example, several states have enacted "apology laws" that make statements of apology, sympathy, and condolence inadmissible at trial, thus eliminating the fear that the apology can be used as evidence of fault.[63] Similarly, the Federal Rules of Evidence state that remedial measures taken after an accident are inadmissible as evidence that the previous conduct was negligent.[64]

While inadmissibility solves a problem that current medical malpractice law creates, it also makes it more challenging for patients to prove negligence, which reduces tort law's efficacy as a deterrent.

B. High Administrative Costs

A liability regime based on the injurer's conduct not only distorts the incentives to invest in risk-reducing measures but is also very costly to operate.[65] In any negligence-based regime, proving conduct, establishing the standard of care, and proving causation create substantial administrative costs. These costs are exceptionally high in medical malpractice cases. According to a recent estimate, more than half of payments related to medical malpractice claims are paid for administrative costs.[66]

These high costs harm both plaintiffs and defendants, but not to the same extent. Plaintiffs are disproportionately affected by the high litigation costs.[67] If

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AM. C. SURGEONS 405 (2008).

63 For a discussion on the constitutionality of laws barring healthcare providers' apologetic statements as evidence of fault, *see* Coleman v. Amon, 498 P.3d 638, 642–44 (Ariz. Ct. App. 2021) (decided that Arizona's apology law is not unconstitutional, as it serves a legitimate interest of encouraging healthcare providers to be more empathetic and candid with patients). Some argue that apology laws reduce patients' incentive to sue and thus reduce liability risk, similar to other tort reforms. *See* Yonathan Arbel & Yotam Kaplan, *Tort Reform through the Back Door: A Critique of Law and Apologies*, 90 S. CAL. L. REV. 1199 (2016) (arguing that apology laws should be viewed as further attempts to reduce medical malpractice liability, similar to other reforms). However, some evidence suggests that apology laws do not reduce the frequency of lawsuits or payments against surgeons and increase both for non-surgeons. *See* Benjamin J. McMichael et al., *Sorry Is Never Enough: How State Apology Laws Fail to Reduce Medical Malpractice Liability Risk*, 71 STAN. L. REV. 341 (2019).

64 *See supra* note 59.

65 For a discussion on administrative cost as part of the costs of accidents that should be minimized, *see* GUIDO CALABRESI, THE COSTS OF ACCIDENTS 26–31, 286–87 (1971).

66 BLACK ET AL., *supra* note 36, at 105–07 (showing that it costs more than $1 in overheads to pay $1 of compensation to the victim).

67 *Id*. at 195 (increased costs correlate with a drop in claims, especially of lower monetary value claims).

the costs of litigation are prohibitive, victims will not sue. Even if some costs can be avoided by settling out of court early on, administrative costs may still limit patients' access to justice in two ways. First, a hospital might suspect that a plaintiff lacks the resources to see the case through to trial and refuse to settle, knowing that the plaintiff will have no choice but to withdraw their claim.[68] Second, even if a hospital agrees to settle, the amount is likely to be low since the litigation costs limit the plaintiff's bargaining power.

The system's costs also affect the affordability of medical care. Proponents of tort reform claim that frivolous lawsuits lead to skyrocketing insurance premiums since insurers incur these costs even if they win most or all cases.[69] Indeed, most plaintiffs who received reasonable care will not receive compensation.[70] However, since insurers bear the costs of litigation, the risk of frivolous lawsuits affects the premiums,[71] and high premiums may result in a shortage of practicing physicians in general and high-risk specialties (such as neurosurgery and OB/GYN) in particular.[72] Such a care shortage negatively affects all patients.[73]

C. Limited Victim Compensation

The last adverse effect of the current liability regime is that victims are grossly undercompensated.[74] Medical malpractice can fulfill its goal of compensating

68 Philip Peters, *Twenty Years of Evidence on the Outcomes of Malpractice Claims*, 467 CLINICAL ORTHOPEDIC RELATED RES. 352 (2009) (showing that while physicians win 80–90% of cases deemed weak by other physicians, they lose only 50% of the cases that other physicians believe show strong evidence of negligence). However, the more significant source of under-enforcement is the result of the patient's decision to file a claim. Most victims of negligent medical errors do not file a claim and receive no compensation. *See* A. Russell Localio et al., *Relation between Malpractice Claims and Adverse Events Due to Negligence*, 325 NEW ENG. J. MED. 245 (1991) (showing that only a small fraction of adverse events due to negligence were followed by claims of medical malpractice).

69 See, e.g., Judy Donlen & Janet Spicer Puro, *The Impact of the Medical Malpractice Crisis on OB-GYNs and Patients in Southern New Jersey*, 100 N. J. MED. 12 (2003) (claiming that the medical malpractice crisis created an insurance affordability problem).

70 *See* Peters, *supra* note 68, at 352 ("malpractice outcomes bear a surprisingly good correlation with the quality of care as judged by other physicians").

71 Real defense costs have risen substantially over the years, and more than doubled since the 1980s (in real costs). Furthermore, payouts, changes in hourly legal fees, and litigation time do not account for this increase in defense costs. *See* BLACK ET AL., *supra* note 36, at 89–104 (showing that defense costs increased between 1988 to 2005 in all personal injury cases, but in medical malpractice cases the increase was more rapid, rising almost four times higher).

72 *See, e.g.*, John H. Chi, *Neurosurgery Tops Malpractice Risk*, 69 NEUROSURGERY N18, N20 (2011) (neurosurgeons were the most likely to be sued, but not the most likely to pay damages following a malpractice claim).

73 *See* Donlen & Puro, *supra* note 69 (claiming that insurance affordability problems lead to limited access for patients).

74 Low expected compensation also affects the efficacy of medical malpractice as a deterrent. When tortfeasors know their expected liability is lower than their expected harm, they are underdeterred. *See* Polinsky & Shavell, *supra* note 51, at 888–89 (when tortfeasors know that they

victims only if all victims of negligent care file a claim and receive full compensation.

In practice, only a fraction, as low as 6%, of medical negligence victims receive any compensation,[75] and most of these victims settle and receive only partial compensation.[76] Even the relatively few cases that reach a final verdict do not result in full compensation, since many plaintiffs agree to a reduced compensation post-verdict, limiting damages to the amount covered by insurance.[77]

There are several reasons for this underenforcement problem.

First, as illustrated above,[78] the substantial cost of litigation can discourage patients from filing a claim. In addition, lawyers working on a contingency fee are reluctant to represent plaintiffs in medical malpractice cases, knowing the substantial cost they must incur.[79]

Second, to win a case against a physician or medical facility, plaintiffs must prove that the care they received did not meet the applicable standard. When evidence of the physician's conduct is unavailable, patients cannot build a case even if they have the resources to do so. This might seem like a general problem with negligence law, but it is especially worrisome with regard to medical care, where physicians are in charge of recording the treatment in the patient's medical records and informing the patient of any errors.[80]

Last, even when negligence is evident, many patients will still fail to prove that it was the cause of their injury. Patients seek medical attention because they already face some risk of harm. In many, if not most, cases, it is impossible to know if the patient's harm resulted from negligent treatment or was an inevitable result of the underlying health condition.[81] Under prevailing law, the plaintiff must

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will pay less in damages than the harm they caused, they will have inadequate incentive to invest in care).

75 *See* BLACK ET AL., *supra* note 36, at 73 ("about 97 percent of the paid claims in our dataset are in cases that are settled prior to a verdict").

76 *See* Localio et al., *supra* note 68 (showing that only a small fraction of adverse events due to negligence were followed by claims of medical malpractice).

77 *See* BLACK ET AL., *supra* note 36, at 55–66 (showing that doctors rarely pay the full awarded compensation).

78 *Supra* Part I.B.

79 *See* Ronen Avraham & John M. Golden, *'From PI to IPIP': Litigation Response to Tort Reform*, 20 AM. L. & ECON. REV. 168 (2018) (suggesting that one potential side effect of tort reform is migration of in-state plaintiff attorneys' lawyers to IP, since caps on damages limit their fees, and their willingness to take on medical malpractice cases and their litigation costs); BLACK ET AL., *supra* note 36, at 195 (noting that some reforms are designed to make medical malpractice lawsuits more costly and less remunerative, explaining the drop in cases in general and small claims in particular).

80 For a discussion on the disincentive to inform patients of medical errors, *see supra* Part I.A.2.

81 *See, e.g.*, Merrell Dow Pharm., Inc. v. Havner, 953 S.W.2d 706 (Tex. Sup. J. 1997) (in a mass tort case, parents claimed that pharmaceutical company's drug caused birth defects. The Texas Supreme Court denied compensation, because plaintiffs failed to prove that the defendant's drug

establish factual causation by showing that it is more likely than not that the negligent care caused the injury.[82] In probabilistic terms, the defendant is liable only if the negligent treatment increased the risk at least twofold, making it more likely than not that the added, unreasonable risk was the but-for cause of the adverse outcome. The preponderance of evidence requirement leads to significant underdeterrence, as the need to prove causation effectively bars high-risk patients from obtaining compensation regardless of conduct. Several states have, therefore, adopted the *loss of chance* doctrine, which allows courts to award compensation that is proportional to the reduced probability of recovery resulting from not receiving reasonable treatment.[83]

One might think that under-enforcement and partial compensation mean that current medical malpractice law does not affect how physicians practice medicine, as argued earlier. However, while under-enforcement reduces liability risk, it does not negate the distortionary effects of malpractice liability. Even when their liability risk is low, physicians may adopt practices that further reduce liability risk rather than the risk of accidents.[84]

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This part explored several ways in which current medical malpractice law fails to achieve its goals of promoting patient safety and compensating victims. It showed that the need to delineate the standard of care and to establish that the treatment falls below the standard distorts the incentives of physicians and hospitals, creates substantial costs, and results in grossly low compensation to victims.

