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SHOULD HEALTH SERVICE PROVIDERS BE STRICTLY LIABLE FOR PRODUCT-RELATED INJURIES? A LEGAL AND ECONOMIC ANALYSIS

by

David Crump* and Larry A. Maxwell**

URING the course of a hospital stay, a patient encounters a vast array of products. These products may be used in conjunction with diagnostic tests, surgical procedures, continuing medical treatment, or routine boarding needs. A survey of these products would include highly specialized apparatus such as computer-assisted tomography (CAT) scanners, X-ray mammographers, and hemolytic dialysis units, as well as simpler devices such as wheelchairs, beds, and gowns. Consumable goods would range from exotic chemotherapy drugs, butterfly valves, and gut sutures to more common items such as aspirin, bandages, and meals.

May a health care provider be held liable without fault when one of these products fails and is associated with a medical accident that causes injury to a patient? Plaintiffs' lawyers in medical malpractice cases have campaigned vigorously for such a result. The traditional and virtually unanimous holding of the courts has been that physicians or hospitals are not strictly liable for the effects of products used incidentally in the provision of their services, although manufacturers may be.1 These courts have reasoned that medical professionals are service providers, not sellers of products. But two recent decisions of intermediate appellate courts have

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The author is Executive Vice President of Gulf & Great Plains Legal Foundation of America and represented the Foundation’s predecessor in the filing of amicus curiae briefs supporting the defendant hospitals in both of the major cases here analyzed. This Article has been prepared as part of the activities of the Foundation. This Article also borrows from the analysis contained in a similar brief by Dan M. Peterson of the firm of Fulbright & Jaworski, filed on behalf of a regional consortium of hospitals. Mr. Peterson’s assistance is acknowledged with thanks.

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held that hospitals are indeed sellers of the products they incidentally use and may be held liable without fault for health care accidents under theories of implied warranty of fitness and strict tort liability. These decisions, rendered by Texas courts of civil appeals in Providence Hospital v. Truly\(^2\) and Thomas v. St. Joseph Hospital,\(^3\) are of national significance.\(^4\) They represent a fundamental departure from well-established previous holdings in jurisdictions throughout the country.\(^5\)

This Article summarizes the factual settings and holdings of Truly and Thomas. It next discusses the body of law governing the application of implied warranty and strict liability to health care providers prior to these two decisions. Thereafter, it compares the reasoning in Truly and Thomas with economic policy rationales for strict liability. The potential for implementing these economic purposes in view of Truly and Thomas and the possible consequences for the medical profession and the public are the focus of this latter section of the Article. A final section summarizes the authors' conclusions.

I. The Truly and Thomas Decisions

In Providence Hospital v. Truly the jury found that a drug called Mixochol, used in an operation performed at defendant hospital upon plaintiff's eye, was unfit and had caused personal injuries to her.\(^6\) However, the jury absolved defendant hospital of fault, holding that it was innocent of any negligence.\(^7\) The unfitness finding was based upon evidence from which the jury apparently concluded that the drug, although initially defect-free, became adulterated during the procedure.\(^8\) The drug was administered entirely in the course of medical services rendered to plaintiff. When plaintiff was discharged, the defendant hospital presented her with a bill containing an item construed by the appellate court as a recovery of the hospital's expense for the cost of the drug.\(^9\) The jury fixed the amount

\(^2\) 611 S.W.2d 127 (Tex. Civ. App.—Waco 1980, writ dism'd).

\(^3\) 618 S.W.2d 791 (Tex. Civ. App.—Houston [1st Dist.] 1981, writ ref'd n.r.e.).

\(^4\) An idea of their significance can be grasped by comparing the decisions to the reaction when strict liability for blood transfusions was imposed by a maverick Illinois decision. One commentator describes that reaction as one of shock throughout the medical world and states that it "opened the floodgates, but not to litigation." In fact, the result was nationwide statutory repeal. See infra note 46 and authorities cited therein. The Truly and Thomas decisions are of greater potential impact than the Illinois blood transfusion decision, since they apply to a broader range of products. Truly is potentially applicable in every state that has adopted the UCC and would create strict liability for every incidentally used product except those, such as blood, that are the subjects of express statutory exemption. 611 S.W.2d at 133. Thomas would create strict liability for every product not "essential" to the health service transaction, a test so ambiguous that its scope is difficult to assess. 618 S.W.2d at 796.

\(^5\) See infra notes 41 & 42.

\(^6\) 611 S.W.2d at 130.

\(^7\) Id. Although the defendant hospital had brought actions for contribution and indemnity against the manufacturer and distributor of the drug and vial, who had settled with plaintiff for $35,000 prior to commencement of trial, the trial court rendered a take nothing judgment for the defendant against these parties. Id.