These shortcomings may explain why the U.S. health system produces poor outcomes. While medical costs are higher in the United States than in any other

increased the risk of such birth defects by more than 50%); *see also* Maytal Gilboa, *Multiple Reasonable Behaviors Cases: The Problem of Causal Underdetermination in Tort Law*, 25 LEG. THEORY 77 (2019) (explaining why the problem of causal underdetermination was overlooked by tort scholars and is perceived by courts as lack of causation).

82 This is in accordance with the preponderance of the evidence rule. *See* Dumas v. Cooney, 235 Cal. App. 3d 1593, 1611 (1991) (stating that California prefers the established rule of tort law causation, denying compensation for *loss of chance*).

83 For further discussion concerning the acceptance of the *loss of chance* doctrine, *see*, *e.g.,* Alice Ferot, *The Theory of Loss of Chance: Between Reticence and Acceptance*, 8 FIU. L. REV. 591 (2013); Matthew Wurdeman, *Loss-of-Chance Doctrine in Washington: From* Herskovits *to* Mohr *and the Need for Clarification*, 89 WASH. L. REV. 603 (2014).

84 *See* Leonard Berlin, *Medical Errors, Malpractice, and Defensive Medicine: An Ill-Fated Triad*, 4 DIAGNOSIS 133, 137 (2017) (claiming defensive medicine became a part of medical culture and education, so these practices are unlikely to decrease as litigation risk decreases).

country,[85] medical outcomes fall below those of many developed countries.[86] There are many possible reasons for this gap, but if medical malpractice law is part of the problem, it is worth exploring possible solutions.

The next part shows that SLUH may solve many of the problems discussed above, at least when applied to medical facilities.

II. STRICT LIABILITY FOR UNREASONABLE HARM

We can now turn to examine SLUH as an alternative liability regime. To understand how the suggested regime might work, consider the following variation on Example 1 above.

> Example 4. *Hospital-acquired infections*. Alex was admitted to the hospital due to a spinal injury that required simple surgery and a short hospital stay. Other than the spinal injury, Alex was generally healthy. While hospitalized, Alex developed an infection that caused permanent harm. A total of 150 patients contracted a similar infection while hospitalized during the same month. Should Alex and the other patients be compensated for their harm?

To apply SLUH to the circumstances of Example 4, we need to ask how many patients would have contracted an infection had the hospital taken reasonable care. For now, let us assume that, given reasonable care, it is likely that only 100 patients would have contracted an infection. Applying SLUH would simply mean that the hospital is liable for the harm to 50 patients. That is the unreasonable harm.

Stating that the hospital is required to pay for the harm of 50 unidentified patients means little in terms of monetary value. Compensation varies depending on each victim's age, income, pain and suffering, and other factors.[87] SLUH does not call for compensating specific victims fully. Instead, the hospital pays a fraction equal to the unreasonable harm divided by the entire harm. In this case, it calls for a third of the harm to all 150 patients who contracted an infection.

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85 *See, e.g.*, Irene Papanicolas et al., *Health Care Spending in the United States and Other High-Income Countries*, 319 JAMA 1024 (2018) (finding that the United States spent in 2016 nearly twice as much as ten high-income countries on medical care, and performed less well on many population health outcomes).

86 *Id.; see also* Luca Lorenzoni et al., *Health-Care Expenditure and Health Policy in the USA versus Other High-Spending OECD Countries*, 384 LANCET 83, 89 (2014) ("The USA is an outlier in the scenery of OECD health-care systems, for its staggering levels of expenditure, the extent of fragmentation of its system and the sheer complexity of its administration, the power of vested interests, and the large number of people left without adequate health insurance coverage").

87 *See* DAN B. DOBBS, PAUL T. HAYDEN & ELLEN M. BUBLICK, THE LAW OF TORTS, § 479 (2d ed. 2011) (describing the elements of damages for personal injury).

In the medical malpractice context, SLUH can operate best alongside an insurance scheme that covers reasonable harm, be that mandatory first-party insurance – meaning each patient buys insurance,[88] or social insurance is put in place that covers only reasonable harm.[89] The hospital, in turn, covers the costs of unreasonable harm, and all victims of medical errors receive full compensation. To illustrate, assuming that patients in Example 4 are insured for reasonable harm, 150 patients who contracted an infection would be fully compensated for medical costs, lost wages, and non-pecuniary loss.[90] Out of the total compensation, the insurer would cover two-thirds. The hospital would pay the remaining one-third of the compensation, as it represents unreasonable harm.

The following sections address the informational requirements for determining reasonable harm. They show that it is possible to implement this liability regime in large medical facilities and how implementing SLUH solves many of the problems created by current medical malpractice law.

A. Determining Reasonable Harm

To implement the SLUH regime, courts must determine the reasonable harm from accidents and decide if and to what extent the harm resulting from the injurer's actual involvement in accidents exceeded the reasonable level.

Determining the reasonable level of harm is similar, in some respects, to

88 Mandatory insurance schemes are widespread. For instance, employers are required by workers' compensation laws to provide third-party insurance to their workers. Similarly, in most states, drivers must acquire some combination of first-party and liability (third-party) insurance. *See* Omri Ben-Shahar & Kyle D. Logue, *Outsourcing Regulation: How Insurance Reduces Moral Hazard*, 111 MICH. L. REV. 197, 219–223 (2012) (describing mandatory insurance schemes for workplace and transportation accidents and illustrating the advantages these schemes offer). This additional insurance layer can either be included in a patient's general health insurance or bought separately for those who do not have any health insurance coverage. Alternatively, the medical facility may be obligated to acquire insurance for all patients and reimbursed by the patient's health insurance provider.

89 A social insurance scheme, similar to first-party insurance, offers compensation to patients who have suffered medical losses. The primary difference between the two insurance schemes is that first-party insurance is funded by individual patients who cover their own risks, while social insurance may be funded by other entities, such as the state. The premiums for social insurance are often not directly related to the risk of each individual insured. For a suggestion to eliminate tort liability altogether, and replace it with a social insurance scheme, *see* STEPHEN D. SUGARMAN, DOING AWAY WITH PERSONAL INJURY LAW: NEW COMPENSATION MECHANISMS FOR VICTIMS, CONSUMERS, AND BUSINESS 127-148 (1989); Stephen D. Sugarman, *Tort Reform through Damages Law Reform: An American Perspective*, 27 SYDNEY L. REV. 507 (2005); Kenneth S. Abraham & Lance Liebman, *Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury*, 93 COLUM. L. REV. 75 (1993).

90 RESTATEMENT (SECOND) OF TORTS: DAMAGES FOR PERSONAL INJURY, §§ 901–903; Fleming James Jr., *Damages in Accident Cases*, 41 CORNELL L. Q. 582, 598–605 (1956) (discussing the elements of personal injury compensation).

determining the standard of care under a negligence regime. To assess the standard of care, courts must determine how much each precaution measure reduces the risk and magnitude of injuries. Theoretically, after a court determines the reasonable risk for patients from the medical care (including, for example, the risk from each day of hospitalization, surgery, or diagnostic test), it simply multiplies the expected harm from each interaction by the number of interactions to determine the level of reasonable harm. For example, assuming there is a 1% chance of contracting an infection for each day of hospitalization when a hospital takes reasonable measures to prevent that risk, then a hospital that admitted patients for a total of 5,000 days should reasonably have fifty cases of hospital-inquired infections.[91]

Note that, unlike the negligence inquiry, determining the level of reasonable harm requires information about patients with no adverse events during their hospital stay. To start, the court needs to know the total number of hospitalization days for all patients, including patients who did not suffer from an infection or any other adverse event during their stay.[92] This information is not required under the negligence regime because that regime focuses on the hospital's conduct towards plaintiffs and disregards other patients. In addition, determining reasonable harm requires information about each patient's underlying (reasonable) risk. Since the reasonable risk to each patient might vary due to his or her characteristics, if the reasonable harm is not adjusted, hospitals may try to avoid liability by denying care to high-risk patients instead of investing in risk-reducing measures.

For example, the risk of complications after surgery depends on measures the medical staff implements before, during, and after surgery and on patient characteristics such as age, gender, and smoking.[93] If the reasonable level of harm is not adjusted to match patients' risk, hospitals will prefer to treat young, female, nonsmoking patients to avoid liability.[94] Adjusting for known risk factors minimizes this incentive to avoid liability by selecting low-risk patients (an adverse selection problem).[95]

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91 *See supra* note 25 and accompanying text.

92 *See* Shavell, *supra* note 40, at 2 ("By definition, under the negligence rule all that an tortfeasor needs to do to avoid the possibility of liability is to make sure to exercise due care if he engages in his activity. Consequently, he will not be motivated to consider the effect on accident losses of his choice of whether to engage in his activity or, more generally, of the level at which to engage in his activity."); SHAVELL, *supra* note 41, at 197-99 (same); *see also* RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL & EMOTIONAL HARM § 3 at para. H (2010).

93 Chun Kevin Yang et al., *Pulmonary Complications after Major Abdominal Surgery: National Surgical Quality Improvement Program Analysis*, 198 J. SURGICAL RES. 441 (2015) (age, gender, and smoking are correlated with postoperative complications).

94 Victims that suffer harm are not chosen at random, as those with higher risk are more likely to be represented than those with a lower risk.

95 Selection may persist if some risk factors are non-verifiable. If a surgeon can surmise that a patient is at higher risk than the estimate based on the patient's known risk factors, hospitals might still try to reduce liability be turning these patients down.

To complete the inquiry, the court must determine the level of harm caused by the tortfeasor over the relevant period (to all victims). This part of the factual inquiry requires the same information as under current medical malpractice law, which bases compensation on the harm victims suffer. There is a significant difference, however. SLUH requires the court to know the sum of the harm to all patients who suffered an adverse event, not just those who decide to file a claim. This requirement might constitute an obstacle when patient information is unavailable without cooperation.[96] When such information is readily available, the SLUH regime is best viewed as a collective litigation mechanism, similar to a class action.[97]

After the total level of harm is established, awarding compensation is a simple matter of subtracting the reasonable harm from the total harm and dividing the compensation among victims.

B. Dealing with Uncertainty and Errors

Courts might be uncertain about both the level of reasonable harm and the actual harm. Even when information about reasonable and actual harm is readily available, it might be inaccurate.[98] The risk of error in estimating unreasonable harm may distort the incentives that the SLUH regime creates.

If courts systematically overvalue the reasonable level of harm, it distorts the hospital's incentives. For example, if a hospital's reasonable harm is 100 but courts consider 130 to be reasonable, the hospital will have no incentive to reduce harm below 130.[99] The same argument cannot be made for errors in the other direction.

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96 The problem persists if we allow victims to opt out of SLUH litigation. David Rosenberg made a similar observation, discussing class action litigation of mass torts. *See* David Rosenberg, *Mandatory-Litigation Class Action: The Only Option for Mass Tort Cases*, 115 HARV. L. REV. 831 (2002) (arguing that *ex ante* potential victims prefer collective litigation but after learning of their individual harm, some victims prefer individual litigation, thwarting efforts to achieve optimal deterrence).

97 Class actions are usually designed as an opt-out mechanism. *See* John E. Kennedy, *Class Actions: The Right to Opt Out*, 25 ARIZ. L. REV. 3 (1983) (tracing the historical development of the right to opt-out of alternative offers). For SLUH to work it is important that compensation to all victims will be adjudicated together, meaning that it should replace the current medical malpractice regime, and not operate alongside it.

98 These risks mirror the risks of errors in setting the due care standard and in assessing the injurer conduct. *See* THOMAS J. MICELI, ECONOMICS OF THE LAW: TORTS, CONTRACTS, PROPERTY, AND LITIGATION 45–46 (1997) (discussing the effects of uncertainty over the determination of fault, showing it may cause over or underdeterrence); SHAVELL, *supra* note 40, at 224–28 (showing that uncertainty about the determination of the standard of care causes overdeterrence); Mark F. Grady, *A New Positive Economic Theory of Negligence*, 92 YALE L. J. 799, 806–13 (1983) (same); Omer Y. Pelled, *All-or-Nothing, or Something—Proportional Liability in Private Law*, 22 THEORETICAL INQ. L. 159, 178–84 (2021) (classifying uncertainty regarding fault as a case of unilateral uncertainty, and showing that unilateral uncertainty may result in over or underdeterrence).

99 This assumes that there are no other costs to liability, such as reputational costs. For the effect

If courts systematically undervalue the reasonable level of harm, hospitals will have to pay damages even when taking reasonable care. Nevertheless, they will not overinvest in risk-reducing measures. For example, if a hospital's reasonable harm is 100 (meaning that any measure that further reduces harm costs more than the harm),[100] but courts consider only 70 to be reasonable, the hospital will opt to pay 30 in damages as any further reduction in harm (by definition) costs more than it saves in damages.

Even assuming that the courts' estimations are unbiased, so they are correct on average, errors distort incentives since the effects of errors are one-sided. If the court (erroneously) decides that actual harm exceeds reasonable harm, the injurer will be liable for the difference. However, if the court (again, erroneously) decides that actual harm did not exceed reasonable harm, the hospital will not be rewarded a prize for causing less harm than is reasonable.[101] The risk of error leads injurers to underinvest in care. To see why, let us assume that while the reasonable harm is 100, there is an equal probability that a court will err and decide that it is 70 or 130. Hospitals can invest $15 in measures that reduce harm from 120 to 100 but would not do so. If they invest in such measures, their expected liability is 15 (50% chance they will have to pay 30 in damages), and 25 if they do not invest in such a measure (50% chance they will have to pay 50 in damages). That means a hospital must invest $15 to reduce its expected liability by $10. Table 1 illustrates the problem.

Table 1: Errors in the estimation of reasonable harm

	Cost to Reduce Harm	*Actual Harm*	*Liability if Reasonable Harm $70*	*Liability if Reasonable Harm $130*	*Expected Liability*	*Total Cost*
No Measures	$0	$120	$50	$0	$25	$25
Measures	$15	$100	$30	$0	$15	$30

It is clear from the table that the hospital reduces its total costs, in this example, by not investing in care. The hospital gains nothing by investing in care when courts overvalue the level of reasonable harm.

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of such costs on optimal damages calculations, *see* Robert Cooter & Ariel Porat, *Should Courts Deduct Nonlegal Sanctions from Damages?*, 30 J. LEGAL STUD. 401 (2001) (discussing how nonlegal sanctions affect deterrence).

100 *See supra* note 40 and accompanying text.

101 Negative damages may have some attractive features. *See* Urs Schweizer, *But-for Causation and the Implementability of Compensatory Damages Rules*, 36 J. L. ECON. & ORG. 231, 247 (2020) (showing that to achieve efficient equilibrium when the standard of care is not set efficiently courts should award negative damages).

A straightforward solution to the distortion of incentives caused by errors is to allow negative damages, meaning that if the court determines that the harm a hospital creates falls below the reasonable level of harm, the hospital will receive a subsidy equal to the difference.[102] For example, if a hospital's reasonable harm is 100 but the courts consider 130 to be the reasonable level, the hospital will invest in care and reduce the harm to 100 to receive the subsidy.

Negative damages solve the problem of underinvestment in care when courts make symmetric errors. For instance, consider Table 2, which is a variation of Table 1, and includes negative damages. By adding a third care level to the table that costs an additional $15 but reduces harm by only $10, Table 2 demonstrates that negative damages do not encourage overinvestment in care measures.

Table 2: Errors in the estimation of reasonable harm with negative damages

	Cost to Reduce Harm	*Actual Harm*	*Liability if Reasonable Harm $70*	*Liability if Reasonable Harm $130*	*Expected Liability*	*Total Cost*
No Care Measures	$0	$120	$50	−$10	$20	$20
Care Measures	$15	$100	$30	−$30	$0	$15
Excessive Care Measures	$30	$90	$20	−$40	−$10	$20

As is clear from the table when negative damages are allowed the effects of errors are symmetrical – the hospital bears an additional cost when courts undervalue reasonable harm, and it receives a benefit when courts overvalue it. This symmetry means that a hospital's incentives are unaffected by the risk of error. It will, therefore, prefer to invest in care, as doing so reduces its total expected costs and will not overinvest in care. Even though excessive measures reduce liability when reasonable harm is set too low and increase the subsidy when reasonable harm is set too high, the additional cost exceeds the benefit.[103]

102 *See* David Gilo & Ehud Guttel, *Negligence and Insufficient Activity: The Missing Paradigm in Torts*, 108 MICH. L. REV. 277, 319 (2009) (suggesting subsidizing activity to correct otherwise distorted incentives).

103 Mathematically, the result is unsurprising. When negative damages are allowed, SLUH is identical to a strict liability regime minus a fixed sum equal to the courts' assessment of reasonable harm. Since the fixed sum is unaffected by a hospital's actions, it does not distort the hospital's incentives.

If legislators implement SLUH alongside an insurance scheme that covers the risk of reasonable harm to patients (be that mandatory first-party insurance or some form of social insurance),[104] then the problem is solved – each patient is insured for reasonable harm and receives full compensation. If the hospital's harm exceeds the level of reasonable harm, the hospital pays the difference. If, however, patients suffered less than reasonable harm, the hospital can receive the difference from the insurer.

A second source of errors in applying SLUH comes from uncertainty about the harm that occurred. Even if the courts accurately determined the reasonable level of harm, there is a risk of random variation in actual harm. We have assumed, for simplicity, that hospitals that take adequate care can foresee the number of accidents that will happen. For example, if all medical staff members regularly wash their hands and take other precautions to prevent infections, *exactly* 100 patients will suffer from infection over the relevant period. However, there is always variation in the harm that materializes, even when we control for factors that affect the risk.

We can think of SLUH as a regime that determines the mean level of harm from the injurer's conduct by using a sample: the actual harm over a specified period.[105] As with all samples, the level detected may vary randomly, but variance decreases as the sample size increases.[106] Therefore, SLUH is more accurate for large medical facilities that treat more patients and handle more accidents.[107]

Consider the example of hospital-acquired infections again. Assume that if a

104 *See supra* notes 88–89 and accompanying text.

105 The class of victims in SLUH litigation is not strictly a sample since it involves everyone who was injured. For an analysis of tort litigation as a sampling of the injurer's conduct, *see* Fennel, *supra* note 13.

106 This variation can be statistically estimated by the standard error of the sample mean, which is affected by the sample size.