\(^8\) Id.

\(^9\) Id. at 131. The appellate court's construction was in response to the hospital's argu-
of plaintiff's damage at $15,000.10

The court of civil appeals held that the administration of the drug was a sale of a product and that the jury's unfitness finding caused the drug to breach an implied warranty11 under the Uniform Commercial Code12 made by the defendant hospital to the plaintiff. The treble damages and attorney's fees provisions of the state's Deceptive Trade Practices—Consumer Protection Act were therefore applicable to the case.13 Under the peculiarities of Texas consumer legislation, this holding meant that defendant had to pay plaintiff $30,000 more than her damages, plus attorney's fees. Thus, without fault, defendant became liable for more than three times the amount it would have had to pay had it actually been convicted of negligence. The hospital applied to the state supreme court for a writ of error, but that court determined the application to be untimely, concluded that it was deprived of jurisdiction, and left the intermediate appellate decision standing.

In the second case, Thomas v. St. Joseph Hospital,14 plaintiff's deceased husband violated his physician's instructions and smoked while in an area of defendant hospital containing oxygen equipment. As a result, the robe the decedent was wearing, which the hospital had furnished, was consumed by fire, and the decedent subsequently died of his burns. The jury absolved defendant hospital of fault in the incident, held that the hospital was not negligent, and at the same time concluded that the decedent's negligence was the proximate cause of his death. The trial court rendered judgment for the defendant.15

Plaintiff complained on appeal of the trial court's failure to submit special interrogatories concerning the asserted strict tort liability of defendant hospital. Plaintiff's theory was that the hospital, by supplying a robe that was not treated with chemicals to make it flame-resistant, had sold the decedent a defective product. The trial judge's refusal to submit the requested issues was apparently based upon his conclusion that established authority precluded this theory of liability.

10. Id. at 130.
11. Id. at 131.
13. Id. §§ 17.41-63 (Vernon Supp. 1982). The Texas Deceptive Trade Practice Act specifies four categories that are within the purview of deceptive trade practices; breach of an implied warranty is one of these areas. Id. § 17.50(a)(2). (The title of the statute is a misnomer, since the practice need not be deceptive to create liability.) At the time of the incident in question in Truly, the Texas act provided for automatic treble damages in most cases. It has since been amended to remove this treble liability in most, but not all, cases. Id. § 17.50(b)(1).
14. 618 S.W.2d 791 (Tex. Civ. App.—Houston [1st Dist.] 1981, writ ref'd n.r.e.).
15. Id. at 793. The plaintiff also brought suit against a supplier of gowns for the hospital, but was unable to establish that the robe company had supplied the particular robe in question since the hospital obtained robes from several suppliers.
The court of appeals reversed. It acknowledged the general rule that the supplying of a product incident to the performance of health care services is not a "sale" by a "seller in the business of selling" products for tort law purposes. Rather, the court recognized that the use of such a product, when related to the hospital's essential professional relationship with the patient, is a part of the rendition of health care services and is to be tested by negligence law, not strict liability. The court concluded, however, that the decision not to treat a hospital robe with chemicals was "unrelated" to any health care function. Hence, the court said that the furnishing of the robe could be considered a sale, and it remanded for a new trial on the plaintiff's strict liability claims.

Ironically, as in Truly, this decision left the hospital in a potentially worse position than if it had been at fault. Had it been convicted of negligence, it could have defeated or offset liability by the decedent's negligence in causing his own death. The appellate decision meant that the hospital was faced with defending against liability to which the decedent's negligence furnished no defense and as to which its own innocence from fault was irrelevant. The hospital applied to the state supreme court for a writ of error, but that court refused the application and left the intermediate appellate decision standing.

II. THE "ESSENCE OF THE TRANSACTION" TEST: A MAJORITY RULE CONFLICTING WITH TRULY AND THOMAS

In the past, when courts have been presented with the question whether warranty or strict tort liability applies to cases involving intermixed products and services, they have uniformly looked to the "predominant purpose" or "essence of the transaction" in determining whether the sale or the service aspect was controlling. Courts using this concept have held that contracts including both services and products are not divisible. This indivisibility precludes the interpretation that a contract made primarily for service can give rise to a claim based upon a sale of goods, even when products are incidentally provided in the course of the service. Thus the health care provider's claim that it does not engage in sales as a merchant or promote products that enter the stream of commerce is not an aberration confined to medical practitioners, but a well-established general principle of law, from which Thomas and Truly signal a significant departure.