107 In some ways, treating the hospital as a unit of investigation may be somewhat arbitrary, stemming from conceptual convenience. SLUH can be applied to a smaller unit, such as a department within a hospital, or to a larger unit, such as a network of hospitals. However, SLUH can only work effectively if there is a single entity that is both financially and operationally accountable. Two conditions need to be met for this to be true. The first condition is that there should be a single entity responsible for paying for damages. This condition is held for a department within a hospital, the entire hospital, and a network of hospitals. It does not hold for two hospitals that belong to different networks. The second condition is centralized management, which means that the entity responsible for paying for damages should have some level of control over the actions of any sub-divisions. Expanding the scope of SLUH from a small unit, like a department, to a larger one, like a hospital, can enhance the accuracy of the results as the sample size increases. This indicates that larger facilities have a lower variance in damages, which gives them an advantage due to their size. However, the size of the hospital has no impact on expected damages, and hence, risk-neutral business entities, such as hospitals, are generally not concerned about this advantage. Applying SLUH to a network may be advantageous when private physicians and several hospitals treat patients within the same network.

hospital takes reasonable care, 100 patients will, on average, contract an infection during hospitalization in a year. Two problems may arise. First, after some time, say eleven months, the hospital might realize that despite acting reasonably, due to bad luck, 130 patients have already contracted an infection. Alternatively, the hospital might realize that despite acting reasonably (without taking excessive care), due to good luck, only 70 patients contracted an infection. In both cases, the actual harm indicates a level of care that does not match the hospital's investment.

The same solution – negative damages – solves this problem as well. If negative damages are allowed, the hospital will take adequate care during the last month, knowing that that is the best strategy to reduce its liability (if, due to bad luck, the harm was high) or to maximize the subsidy (if, due to good luck, the harm was especially low).

C. Available Data About Reasonable Harm in Medicine

The previous sections laid out the theoretical foundations of the SLUH regime and showed what information is required to implement it. To replace current medical malpractice law, we need to know whether the information required to implement SLUH is available. Even if it is not, the foregoing theoretical exercise has value: it may persuade us that the information is worth gathering. Once health regulators compile the data, we can examine the practical use of SLUH once more.

We will not have to wait long. Legislators can already apply SLUH instead of the current medical malpractice law to most risks. In fact, although no one has suggested examining the outcomes of hospitals to determine legal liability, medical associations have assessed the safety and efficacy of various hospital departments based on outcomes for some time. For example, the American Heart Association (AHA) has long suggested comparing heart surgery patient outcomes with the anticipated risk-adjusted rate of complications to assess efficacy and safety in cardiovascular surgery departments.[108] In addition, the State of New York, the U.S. Veterans Administration, and the Society of Thoracic Surgeons have created cardiac surgery registries that record risk-adjusted outcome data based on these suggestions. These datasets have been used to conduct several performance assessments and interventions at the hospital level.[109]

The American College of Surgeons (ACS) has implemented a much more robust program known as the National Surgical Quality Improvement Program (ACS NSQIP). More than 2,500 participating hospitals send detailed reports of

108 *See* Hillis et al., *supra* note 16, at § 5.1 (finding that "the common denominator among successful performance improvement strategies is the implementation of a formal quality assessment and feedback program benchmarked against regional or national results").

109 *Id*. (noting that these datasets where developed "[t]o address the need for valid and reliable risk-adjusted outcomes data").

their surgeries, including outcomes and complications, and receive an assessment of patient safety based on risk-adjusted outcomes.[110]

The massive dataset that ACS NSQIP has created allows physicians to assess the risk of any complication following surgery, as well as the risks of specific complications, according to the surgery type, the patient's comorbidities (e.g., hypertension, diabetes, or cancer), and personal characteristics that might affect the risk of complications, such as age, sex, weight, and smoking habits.[111] Since these risk calculations assume reasonable care, they allow us to assess a hospital's risk-adjusted rate of complications, such as surgical-site infection,[112] and compare them to the actual rate a hospital experiences. These risk management programs are very similar to SLUH and require the same data.

The information allows the court to determine the reasonable and actual level of harm due to medical errors, infections, complications, and other relevant risks in each department. Subsequently, the courts can assign liability to each department and each type of harm separately provided that each department has enough patients. Alternatively, the courts can determine the total liability for the entire hospital based on the sum of reasonable and actual risk in each department.

The first option resembles the negligence inquiry under current medical malpractice law. We usually think of reasonable care vis-à-vis a specific risk that precautions might prevent.[113] If we take the same approach to harm, we should look at specific types of harm rather than the total harm suffered by patients in the hospital. This approach also provides valuable information to the hospital (and other hospitals) about the risks it needs to decrease further.[114]

The second option has several advantages. First, dividing risk types might obscure cases of unreasonable harm because the risk of specific complications might be too low to detect deviations in hospitals smaller than a certain size. Second, from an incentives standpoint, we care about total harm, not the rate of one type of complication. When a practice reduces one type of risk but increases another, it should be encouraged if it lowers the total expected harm (i.e., from

110 *See* Mark E. Cohen et al., *Improved Surgical Outcomes for ACS-NSQIP Hospitals Over Time*, 362 ANNALS OF SURGERY 267 (2016) (describing the methodology of data collection in ACS-NSQIP and showing that participating in the program led to a reduction in postoperative complications).

111 The ACS NSQIP surgical risk calculator is available at https://riskcalculator.facs.org/RiskCalculator/.

112 *Id*. (the risk calculator uses twenty patient predictors and the planned procedure to predict the chance that patients will have any of eighteen different outcomes, one of which is surgical-site infection).

113 *See* RESTATEMENT (THIRD) OF TORTS, *supra* note 92, at § 29 ("an actor's liability is limited to those harms that result from the risks that made the actor's conduct tortious").

114 *See* Teitelbaum, *supra* note 46, at § 4 (showing that when it is difficult to compute the standard of care, searching for more efficient precautions involves learning-by-experimentation).

both complications combined). By examining each complication separately, we might discourage such practices.

Interestingly, negative damages allow us to enjoy the benefits of both options. Courts should assess each risk separately, thus informing the hospital about unreasonable harm and indicating that it should adopt specific practices. At the same time, if the hospital realizes it can reduce one type of risk below the reasonable harm threshold while creating another less substantial risk, it will do so, knowing it will receive the subsidy for lower-than-reasonable harm.

Courts can use the rich data regarding risks to further adjust the reasonable harm assessment to the hospital's characteristics.[115] For example, smaller-volume hospitals may have a higher risk of surgery complications than high-volume ones.[116] Courts should consider only those characteristics related to the cost of care measures and experience.[117] If low-volume hospitals have higher complication rates because volume is correlated with resources, and hospitals with fewer resources cannot invest as much in care, the reasonable level of harm can be adjusted according to resources, not volume.[118] If a high volume of surgeries provides experience in performing surgeries, which affects the success rate, reasonable harm should be adjusted accordingly.

Programs such as ACS NSQIP show that it is possible to assess reasonable harm, at least regarding complications and medical errors. This conclusion should not come as a surprise. Medical care, in general, and particularly in hospitals, is information-intensive. Hospitals record information about treatment and outcomes in the patient's medical records and submit that information to insurers for payment. Many adverse events, such as hospital-acquired infections, are also

115 Some hospitals serve certain types of patients. For example, veterans' health facilities cater to a specific type of patients (veterans), who might face different risks than other patients. As long as these patient-related risks, however, are already a part of the risk-adjusted reasonable harm assessment, the fact that the medical facility treats veterans should not be further taken into account.

116 See, e.g., M. Moschini et al., *Critical Review of Outcomes from Radical Cystectomy: Can Complications from Radical Cystectomy Be Reduced by Surgical Volume and Robot Surgery?*, 2 EURO. UROLOGY FOCUS 19 (2016) (finding correlation between hospital volume and patient outcomes and complications).

117 A similar discussion has been raised concerning the personalization of the standard of care under negligence. *See* Omri Ben-Shahar & Ariel Porat, *Personalizing Negligence Law*, 91 N.Y.U. L. REV. 627 (2016) (suggesting that courts would set a personalized standard of care for each injurer, based on the injurer characteristics).

118 Allowing a poorly funded community hospital a higher level of reasonable risk reflects the ability of the hospital to avoid risks but implies that the patients in these hospitals, who usually come from low-income families, may receive a lower level of care. Ignoring the hospital's ability to reduce risks will not reduce the hospital's rate of compensation and will only serve to increase the hospital's liability, further reducing the poorly funded hospital's ability to treat patients. A similar dilemma exists regarding the standard of care in a negligence regime. *See id.* at 627, 637, 643–44 (2016); OMRI BEN-SHAHAR & ARIEL PORAT, PERSONALIZED LAW: DIFFERENT RULES FOR DIFFERENT PEOPLE 61–64, 67–69 (2021) (the standard of care should be based on the resources available to the injurer).

reported to a centralized registry. The collected data includes treatments and outcomes of all patients, allowing us to compare reasonable harm to actual harm.[119]

One of SLUH's limitations is that it requires continuous access to data about patients' characteristics and outcomes. ACS NSQIP and similar programs gather data based on the continuous cooperation of participating hospitals. These hospitals receive advice about how to improve patient safety, so they have no incentive to send misleading information. We may fear that once the information is used to assign liability, hospitals will no longer willingly share information or that some might try to hide complications and overestimate patients' risks. This fear is justified as some complications are recorded in patients' charts but underreported to insurers.[120] The risk of this happening, however, can be mitigated. First, if legislators decide to apply SLUH, hospitals should be required to grant access to patients' data directly from their medical charts (it is difficult to underreport a complication in a patient's chart). Regulators and plaintiff lawyers can later supplement the data with post-discharge patient surveys[121] and assess the data's accuracy by reviewing a random sample from the patient pool.

D. Advantages of SLUH over Medical Malpractice Law

Tort reform became a popular legislative tool for addressing the shortcomings of the medical malpractice liability regime.[122] The most common reform used to decrease medical malpractice liability risk is placing caps on damages.[123] Even the ban on apologies as evidence of negligent treatment was recognized as a (soft) form of tort reform.[124] The data suggest these reforms failed to significantly reduce the cost of medical care, increase access to care, or improve safety. The current system's limitations include inadequate incentives to invest in reasonable

119 *See supra* note 110 and accompanying text.