A. Development of the Essence Test for Mixed Sales-Service Transactions

This section traces the sales-service hybrid through its treatment in general nonmedical situations, in early blood bank cases, and finally, in non-

16. Id.
17. Id. at 796.
18. Id. at 796-99.
19. Id. at 797.
20. Id. at 796-97.
blood bank medical decisions. These cases have entertained a variety of questions ranging from the proper statute of limitations to the proper theory of suit or the elements of damages, in industries including printing, publishing, feed-lot management, and hospital care. The results display a high degree of consistency.

**Mixed Sales-Service Transactions Outside the Medical Context.** The sales-service hybrid was examined in a nonmedical situation more than one hundred years ago, in 1856, in the leading English case of *Clay v. Yates.*

The case, which concerned the printing and binding of a book, necessarily involved both labor and the supplying or incidental sale of binding cloth and paper to be incorporated in the finished product. The court defined the issue in *Clay v. Yates* in the following manner: "It seems to me that the true criterion is, whether work is the essence of the contract, or whether it is the materials supplied." This early statement that mixed transactions were to be viewed in their "essence" has been frequently cited in both English and American decisions. Contemporary recognition of the rule was set forth by the Eighth Circuit in *Bonebrake v. Cox* in the following frequently cited formula: "The test for inclusion or exclusion is not whether [goods and services] are mixed, but . . . whether their predominant factor, their thrust, their purpose . . . is the rendition of service, with goods incidentally involved. . . or is a transaction of sale, with labor incidentally involved." This statement was most recently approved in 1978 by the same court system that decided *Thomas* and *Truly.* The decision in *R.C. Freeman v. Shannon Construction, Inc.* cited *Bonebrake* in holding that a subcontractor’s agreement to supply labor and materials was to be viewed in its essence, as an agreement for services. Similarly, the time-tested rule that the predominant purpose of the contract controls the entire transaction enjoys modern acceptance in virtually all jurisdictions.

The reasons underlying the rule are seldom expressed in the decisions,
but they are based on sound policy. The sale of a product is a discrete, isolated event, and the product can sensibly be subjected to expectations of uniformity. Therefore, miscarriages in its production can be fairly attributed to its source even in the absence of fault. A service, on the other hand, is an event with a time duration. It requires not uniformity, but adjustment to surrounding circumstances. Fault-free accidents in the provision of services are not as clearly attributable fairly to the service provider. The inquiry more appropriately focuses upon the quality (reasonableness) of the service. This focus entails the rhetoric of negligence, not strict liability. If it were possible, however, to treat service transactions as sales because products were incidentally involved, most such transactions would be converted into occasions for strict liability. The service provider would then become an insurer, despite the inappropriateness of that role, because service providers almost always use, lend, or incidentally furnish products in the provision of the service. Alternatively, the result might be irrational adjudication, in which the chance degree of proximity of damage to an identifiable product would determine whether a fault-free service provider was liable.

Thus, a simple dividing line between sales and services is needed, a dividing line that can be readily understood and readily, even though not unerringly, applied. The essence or predominant purpose test fits this need as well as can be expected of legal line-drawing. Liability is relatively predictable under it, and service providers can rely upon it. The service purchaser is able to receive individualized treatment under this test—a benefit that would be less likely if providers were induced by insurers to make their services uniform to avoid fluctuations of risk.

The Mixed Sales-Service Hybrid in the Medical Context. The first influential consideration of the sales-service hybrid in the medical context was in 1954, in a blood transfusion case. The court in Perlmutter v. Beth David Hospital stated the rule that is now generally followed: "Concepts of purchase and sale cannot separately be attached to the healing materials—such as medicines, drugs or, indeed, blood . . . ." This interpretation follows the rule applied in nonmedical situations that a contract for services cannot be divided into a sale of goods and a sale of services. The court relied expressly on the essence test, holding that since the transaction was not a sale, the hospital was not liable without fault under a warranty theory for the infusion of infected blood into the patient. Virtually all jurisdictions considering the problem have adhered to this approach to blood transfusions. For example, the recent case of Foster v. Memorial Hospital
Association followed Perlmutter and adopted its reasoning. The court in Foster declined to categorize a blood transfusion as a sale. In rejecting hospital liability, the court concluded:

There is a reasonable difference between a merchant on the one hand who is engaged in the active promotion and sale of his product such as coca cola bottles, automobile axles, or standardized drugs and a doctor, dentist or lawyer on the other hand who supplies medicine, blood, tooth fillings, or legal briefs in the course of his professional relationship with a patient or client.

The holdings in Perlmutter and Foster that the provision of blood was a service, not a sale, were followed in Texas in Goelz v. J.K. & Susie L. Wadley Research Institute & Blood Bank. Goelz has been cited by one Texas court as supporting the rule that health care providers do not engage in sales when furnishing goods incident to services. The Truly and Thomas decisions are aberrations in this precedential context.