120 Steven M. Steinberg, et al., *Comparison of Risk Adjustment Methodologies in Surgical Quality Improvement*, 144 SURGERY 662, 665 (2008) (finding that ACS NSQIP identified 26% more complications than what is reported to insurers).

121 For a study suggesting that post-discharge interviews can reveal preventable events which were not documented in patients' records, *see* Joel S. Weissman et al., *Comparing Patient-Reported Hospital Adverse Events with Medical Record Review: Do Patients Know Something That Hospitals Do Not?*, 149 ANNALS INTERNAL MEDICINE 100 (2008).

122 For an extensive examination of the challenges of the medical malpractice system, as well as critical analysis of the effects of tort reforms on outcomes and medical costs, *see generally* BLACK ET AL., *supra* note 36.

123 *Id*. at 111–21 (reviewing the use of capping noneconomic damages in Texas); *see also* Avraham & Schanzenbach, *supra* note 53 (examining the effect of caps on damages on treatment intensity in eight states).

124 *See* Arbel & Kaplan, *supra* note 63, at 1201 (maintaining that apology laws are structured as "de facto tort reform"); W. Kip Viscusi, *Medical Malpractice Reform: What Works and What Doesn't*, 96 DENV. L. REV. 775 (2019) (same).

precautions,[125] high administrative costs,[126] and a low compensation rate.[127] SLUH solves all these problems.

1. SLUH Creates Better Incentives to Invest in Care

A negligence-based regime distorts incentives in three ways: (i) it encourages hospitals to prioritize care measures that are more likely to be part of the negligence inquiry; (ii) it encourages defensive medicine; and (iii) it discourages risk-reducing practices that may later be used as evidence of prior negligence.

Negligence law encourages hospitals to prioritize measures that are included in the negligence inquiry. Under SLUH, liability depends only on outcomes. SLUH thus incentivizes hospitals to take all measures that reduce patient harm at a low cost, regardless of whether the court observes such measures.

Consider, for example, the response time at an intensive care unit (ICU). Patients in the ICU are connected to a monitor that sounds an alarm if the patient's vital signs cross a threshold. The nursing staff's response time affects patient outcomes and is easy to monitor and record. In such cases, the court might examine only the staff response time and ignore other, less salient circumstances. In response, nursing staff at the ICU might try to reduce the response time to every alarm at the expense of other safety measures. For example, sterilization might be impaired if a nurse abruptly stops treatment for one patient to respond to an alarm from another patient's monitor.[128]

Second, SLUH eliminates the incentives to adopt defensive practices. These practices are supposed to reduce liability risk at a reasonable cost without affecting patient outcomes. Since under SLUH, liability is determined only by patient outcomes, physicians will be encouraged to prescribe only those tests and treatments that are likely to (efficiently) affect outcomes.

Third and last, SLUH reduces the disincentive to collect and share information about mistakes. Under current medical malpractice law, information about preventable harm and errors can lead to litigation and liability.[129] Under SLUH,

125 *See supra* Part I.A.

126 *See supra* Part I.B; BLACK ET AL., *supra* note 36, at 168–70 (showing that while tort reform in Texas during 2003 did limit physicians' exposure to liability, it had little effect on improving access to care for patients).

127 *See supra* Part I.C.

128 *See* Yuval Bitan, et al., *Nurses' Reactions to Alarms in a Neonatal Intensive Care Unit*, 6 COGNITION, TECH. & WORK 239 (2004) (showing that nurses prioritize responses to alarms, treating patients in need quickly but ignoring alarms to focus on other tasks when these alarms are not likely to have medical significance).

129 See, *e.g.*, Sandra Petronio et al., *Disclosing Medical Mistakes: A Communication Management Plan for Physicians,* 17 PERMANENTE J. 73 (2013) (despite a consensus that disclosure of medical error is ethically and legally appropriate, concern about medical malpractice suits, among other concerns, make disclosure difficult).

sharing information becomes a vital tool to reduce liability. While it is true that physicians might still be reluctant to tell their colleagues about their mistakes for reputational reasons,[130] the legal system under SLUH works against this tendency instead of encouraging it.

Adopting SLUH may indirectly promote patient safety and care. Currently, programs such as ACS NSQIP are voluntary and limited to specific medical practices and participating hospitals. Nevertheless, the massive data gathered by ACS NSQIP allows researchers to explore numerous questions regarding care practices,[131] staff management,[132] and risk factors for diseases or complications.[133] Under SLUH, data will be collected from more hospitals, covering more procedures and risks. This great mass of information will constitute an extensive database for future studies, further advancing patients' safety and care.

2. Reducing Administrative Costs

The current liability system creates high, often prohibitive, litigation costs for plaintiffs, with increasing costs for defendants as well.[134] One reason for this excessive cost is plaintiffs' tendency to sue multiple defendants, including physicians and hospitals.[135] Under SLUH, only the hospital is sued since the individual physician and her or his conduct are irrelevant.

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130 *See, e.g.*, Tsachi Keren-Paz, *Liability Regimes, Reputation Loss, and Defensive Medicine*, 18 MEDICAL L. REV. 363 (2010) (analyzing the effects of negligence and strict liability on physicians' reputation).

131 *See, e.g.*, Angela M. Ingraham, et al., *Comparison of Outcomes after Laparoscopic versus Open Appendectomy for Acute Appendicitis at 222 ACS NSQIP Hospitals*, 148 SURGERY 625 (2010) (analyzing data of 32,683 appendectomy patients from 222 participating hospitals to find the relative risk of different approaches given patients' characteristics).

132 *See, e.g.*, Hadiza S. Kazaure, Sanziana A. Roman & Julie A. Sosa, et al., *The Resident as Surgeon: An Analysis of ACS-NSQIP*, 178, J. SURGICAL RES. 126 (2012) (analyzing data of patient outcomes based on whether the operation was conducted by a resident, a resident guided by an attending, or an attending operating alone found that residents had a longer operating time, but selection of surgeries to residents and supervision prevented compromising patient outcome for medical education).

133 *See, e.g.*, Hadiza S. Kazaure, et al., *Cardiac Arrest Among Surgical Patients: An Analysis of Incidence, Patient Characteristics, and Outcomes in ACS-NSQIP*, 148 JAMA SURGERY 14 (2013) (analyzing data of 6,382 patients who underwent CPR following surgery to find risk factors to and from postoperative heart failure).

134 *Supra* Part I.B.

135 Hospital enterprise liability was considered as a way to reduce administrative costs by making the hospital the sole defendant in each case involving care inside a hospital. *See* Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 406 (1994) (explaining the potential of administrative cost reduction in enterprise liability); Philip G. Peter Jr., *Resuscitating Hospital Enterprise Liability*, 73 MO. L. REV. 369, 388 (2008) (hospital enterprise liability as a more economical administrative system).

More importantly, the high costs of litigation stem from the need to collect evidence and produce expert reports regarding conduct and causation.[136] The cost of litigating these issues is substantial, even relative to the stakes of the average case.[137] SLUH eliminates some of these costs. Since the court compares the actual harm to a level of harm determined to be reasonable without trying to identify which incident resulted from which conduct, there is no need to prove causation in any individual case. Furthermore, since conduct is never examined, there is no need to collect evidence regarding the standard of care applicable to each incident or the actual conduct.

SLUH creates its own costs, of course, including the cost of collecting and assessing patient data. If hospitals have the ability to manipulate data, plaintiffs' lawyers will need to carefully review the accuracy of the hospital's reports on their patients' outcomes. To verify the precision of the hospital's report on adverse outcomes, lawyers may contact a random sample of the hospital's patients. This process will ensure that the hospital has reported all adverse outcomes correctly, but it creates additional costs. Nevertheless, this all costs much less per case than the current regime. Assessing a sample of patients is costly, but the information is readily available. Examining conduct requires much more evidence, and that evidence is likely unavailable.

3. Better Enforcement

The last major concern regarding the current liability regime is that most victims never receive any compensation.[138] This well-known phenomenon can be attributed, at least partially, to the high litigation costs and difficulty in proving negligent conduct and causation. Since the expected liability from negligence is much lower than the expected harm, the current law is a poor deterrent.

SLUH solves the problem of underenforcement by operating as a form of aggregate litigation, similar to a class action. Like in class actions, lawyers and class representatives collect the evidence and manage the litigation for all the class members. Victims do not necessarily even know that their case is being litigated until the court assigns liability and the compensation stage commences. At this point, each class member must bring evidence regarding their individual harm, including medical costs, lost wages, and non-pecuniary losses such as pain and suffering.[139]

Assuming SLUH is applied alongside mandatory first-party insurance, the insurer will pay all victims full compensation, and the hospital will just have to

136 *See supra* notes 81–83 and accompanying text.
137 *See supra* notes 69–67 and accompanying text.
138 *See supra* notes 68, 75–76, and accompanying text.
139 *See supra* note 96.

pay the insurer for unreasonable harm, meaning that only one entity receives compensation.

III. CRITICISM AND OBJECTIONS

One objection to the SLUH regime may be that victims of negligent treatment will receive only partial compensation for their harm, assuming that the liability regime is implemented without first-party insurance. Partial compensation may seem especially troubling for patients who can easily prove that their harm resulted from negligent treatment, even though the hospital's total rate of harm was under the reasonable harm threshold. Another objection to the SLUH regime is that it might encourage practices that reduce harm in the short run while discouraging practices that temporarily increase patient risk while improving patient safety over time. Additionally, one could argue that other liability regimes can better resolve the problems of the current medical malpractice regime. Finally, SLUH may face strong political opposition. The discussion below addresses each of these objections in turn.