Significantly, early cases such as Perlmutter concerned blood transfusions. Blood presents special difficulties since it is much in demand and detection or elimination of certain risks is impossible. Therefore, even after the early blood cases the question whether a health care provider could be considered a seller of other medical products arguably remained open. The same principle has emerged from medical cases not involving blood, however. For example, in declining to apply strict liability for the use of a defective surgical needle, the court in Silverhart v. Mount Zion Hospital reasoned that the definition of a seller, under either implied warranty or


33. 219 S.E.2d 916 (W. Va. 1975).
34. Id. at 920.
35. Id. (footnote omitted).
36. 350 S.W.2d 573 (Tex. Civ. App.—Dallas 1961, writ ref’d n.r.e.).
38. The Truly opinion declined to follow Perlmutter and cited as authority Cunningham v. MacNeal Memorial Hosp., 47 Ill. 2d 43, 266 N.E.2d 897 (1970), although the Cunningham holding was overruled by statute and has enjoyed little acceptance. See infra note 46.
strict liability, suggests an entity that actively promotes a product or is usually involved in the business of selling. As the court observed,

A hospital is not ordinarily engaged in the business of selling any of the products or equipment it uses in providing such services. The essence of the relationship between a hospital and its patients does not relate essentially to any product or piece of equipment it uses but to the professional services it provides.\(^{40}\)

*Silverhart* represents a consistent application of the essence of the transaction test.\(^{41}\)

Thus the essence or predominant purpose test appeared to be settled law in many jurisdictions\(^{42}\) until the decisions in *Truly* and *Thomas*. An analysis of the opinions in these two decisions indicates a departure from generally accepted views by the *Truly* court\(^{43}\) and a novel interpretation of the "essence of the transaction" test by the *Thomas* court.

**B. The Court's Analysis: Rejection of the Essence Test**

In *Providence Hospital v. Truly*\(^ {44}\) the court of appeals erroneously treated the service-or-sale issue as one of first impression.\(^ {45}\) It discussed the reasoning of cases involving nonstatutory claims, such as those based upon strict liability in tort or implied warranty under common law, but refused to apply those principles, including the essence test, to the case before it.\(^ {46}\) The court apparently considered the Texas Deceptive Trade
Practices—Consumer Protection Act, which incorporates the sale and warranty definitions of the UCC, as different in scope. The court did not cite, and was evidently unaware of, the body of authority applying to the UCC the same essence test that is generally used to differentiate sales from services in common law and tort claims.

The Truly court based its conclusion in part upon the absence of any express statutory exclusion of medical services from coverage as sales. In the wake of early blood bank litigation, the state legislature had passed an express statutory exemption of transfused blood from treatment as a sale.

by the courts in Vergott and Shivers the court in Truly decided that the essence test was not a firmly accepted proposition. The Truly court characterized the leading case in support of the essence test, Perlmutter v. Beth David Hosp., 308 N.Y. 100, 123 N.E.2d 792 (Ct. App. 1954), as one that "has been followed, questioned, criticized, and rejected." 611 S.W.2d at 132 n.2. While literally true, this statement fails to reflect the overwhelming weight of authority following Perlmutter or the short life of the major case rejecting it. The Truly court looked to the authority of Cunningham v. MacNeal Memorial Hosp., 47 Ill. 2d 43, 266 N.E.2d 897 (1970), the leading case rejecting Perlmutter, as support for its position. 611 S.W.2d at 132 n.2. The reaction to this decision has been succinctly described by a distinguished commentator on drug products liability law.

In a leading 1970 case, the medical and hospital world was shocked when strict liability for transfusion hepatitis was applied to a hospital [citing Cunningham]. Here the Illinois Supreme Court ignored precedents from other jurisdictions and applied strict tort liability to blood transfusions. The court held that the hospital was in the business of selling blood products incidental to its other duties, but nevertheless, engaging in a sale rather than a service. The court noted that whole blood was a product even though it had not undergone processing.

The Cunningham decision opened the floodgates, but not to litigation. As a result of this decision, the legislators of every state were bombarded with a lobbying effort to reverse or prevent the application of Cunningham. As a result, most states now have statutes which characterize the transfusion of blood as a service rather than a sale for the purposes of applying strict liability in tort.


47. Tex. Bus. & Com. Code Ann. § 17.50(a)(2) (Vernon Supp. 1982). The Truly court supported its conclusion that a sale had been made by observing that the hospital had billed the patient for an item construed by the court as recovery for drugs provided during surgery. 611 S.W.2d at 131. This reasoning seems particularly suspect, since it would make liability depend upon the form of invoice sent the patient after the injury.