A. Compensating Victims

When hospitals are liable under the SLUH regime, the amount paid in damages is close to the amount the hospital would have paid under the negligence regime if every patient harmed by negligent care received full compensation. However, the distribution of compensation among patients may be different. Under a negligence regime, only victims of negligent care receive compensation. Under SLUH, when a complementary insurance scheme that covers reasonable harm is in place, every patient who suffered from an adverse event is fully compensated, partially by the insurer. One could argue that even though all patients are compensated, and the hospital pays exactly what it should have under a negligence regime, the compensation scheme is still unjust. According to corrective justice principles, the hospital, as a tortfeasor, must compensate only those patients who received negligent care and suffered harm as a result, and should not compensate at all patients who had an adverse outcome from bad luck, after receiving reasonable care. [140] It is not easy to reconcile these characteristics of the SLUH regime with corrective justice principles. It is unfair to hospitals that compensate patients who did not sustain a normative loss, and it is unfair to victims of negligent care whose normative losses are not fully compensated.[141]

140 Ernest J. Weinrib, *The Gains and Losses of Corrective Justice*, 44 DUKE L.J. 277, 283 (1994) (distinguishing between material loss and normative loss, and stating that "if you injure me nontortiously, the loss I suffer falls under the material conception, but because you have breached no norm, the normative conception of loss is inapplicable").

141 *Id*. at 290 ("one cannot justify tort liability by reference to the need both to deter actors and

Furthermore, if a complementary insurance scheme is unavailable, victims receive only partial compensation, in which case victims of negligent care are denied some or even most of the compensation they would have received under the negligence regime. Even if patients are only partially compensated, there are several reasons beyond the incentivizing rationale discussed above to prefer the SLUH compensation system to the existing one.

Risk-averse patients prefer to receive partial compensation with certainty rather than full compensation with some probability.[142] Patients always face some risk regardless of the hospital's care level. Let us assume that out of 100 patients who had an adverse event, 50 suffer harm from reasonable risk, and 50 others suffer harm from negligent care. Risk-averse patients prefer compensation for half of the harm whenever harm is done to full compensation in half of the accidents. If patients are especially fearful of being undercompensated when a negligent doctor injures them, they can always purchase insurance, even if insurance is not required.

Another reason for patients to prefer SLUH to the current system is that patients pay for the distorted incentives that the current regime creates. When physicians and hospitals pay high insurance premiums and adopt defensive practices, patients directly bear the costs. Adopting SLUH will decrease the cost of care and improve outcomes while retaining a (limited) right of compensation when negligent care increases harm caused to patients.

Last, and most importantly, while SLUH might not fully adhere to the principles of corrective justice, it is undoubtedly better than the current medical malpractice regime. Today, only a tiny fraction of patients receive any compensation; of those, only a fraction receive full compensation.[143] It is difficult to argue that the current system promotes justice when in practice, many patients are injured by negligent care, and almost no one is compensated.[144] Under SLUH,

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to compensate sufferers. To be sure, such a combination produces a normative gain for the defendant and a normative loss for the plaintiff. But because the reason for thinking the defendant to have gained is not the same as the reason for thinking the plaintiff to have lost, the gain and the loss are not normatively correlative"); *see also* ERNEST J. WEINRIB, THE IDEA OF PRIVATE LAW 157 (2012) ("Corrective justice requires not factual but normative loss consisting in wrongful infringement of the plaintiff 's right").

142 *See* David Rosenberg, *Individual Justice and Collectivizing Risk-Based Claims in Mass-Exposure Cases*, 71 N.Y.U. L. REV. 210, 246 n.90 (1996) (noting that risk-averse individuals "would, of course, prefer an averaging rule that conformed to the insurance model as against the standard, all-or-nothing rule that, depending on the fortuitous availability of a preponderance of evidence showing specific causation, awards the individual claimant 100% of the loss or nothing."); *see generally* STEVEN SHAVELL, ECONOMIC ANALYSIS OF ACCIDENT LAW 186–87 (1987) (explaining that as opposed to risk-neutral parties, risk-averse parties "care not only about the expected value of losses, but also about the possible magnitude of losses").

143 *See supra* note 68 and accompanying text.

144 One might argue that corrective justice is only concerned with those patients who file a

a hospital's duty to compensate is closely related to its violation of patients' rights, such that victims receive at least partial compensation when it does cause unreasonable harm.

B. Short-Termism Under SLUH

Short-termism refers to the tendency to give excessive weight to short-term outcomes over long-term outcomes. In the medical malpractice context, short-termism refers to practices that reduce risk in the short term instead of practices that might not affect short-term risk or might even increase it, but that significantly decrease risk in the long term.

The SLUH regime assigns liability according to the harm the hospital creates over some period. A problem arises when investments in care may increase harm during one period but significantly decrease it over the next several periods.

For example, a hospital might consider purchasing a new EHR system. These systems improve information sharing and thus reduce the risk of errors when patients are transferred from one physician to another. However, it takes time for staff to become proficient in these systems, and the number of accidents may increase during that time.

Interestingly, with negative damages (i.e., a subsidy for hospitals that create less than reasonable harm), hospitals will still have an incentive to invest in precautions because they will know that while they might pay more damages in the short run, decreasing harm will translate to lower (or negative) damages in the long run.

However, a significant problem might arise with respect to physicians' training. New doctors learn to treat patients during residency by practicing (under some supervision). As doctors-in-training, residents naturally pose a higher risk of error than experienced physicians. While limiting what residents are allowed to do may reduce that risk in the short run, it hinders their training and thus increases the risk to (other) patients in the long run. The problem is that, unlike acquiring new technology, when a hospital invests in training physicians, the hospital assumes the risk of more errors, but it may not recoup any return on that investment because physicians often change workplaces, especially after residency. Training physicians is a public service, and hospitals should be encouraged to do so.[145]

The specific problem of physician training can be solved under SLUH by

claim, since an important aspect of the right to autonomy is the person's right to decide whether to enforce.

145 *See* Ariel Porat, *Private Production of Public Goods: Liability for Unrequested Benefits*, 108 MICH. L. REV. 189, 190–91 (2009) (reviewing the different legal treatment of negative and positive externalities); Giuseppe Dari-Mattiacci, *Negative Liability*, 38 J. LEGAL STUD. 21, 22–23 (2009) ("In general, positive-externality problems are commonly regarded as a justification for public goods provision, subsidies, or regulation rather than for liability").

adjusting reasonable harm to fit a hospital's specific characteristics. Considering the residency training program when determining the reasonable level of harm will encourage hospitals to train physicians.

C. Other Alternatives

SLUH is not the only regime that can address current medical malpractice law issues. In this section, I will briefly discuss some alternatives.

One potential solution, previously mentioned, is to hold hospitals solely responsible for negligent treatment, rather than individual physicians, through the enterprise liability system. Under the current system, plaintiffs sue the physician for direct liability, while they may also sue the hospital as either directly or vicariously liable for the physician's actions. In some cases, several physicians may be involved in the treatment, further complicating the case. Enterprise liability reduces the administrative costs associated with the current system by eliminating the additional costs that additional defendants bring.

However, the plaintiff needs to prove all the elements of negligence under enterprise liability, creating most of the problems associated with the current medical malpractice regime. Enterprise liability still encourages the hospital to adopt defensive practices, discourages information-sharing, and makes it challenging to establish liability in cases where conduct and causation are difficult to prove.

The most obvious alternative to SLUH is a simple rule of strict liability or a no-fault system. Under such a rule, hospitals will pay for every adverse event in their facilities, regardless of fault. Such a system is even less expensive to implement than SLUH because courts are not required to determine the reasonable level of harm. Furthermore, since hospitals will pay for both harm and harm prevention, strict liability creates efficient incentives to invest in care. This regime also eliminates incentives for defensive practices since fault is not dependent on evidence of conduct. Moreover, since patients do not need to litigate complicated issues on conduct and causation, such a system would likely reduce the problem of under-enforcement.

However, strict liability creates other problems that might make it less efficient than the current, negligence-based regime, and clearly less desirable than SLUH. Most importantly, hospitals might deal with strict liability by not treating high-risk patients.[146] SLUH solves this problem by adjusting the reasonable level

146 *See* Andis Robeznieks, *Wary Physicians*, 35 MOD. HEALTHCARE 8 (2005) (finding that defensive clinical practices lead to a high degree of avoidance of treating risky patients); John Adwok & Ellen Hope Kearns, *Defensive Medicine: Effect On Costs, Quality & Access to Healthcare*, 3 J. BIOLOGY, AGRIC. & HEALTHCARE 29, 31 (2013) ("Perhaps the practice of over-investigating patients provides an element of protection for the doctor and a marginal benefit for the patient, but the

of harm to the patient's underlying risk. Furthermore, SLUH can be applied to any adverse event, including errors, complications, and hospital-acquired infections, whereas applying a no-fault regime to these risks is impossible. The cost of paying for all adverse events in a hospital, most of which are beyond the hospital's control, would be astronomical.[147]

In theory, hospitals can be strictly liable only for medical errors (negligent or not) and not for every adverse result of medical care. This type of strict liability creates two problems, like those plaguing the current negligence regime. First, even if they can, hospitals will have no incentive to reduce risks that fall outside the scope of what is considered medical error under the regime. Programs such as ACS NSQIP show that some hospitals fail to use simple measures to reduce the risk of complications, and these failures are not considered medical errors.[148]

Second, to determine whether an adverse event was caused by medical error, courts must assess the medical care provided and determine causation. In many instances, patients do not know if their harm came about due to medical error. Having to prove causation aggravates the problem. Since patients face risk regardless of care, it is difficult for them to prove that medical error rather than inherent risk caused their harm. These evidentiary constraints limit patients' ability to obtain compensation for medical errors under a strict liability regime.[149]

One last alternative worth exploring is a negligence regime coupled with proportional liability. In a proportional liability regime, plaintiffs need not prove causation to obtain compensation. Instead, if they prove they received negligent care, they will receive compensation discounted by the probability that the harm was caused by a physician's negligent conduct.[150]

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overwhelming evidence suggests it increases the cost of care and may increase patient risk.").