- No physician, surgeon, hospital, blood bank . . . or other person or entity who donates, obtains, prepares . . . transfuses or otherwise transfers, or who assists or participates in obtaining, preparing . . . transfusing . . . blood . . . from one or more human beings . . . to another human being, shall be liable as the result of any such activity, save and except that each such person or entity shall remain liable for his or its own negligence.

Id. § 2. Policy reasons for limiting liability were stated by the legislature:

The availability of scientific knowledge, skills and materials for the . . . transfusion . . . of human . . . blood . . . is important to the health and welfare of the people of this State. The imposition of legal liability without fault upon the persons and organizations engaged in such scientific procedures inhibits the exercise of sound medical judgment and restricts the availability of important scientific knowledge, skills and materials. It is therefore the public policy of this State to promote the health and welfare of the people by limiting the
The narrowness of this exemption proved persuasive to the court. The court concluded that the legislature's failure to exempt expressly other medical transactions constituted an implied legislative recognition that medical transactions other than transfusions, although incidental to services, could constitute sales.\footnote{49} Again, the court failed to deal with the body of applicable authority. It did not recognize that controlling cases excluded blood from consideration even before the statutory exemption, on grounds generally applicable to mixed sales-service transactions.\footnote{50} More importantly, it failed to recognize that controlling case law after the statutory exemption of blood continued to apply the essence test to determine whether a transaction was a sale or service.\footnote{51}

The \textit{Truly} court's finding of a sale, furthermore, required considerable stretching of commercial concepts. To be termed a "sale" under the UCC, a transaction must result in "passing of title" from buyer to seller. Application of UCC provisions also requires an assumption that notions of intent to form a contract, offer, and acceptance characterize incidental uses of products between a health care professional and his patient. A product used by a physician to treat an unconscious patient, whether it be a clamp, a stretcher, an injected fluid, or a strand of suture, fits this framework only with difficulty. Finally, the use of such commercial concepts in a health care setting should be affected by the Code's official commentary, which provides that whether entities should be considered merchants depends upon the standards of skill and judgment that can appropriately be applied to them.\footnote{52} Application of the commentary to a hospital would emphasize as controlling the fact that its skill and judgment rests in the provision of services rather than in sales of goods.

\footnote{Id.}
In fact, as the defendants in both *Truly* and *Thomas* argued, hospitals can more readily be viewed as consumers of products than sellers. They purchase a bewildering array of goods and must depend, as do consumers, upon manufacturers for prevention of latent defects. They do not usually promote the sale of these goods or make individual contractual arrangements with patients for them. While they have responsibility for selection of an appropriate product, and they are liable if they discharge that function unreasonably, selection is an act forming part of the hospital's service and is cognizable under negligence principles.

These concerns aside, the *Truly* court's analysis has at least two potentially troublesome implications: The concept of sale is substantially enlarged, and the variety of parties able to make a sale is similarly increased. The expanded concept of a sale in *Truly* makes virtually every health care accident susceptible to an action under implied warranty since most health care involves the use or provision of some external product or material, and miscarriages or failures generally involve or are affected by products. *Truly* indicates that even when products are initially defect-free and malfunction without fault on the provider's part during the health care service, the health care provider may be subjected to liability; indeed, precisely that result was reached in *Truly*. Thus a sale expands to include not only the isolated event of providing the product, but assurance of the ongoing function of the product in the process of health care. The following examples illustrate possible results under *Truly*'s reasoning:

1. During a mitral valve replacement, the physician installs a valve that is ostensibly free of defect. Owing to unrelated events, the patient dies, and during the course of the procedure, the mitral valve malfunctions and becomes defective or "unfit" (as it naturally would). This malfunction is the immediate cause of death (as it naturally would be). The court's opinion in *Truly* would convert the survivor's claim for such a malfunction into a no-fault action.

2. A surgeon performs sutures with gut that is free of defect. The procedure requires a lengthy healing process (usually, gut is used when it is to be assimilated into the tissues). While the health care process initiated by the surgery is still continuing and the patient remains confined in the hospital, the sutures break for reasons unrelated to any inherent defect in the material (an occurrence that is common in the use of gut). The "product" "sold" to the patient is now "unfit" and the implied "warranty" is "breached." Any damages incurred by

55. The *Truly* court did not consider it significant that the product was initially defect-free. According to the court, the medical service itself caused a non-negligent miscarriage in its handling while the operation was ongoing. Furthermore, it was not until considerably after the patient's release that all of the evidence considered by the court in characterizing the transaction as a sale coalesced, because the court considered the bill to the patient in this respect. 611 S.W.2d at 131.

56. The situation in the *Truly* case involved allegations by the plaintiff, Mrs. Truly, that the stopper on the vial of the drug was loose and became contaminated during contact with sterilized solution. Although the jury absolved the defendant hospital of any negligence, it found that the provision of the contaminated drug, regardless of when or how it became contaminated, was a breach of an implied warranty. Id. at 130.
the patient are, now, the subject of a no-fault claim, and the hospital, (which supplied sound materials and is free of negligence), may even be liable for treble damages under broad consumer protection laws such as the one in question in Truly.

3. An anesthesiologist administers halothane. Unbeknownst to him or to the practitioner of his day, this anesthesia causes severe damage to internal organs of certain genetically disposed persons—not on the first application, but on the second, according to a mechanism that is little understood. The patient, undergoing his second application, dies. The non-negligent anesthesiologist has “sold” a product that is “unfit”—and is strictly liable.

Under these scenarios, Truly means that the medical professional becomes not a mere provider of services, but an insurer of desired results from the entire panoply of health care products.

The second major implication of the Truly opinion is its expansion of the group of sellers to include all providers of service.57 As an example, the Truly decision would mean that an attorney’s filing of a petition or complaint would become a sale of the document to the client. Consider an outlandish, but nevertheless real, possibility: If a lawyer filing a petition or complaint in a medical malpractice case prior to Truly failed to anticipate the Truly result, and therefore failed to allege a strict liability claim, the petition itself would arguably breach a warranty to the patient-client and would give rise to a strict liability claim against the plaintiff’s lawyer under the Truly court’s reasoning. This result follows from the conclusion that the petition could, under the Truly reasoning, be considered a product or good sold to the client. It would be unfit and would thus breach an implied warranty. This conclusion especially follows if the lawyer has, as is customary even in contingent fee cases, charged a suit fee or caused his contractual contingent fee to graduate upon filing of the suit. The conversion of the lawyer’s professional services into the sale of a good, giving rise to a no-fault suit, would naturally follow from the Truly court’s opinion.

These logical implications from the Truly opinion are not the intended results of the legislature’s grant of immunity from implied warranties for blood banks.58 The legislature did not envision the adoption of the UCC or consumer legislation as a method for holding professionals who are free from fault liable for more damages than if they had been convicted of negligence. The Truly decision, however, does more than contravene the legislative intent. Its abandonment of the widely sanctioned essence test makes new law without appropriate analysis of either past decisions or future consequences.

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57. The concern that this implication creates was voiced by the court in Foster v. Memorial Hosp. Ass’n, 219 S.E.2d 916 (W. Va. 1975). See supra text accompanying note 35.
58. See supra note 48 for the legislature’s statement of public policy considerations underlying the grant of immunity to blood providers. The legislature seemingly did not intend for this statute to extend liability, which previously did not exist, in all other circumstances.
C. Thomas v. St. Joseph Hospital: *An Exception Swallows the Rule*

The confusion created by the *Truly* court's failure to follow the essence test also characterized the court of appeals' opinion in *Thomas v. St. Joseph Hospital*.69 The *Thomas* court, however, reached its result by a fundamentally different route. As had the court in *Truly*, the court in *Thomas* began by observing that the case was one of first impression.60 The court recognized the line of cases that had applied the sales-service concept to medical professionals and agreed that the essence of the transaction between a doctor and patient was the rendering of service.61 The court further accepted the view that strict liability was inappropriate when no product was alleged to be defective62 or "when the professional services could not have been rendered without using the product."63 But in making this last distinction, the court retreated from a full application of the essence test and held that: "Where, as here, a hospital apparently supplies a product unrelated to the essential professional relationship, we hold that it cannot be said as a matter of law the hospital did not introduce the harmful product into the stream of commerce."64 Thus the *Thomas* court did not actually view the controlling question as dependent upon the essence of the transaction. It appears to have asked, instead, whether the product was so essential to the service that the service could not be performed without the product—a focus that has never before characterized the sales-service cases. Having pronounced the surgical gown not "essential" to the hospital service in question, the court followed with the questionable conclusion that it was therefore "unrelated" to the service.65 Through this reasoning, Thomas's wearing of the gown became a sale implicating strict liability principles.66

This novel interpretation of the sales-service concept allows some products to be viewed as separate from the basic service transaction while others are not, even though all are used as part of an ongoing health care process. Whether this reasoning was intended is uncertain, because the opinion supports this new rule by citing two cases in which the professional services in question could not have been rendered without the products involved.67 However these inconsistencies are resolved, the *Thomas* court's conclusion that products not essential, or not related, to the profes-