147 No-fault liability for medical errors has been debated and deemed unfeasible due to high rates of compensation. *See*, *e.g.*, Kristie Tappan, *Medical-Malpractice Reform: Is Enterprise Liability or No-Fault a Better Reform*, 46 B.C. L. REV. 1095, 1114–15, 1121–24, 1126–27 (2005) (limited resources justify limiting compensation for victims of negligent treatment or restrict the amount of payments made to them; the implementation of such a regime may face political opposition from the plaintiffs' bar, who may see it as a threat to the scope of their work); Frank J. Vandall, *Applying Strict Liability to Professionals: Economic and Legal* Analysis, 59 IND. L. J. 25 (1983) (A no-fault regime that covers a wide range of complications is likely to be too expensive for hospitals.)

148 *See supra* notes 106–110.

149 Some suggest a no-fault system for medical errors could potentially solve the issue of smaller claims that are currently never compensated due to the high administrative costs of the current liability system. This solution involves having claims decided by a medical board instead of a judge. The board will only have to determine whether a medical error occurred and if it caused the injury, without going through a lengthy legal process. *See* BLACK ET AL., *supra* note 36, at 342–43. However, I am skeptical about this solution as it may still involve substantive costs in determining what exactly happened and whether a doctor's actions, whether negligent or erroneous, caused the injury.

150 In medical malpractice cases, proving causation is inherently difficult since patients require medical treatment because of some inherent risk. Some jurisdictions allow for proportional liability under the *loss of chance* doctrine. *See, e.g.*, Herskovits v. Group Health Coop. of Puget Sound, 664

In some ways, the SLUH regime is similar to proportional liability. Under SLUH, the hospital's liability is determined according to each victim's harm discounted by the probability that his or her harm would have been avoided had the hospital acted reasonably when treating all its patients.[151] However, SLUH has an informational advantage since it does not require the court to assess the conduct and the probability of causation in each case. Instead, SLUH averages the ratio between reasonable and unreasonable harm across all cases. Thus, while proportional liability creates better incentives than the current negligence-based regime,[152] SLUH is less expensive to implement and creates better incentives for hospitals to reduce the risks posed to patients.

D. Political Feasibility

Earlier we have seen that it is possible to meet the informational requirements SLUH poses, meaning that the liability regime is technically feasible.[153] However, changing the liability regime would require amendments to current legislation, and we must consider whether such changes are politically feasible. Theoretically, if healthcare networks or major hospitals find SLUH more favorable than the current liability regime, they may choose to adopt the regime voluntarily through contractual agreements with their patients. These contracts would require patients to give up their right to sue for negligence. Instead, they would automatically be entitled to a portion of the compensation under SLUH if they suffer from an adverse outcome and the hospital surpasses the reasonable harm threshold. However, courts will likely find any clause that prospectively eliminates the hospital's liability for negligence unconscionable and thus unenforceable, exposing the hospital to the risk of liability under both regimes.[154] Even if courts

P.2d 474, 476–77 ("The ultimate question raised here is whether the relationship between the increased risk of harm and Herskovits' death is sufficient to hold Group Health responsible. Is a 36 percent (from 39 percent to 25 percent) reduction in the decedent's chance for survival sufficient evidence of causation . . . We answer in the affirmative."). For further discussion, *see* Ariel Porat, *Misalignments in Tort Law*, 121 YALE L. J. 82, 110–11 (2011).

151 *See supra* Part II.A.

152 *See* Steven Shavell, *Uncertainty over Causation and the Determination of Civil Liability*, 28 J.L. & ECON. 587, 589 (1985) (stating that whenever there is uncertainty over causation, liability in proportion to the probability of causation creates better incentives than any threshold criterion); John Makdisi, *Proportional Liability: A Comprehensive Rule to Apportion Tort Damages Based on Probability*, 67 N.C. L. REV. 1063, 1067–75 (1989) (claiming that proportional liability promotes both efficient incentives and corrective justice principles); Porat, *supra* note 150, at 108–14 (same); Pelled, *supra* note 98, at 173–78 (arguing that uncertainty over causation should be treated the same as uncertainty regarding the level of harm, and allow for proportional liability).

153 *See supra* Part II.C.

154 *See* RESTATEMENT OF THE LAW THIRD, TORTS: MEDICAL MALPRACTICE. TENT. DRAFT 1 § 9 (Am. L. Inst. Tentative Draft No. 1, 2023) ("(1) An agreement that prospectively eliminates or substantially curtails the liability of a medical professional or institution to a patient for breach of a

are convinced that victims of negligence will receive limited compensation under SLUH, they may still refuse to enforce clauses that limit the scope of liability for personal injury and wrongful death because it violates public policy.[155]

It is unlikely that SLUH can be implemented through courts' decisions without legislative support. Although courts have previously implemented several aggregative mechanisms, such as market-share liability,[156] to address issues with the traditional liability paradigm, these solutions utilize aggregative measures to loosen the factual causation requirement rather than the burden of proving negligence.[157]

Two interest groups might oppose implementing SLUH – the healthcare industry and the plaintiffs' bar. Healthcare providers may fear that implementing SLUH will increase their payments substantially, as today, most victims of negligent treatment receive no compensation. On the other hand, SLUH eliminates the incentives to practice defensive medicine, which supporters of tort reform believe creates a significant financial burden for healthcare providers.[158]

Opposition from plaintiffs' lawyers may arise against SLUH because it

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duty . . . is unenforceable").

155 For example, in Gessa v. Manor Care of Fla., Inc., the Florida Supreme Court refused to enforce a clause limiting punitive damages and noneconomic damages to $250,000. *See* Gessa v. Manor Care of Fla., Inc., 86 So. 3d 484, 493 (Fla. 2011).

156 *See* Sindel v. Abbott Labratories, 26 Cal. 3d 588 (1980) (formulating the rule of market share liability, which allots compensation between multiple manufacturers according to their market share); David A. Fischer, *Products Liability – An Analysis of Market Share Liability*, 34 VAND. L. REV. 1623, 1623–26 (1981) (explaining the importance of market share liability). *But see* Ernest J. Weinrib, *Casual Uncertainty*, 36 OXFORD J. LEGAL STUD. 135 (2016) (criticizing the use of market share liability as violating the principles of corrective justice). Alternative liability doctrine is another aggregative solution to uncertain causation. First implemented in the celebrated case of Summers v. Tice, it states that when multiple defendants create an unreasonable risk to the victim, but it is unclear which defendant caused the victim's injuries, the burden of proof shifts to each defendant to demonstrate that they did not cause the plaintiff's injury. If a defendant fails to prove that their actions did not cause the injury, they will be held jointly and severally liable for the plaintiff. *See* Summers v. Tice, 33 Cal. 2d 80; Roger B. Dworkin, *Easy Cases, Bad Law, and Burdens of Proof*, 25 VAND. L. REV. 1151, 1167–76 (discussing Summers v. Tice); Randy S. Parlee, *Overcoming the Identification Burden in DES Litigation: The Market Share Liability Theory*, 65 MARQ. L. REV. 609, 622–27 (1982) (explaining the importance of Summers v. Tice).

157 See PORAT & STEIN, *supra* note 20, at 59–67 (suggesting joint tortfeasor liability as a solution to uncertainty when several potential tortfeasors might have caused the injury). There is a theoretical justification for distinguishing between factual causation and negligent conduct. While causation may be uncertain for all parties, including potential injurers, the conduct – as an element of liability – is known to the defendants. This difference in the state of information alters the way aggregative and probabilistic solutions to uncertainty affect injurers' incentives. See Pelled, *supra* note 98, at 171–73 (explaining that the difference in the state of information of the parties affects the way in which different aggregative solutions affect the incentives of the parties).

158 Sandro Vento, Francesca Cainelli & Alfredo Vallone, *Defensive Medicine: It is Time to Slow Down an Epidemic*, 6(11) WORLD J. OF CLIN. CASES 406, 407 (2018) (defensive medicine leads to an increase in healthcare costs).

consolidates claims during the initial stage of determining whether the hospital exceeded the reasonable harm standard, which means that only a few attorneys are representing the group of patients who suffered adverse outcomes at the hospital, leaving most lawyers that specialize in medical malpractice unemployed. However, if SLUH is implemented alongside insurance covering reasonable harm, plaintiffs' lawyers should expect many more claims. Each patient will have a shorter procedure, possibly in front of a medical review panel, to determine the extent of their harm. Most of these claimants are not recovering damages today and, therefore, do not pay attorney fees.

SLUH may find support from two other interest groups – physicians and patients. Physicians may prefer a system that doesn't scrutinize their actions individually and doesn't require a lengthy trial.[159] SLUH reduces the reputational costs of the current liability regime.[160]

If patient groups are aware of the significant costs and limitations of the current medical malpractice system, they may also support SLUH. By improving the incentive to offer reasonable care while reducing the incentive to practice defensive medicine, SLUH should help to reduce the costs of care and improve patient safety.

If implementing SLUH nationwide is politically unfeasible, it can still be implemented gradually. Some states can decide to enact SLUH, similar to other state-specific tort reforms. Furthermore, states can initially apply SLUH to volunteering hospitals and limit the liability regime to the units in the hospital that already report about adverse events to an existing registry. Volunteering units would only bear liability for excessive harm, and would not face negligence claims in court. If SLUH operates as anticipated, participating units will owe very little liability and pay lower insurance premiums. If the physicians' claims about defensive medicine are valid, we should also see a substantial drop in medical costs. A successful experiment will likely induce other hospitals to join.[161]

159 Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 926–28 (1993) (one advantage of no-fault medical liability regime is that it can lead to shorter procedures and cost savings).

160 From a social perspective the information-production of a negligence regime may be viewed as an advantage, but from the physicians' perspective the regime mainly creates costs. *See* Assaf Jacob & Roy Shapira, *An Information-Production Theory of Liability Rules*, 89 U. CHI. L. REV. 1113, 1127 (2022) (negligence regime is better at providing patients with information about their physicians than strict liability).

161 For a discussion about the advantages of experimenting with the administration of legal rules, *see* Colleen v. Chien, *Rigorous Policy Pilots: Experimentation in the Administration of the Law*, 104 IOWA L. REV. 2313 (2018)

IV. APPLYING SLUH TO OTHER AREAS OF TORT LAW

Thus far, we have explored the advantages of SLUH as an alternative to medical malpractice law. This regime, however, can apply to other areas of tort law.

In general, the SLUH regime should be considered whenever (i) due to risks inherent in the injurer's business, it frequently causes harm; and (ii) it is difficult and expensive to set the standard of care, observe the conduct, and prove causation in each incident.

One type of case that meets these criteria is mass exposure to pollution. Environmental torts pose a significant causation problem. Even if a court can determine that a tortfeasor increased the risk to the people exposed, it is impossible to determine whose illness was caused by the exposure. If the law allows the polluter to create some harm from pollution,[162] it would be even more difficult to decide who developed the disease because of the excessive pollution. SLUH solves this problem by awarding damages according to the excess harm without requiring victims to prove causation.

Product liability might be another prominent example. Liability for design defects presents many of the same difficulties as liability for negligence.[163] Plaintiffs must prove that the design is defective and that the defective product in fact caused their accident.[164] When the use of a particular product might reasonably result in accidental harm, it is easier for a court to determine whether the harm crossed a reasonable harm threshold and make the manufacturer pay damages for the difference between reasonable harm and actual harm than it is to determine if an alternative, safer design is reasonable.

This is especially true for smart AI devices and autonomous vehicles (AVs). The design of these devices raises challenging questions regarding tort liability.

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162 *See* Polinsky & Shavell, *supra* note 51, at 888 (discussing different general reasons tortfeasors sometimes escape liability for harms for which they should be liable).

163 *See, e.g.*, Prentis v. Yale Mfg. Co., 365 N.W.2d 176, 184 (Mich. 1984) ("in a design defect case, the issue is whether the manufacturer properly weighed the alternatives and evaluated the trade-offs and thereby developed a reasonably safe product . . . [t]he risk-utility balancing test is merely a detailed version of Judge Learned Hand's negligence calculus."); Castro v. QVC Network, 139 F.3d 114, 116 n.3 (2d Cir. 1998) (holding that the risk-utility calculus in product liability cases "is in many ways similar to the Learned Hand negligence test"); Liriano v. Hobart Corp., 132 F.3d 124, 131 n.12 (2d Cir. 1998) (a design defect is determined by a cost-benefit analysis to gauge the benefits of a product in relation to its dangers, similar to the Learned Hand cost-benefit analysis undertaken to determine whether negligence exists).

164 *See, e.g.*, Blair v. Eagle-Picher Indus., Inc., 962 F.2d 1492, 1495 (10th Cir. 1992) ("[i]n order for a plaintiff in Oklahoma to prevail . . . the plaintiff must first prove that the defendant's product actually caused the injury"); Cole v. Janssen Pharm., Inc., 759 F. App'x 518, 519 (7th Cir. 2019) (in product liability cases, a plaintiff has the burden of proving that a defective product is a legal cause of an injury).

Automobile accidents (including nonlethal accidents) are very common.[165] While AVs should be safer than cars with human drivers (because robots are not prone to lapses in attention and other human failings), it is difficult to design a system that can determine when such a device malfunctions or is defective in the sense that another design would have prevented a particular accident. There are two main issues with finding a smart device defective. First, most devices use learning algorithms that render their decision-making process a "black box."[166] The device learns patterns from information not easily translated to considerations humans can readily follow.[167] For example, if an AV swerves, it may be because of a malfunction, or swerving is the best way to reduce harm from a collision. It is unlikely that future inquiry could easily distinguish between the two options.

Second, looking at the actions of a smart device or other AI-driven device in a particular instance challenges how we would usually define a design defect.[168] AI-based systems make decisions that, until recently, were reserved for human actors, but they follow a different decision-making process. The only practical way to determine whether their design is reasonably safe is to examine their accident rate rather than a decision in a particular instance. Again, think of road accidents involving AVs. Assume that one manufacturer designed a system that reduces the risk of road accidents by 50% relative to human drivers, but it does so by avoiding all accidents that human drivers would not have avoided and creating a new risk of road accidents that reasonable human drivers would always avoid. By focusing only on AVs' accidents, courts might determine that the design is defective since even the alternative of human drivers is safer. Only by comparing the total harm these vehicles cause over time to a level of harm determined to be reasonable is it possible to determine whether the design is reasonably safe compared to the alternative (be it a reasonable human driver or a differently designed other AV).

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165 *See supra* note 2.

166 Alice Guerra, et al., *Liability for Robots I: Legal Challenges*, 18 J. INSTITUTIONAL ECON. 331 (2022) (describing the challenges of attributing fault to an AI device).

167 Suhrid A. Wadekar, *Autonomous Vehicles: As Machines Learn to Drive, What Must We Learn?*, 27 B.U. J. SCI. & TECH. L. 345, 361 (2021) (noting that "even if functionality testing shows that the AV Software would behave as specified, that in itself would generally not provide adequate assurance about the safety of the AV"); Rick Salay & Krzysztof Czarnecki, *Using Machine Learning Safely in Automotive Software: An Assessment and Adaption of Software Process Requirements in ISO 26262*, ARXIV ABS/1808.01614, 7 (2018) (explaining that autonomous driving requires perception of the environment, and this functionality may not be completely specifiable. Since a vehicle must move around in a human world, advanced functionality must involve perception of human categories, such as pedestrians. There is evidence that such categories can only partially be specified using necessary and sufficient conditions).

168 For the restatement's definition of defect in design, *see* RESTATEMENT (THIRD) OF TORTS: PROD. LIAB. § 2 (1998) ("[a product] is defective in design when the foreseeable risks of harm posed by the product could have been reduced or avoided by the adoption of a reasonable alternative design by the seller or other distributor, or a predecessor in the commercial chain of distribution, and the omission of the alternative design renders the product not reasonably safe").

CONCLUSION

Tort liability is a peculiar way to regulate behavior. It aims to reduce accidental harm but does not try to observe the overall harm tortfeasors create over time, even when such information is readily available. Instead, the tort system imposes liability based solely on conduct. For the paradigmatic injurer and victim, there are no practical alternatives. When an injurer is involved in a few accidents in their lifetime, it is impossible to draw any meaningful statistical inferences from such accidents. For example, most car drivers will be involved in only a few accidents, if that, over their driving life. Similarly, most physicians might make a medical error, but very few are involved in several serious incidents over a short period. The only liability regimes available when dealing with small-scale injurers are, therefore, based on conduct or strict liability.

The same is not true for large organizations involved in many incidents, for which it makes little sense to examine the level of care in every instance. This article, therefore, analyzed the use of the aggregative liability regime and examined how applying it to medical facilities can promote patient safety and reduce the cost of medical care.

As mentioned above, the SLUH regime is designed for large-scale injurers. In the medical context, the regime applies to hospitals, not private practices.[169] It nonetheless significantly changes the medical malpractice system. Hospitals employ around 40% of the doctors operating in the United States and more than half of the physicians in most EU member states.[170] Furthermore, many of the high-risk procedures, which are the kinds of procedures that would benefit most from a functioning tort system, are done in hospitals.

The current liability system fails most patients. It offers little in terms of compensation while distorting treatment decisions. Patients should welcome the shift to the SLUH regime. Doctors should welcome it as well. Many complain about the fear of liability and the incentive it creates to overprescribe, overtest, and

169 Some injuries cannot be solely directed at the hospital. Patients arrive at the hospital after receiving initial treatment at a private clinic, and patients may have suffered an injury due to the combined negligence of the private physician and the hospital staff. A following suit may be directed at both a private practitioner and a hospital. In these types of situations, where SLUH has to be implemented alongside a negligence inquiry against third parties, the plaintiff would recover damages from the hospital for a portion of the harm, according to SLUH, and could sue the private practitioner for the share of the harm not covered by the hospital.

170 *See* BUREAU OF LABOR STATISTICS, U.S. DEPARTMENT OF LABOR, *Occupational Outlook Handbook: Physicians and Surgeons* (last modified Sept. 6, 2023), https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm; WHO Reginal Office for Europe, *% of Physicians Working in Hospitals*, EUROPEAN HEALTHCARE FOR ALL DATABASE (last updated Oct. 4, 2023), https://gateway.euro.who.int/en/indicators/hfa_506-5270-of-physicians-working-in-hospitals.

overtreat.[171] SLUH should make these phenomena a thing of the past.

171 *See, e.g.*, Summerton, *supra* note 52.