59. 618 S.W.2d 791 (Tex. Civ. App.—Houston [1st Dist.] 1981, writ ref'd n.r.e.).
60. *Id.* at 796.
61. *Id.*
62. *Id.; see* Barbee v. Rogers, 425 S.W.2d 342 (Tex. 1968).
63. 618 S.W.2d at 796.
64. *Id.* at 796-97.
65. *Id.*
66. Texas courts have recognized, as have many jurisdictions, that the exchange of goods for money with passage of title is not always necessary for an entity providing goods to be considered a seller under strict tort liability. Lessors were recognized as liable in Rourke v. Garza, 530 S.W.2d 794 (Tex. 1975), as were bailors in Armstrong Rubber Co. v. Urquidez, 570 S.W.2d 374 (Tex. 1978). *Truly*, however, is based on a statutory claim that includes a statutory definition of sale, and the tort concept is therefore inapplicable.
67. 618 S.W.2d at 797 (citing Providence Hosp. v. *Truly*, 611 S.W.2d 127 (Tex. Civ. App.—Waco 1980, writ dism'd) (contaminated drug provided during course of surgical pro-
sional relationship are a basis for imposition of strict liability upon health care providers poses numerous problems. Future litigation may be complicated by determinations of relationships between doctor, patient, and product. Erosion of the sales-service distinction may result in legal decisions in areas of medical judgment that could significantly affect the administration of health services.

The *Thomas* fact situation is itself an example. The court's conclusion that the surgical gown provided the patient could have been treated with flame retardant chemicals so as to prevent the occurrence ignores self-evident countervailing medical considerations. Chemical treatment may not be medically wise when the fabric is to be used around the clock next to the skin of a patient who spends most of his time in bed and who is especially prone to the contraction of bedsores. Prevention of this skin condition requires, among other treatments, the frequent changing of position of bedridden patients. The Federal Trade Commission required one flame retardant chemical, Tris, to be withdrawn from the market because it proved to be a carcinogen to the skin of those who wore fabrics treated with it. The use of chemically drenched fabrics might particularly be contraindicated for patients with poor circulation, epidermal difficulties, or respiratory problems. Since most hospital patients would fall into these categories, sound medical judgment would not be indifferent to the use of such fabrics, as the *Thomas* court seems to assume it would be. To premise liability on the conclusion that the gown is not essential, or that it is not related to the hospital's provision of medical care, ignores the proper consideration of all these medical questions in the hospital's overall rendition of care. This approach would mandate legal evaluation of a vast array of products used in a medical setting. Also, to the extent this approach had an effect on hospital decisions (as tort rules are intended to do), it would encourage a health care provider to choose a product based on considerations other than medical suitability.

68. 618 S.W.2d at 797-98. The *Thomas* court also noted that a fabric can be made more flame resistant by choice of the raw material from which it is made. *Id.* For example, wool, an animal fabric that is superior to cotton when flame resistance alone is considered, may be used instead of cotton. But again, the substitution of wool for cotton in hospital gowns is probably not a matter of medical indifference, as the court tacitly assumed it is. In fact, no readily available natural or synthetic fibres allow the wearer's skin to transpire (or breathe) as does cotton, which was the material actually used in *Thomas*. Cotton is lightweight, soft, and nonabrasive. It is an ideal fabric for sensitive skin. Furthermore, it cleans and sterilizes with greater ease and more completely than many other fabrics.

69. Actually, flame resistance is only one of many features that may be significant to a physician in the choice of a gown. Access to all parts of the body for treatment or surgery would appear medically necessary. Thus a pants-and-shirt arrangement, as in traditional pajamas, might be medically contraindicated. The fastening mechanisms of a hospital gown should not be sharp, hard, or pointed so as to irritate the skin of a patient confined to bed for great parts of the day; nor should they consist of drawstrings or ties that are either difficult to remove or capable of choking a patient unable to move easily. All these features, as well as the choice of fabric might be considered differently by a provider of health care services than by others. But the *Thomas* court's opinion consigns all such concerns to medical irrelevance, holding that the gown itself is unrelated to the professional service. *Id.* at 796.
Furthermore, the *Thomas* court stated that questions regarding the relationship of the product, in this case a hospital gown, to the professional service can not be decided as a matter of law.\textsuperscript{70} As a result, juries must confront a new standard for assessing the propriety of medical decisions. Difficulties inherent in the use of expert medical testimony in malpractice cases, which produce lengthy and confusing trials, are significant enough. But the usual standard of care in such cases, that of negligence, is at least workable. After *Thomas*, a case incidentally involving a product may be further complicated as medical experts, product purchasing experts, and physicians seek to clarify the nature of the product and its relationship to doctor and patient in an effort to show that the product is or is not essential or that it is or is not related to the health care service. Even if such a basis for imposition or nonimposition of liability were feasible, it seems likely to produce arbitrary results.

Nevertheless, if properly used, the basic proposition underlying the *Thomas* court’s opinion is sound despite its problems. When a hospital ceases to act as a health care provider selling services and embarks upon an extraneous commercial business in which it sells and promotes products, it should be subject to different rules. Thus, if a hospital were to open a used-car lot across the street, it would not be able to claim that it was not liable to injured purchasers of defective vehicles merely because it provided health care services in its unrelated hospital facility. Likewise, if a hospital were to operate a public cafeteria and sell a nonpatient a hamburger containing a foreign ingredient, it would be in the position of any other restauranteur.\textsuperscript{71} However, the *Thomas* court’s strange conclusion that a hospital robe may be in a category with an unrelated used-car lot or public cafeteria honors the “essence of the transaction” rule more in the breach than in the observance. The *Thomas* court asked the question, “When is a hospital robe not a hospital robe?” and, in providing an answer to this extraneous question, created an exception that swallows the rule.

III. ECONOMIC POLICY CONSIDERATIONS UNDERLYING STRICT LIABILITY AND THEIR RELEVANCE IN THE HEALTH CARE CONTEXT

The theories of implied warranty and strict tort liability are based upon several economic policy considerations. This section will examine those considerations and discuss their application to recovery from health care providers. In particular, this section seeks to discern the extent to which the economic goals of strict liability are furthered by application to health

\textsuperscript{70} *Id.* at 796-97.

\textsuperscript{71} Similar hypothetical situations were posited by the courts in *Silverhart* v. Mount Zion Hosp., 20 Cal. App. 3d 1022, 98 Cal. Rptr. 187, 191 n.4 (1971), and *Perlmutter* v. Beth David Hosp., 308 N.Y. 100, 123 N.E.2d 792, 795-96 (Ct. App. 1954). These courts agreed with the analysis given here. In particular, *Silverhart* expressly rejected the possibility that a lawyer could become liable as a seller of goods in such a situation. 20 Cal. App. 3d at 1027, 98 Cal. Rptr. at 190.
service providers and whether potential benefits outweigh costs to the public.

A. Implied Warranty

The generally recognized purposes of warranty law are to protect the buyer's expectation interest, to promote the continued expansion of commercial practices, and to establish appropriate commercial standards of reasonableness and fair dealing. Courts have typically enforced these interests in situations involving economic loss. This concept includes the cost of the warranted goods and any incidental or consequential damages resulting from the provision of substandard goods. In assessing damages for such economic loss, the courts encourage merchants to provide goods of a quality and in a manner reasonably expected by the consumer.

These goals of warranty law have little relevance when applied to the health care provider. The consumer in a health care facility does not complain that medicines were supplied by an off-brand manufacturer or that the sutures used in an operation did not meet his specifications. Rather, his concern is with the overall result of the service. Furthermore, the expectancy interest protected by warranty law assumes a market for goods, regulated by supply and demand, in which quality and price are negotiated. The average consumer-patient does not go to the hospital expecting to bargain with the doctor or pharmacist for an appropriate price for incidentally used products.

Warranty law leaves open the question of compensable losses. Its flexibility is characterized by the UCC's suggestion that leading court cases guide the imposition of consequential damages. The question whether such damages should be awarded for personal injuries caused by a hospi-

73. In the jurisdiction in which Truly and Thomas were decided, for example, the courts have tended to construe economic loss narrowly. See, e.g., Nobility Homes of Texas, Inc. v. Shivers, 557 S.W.2d 77 (Tex. 1977), in which the court held that strict tort liability was not the proper theory for recovery of economic losses, but that the UCC "was drafted specifically to govern commercial losses and obviously provides the proper remedies to cover such losses." Id. at 80. But see Signal Oil & Gas Co. v. Universal Oil Prods., 572 S.W.2d 320, 325 (Tex. 1978) (holding that the consequential damages provision provides for damages to the consumer user or his property). Although the Signal Oil & Gas court extended warranty theory beyond the coverage contemplated by Nobility Homes, it simultaneously created a requirement not generally associated with warranty. It held that personal injuries must be predicated on reasonable use and proximate causation in order to be compensable as consequential damages. Id. at 328. The holding thus resembles tort liability. Indeed, the court so recognized; it said, "Such a reasonable use standard is normally associated with theories of negligence." Id. See also Garcia v. Texas Instruments, Inc., 610 S.W.2d 456 (Tex. 1980) (UCC establishes alternative remedy for personal injuries resulting from breach of implied warranty of merchantability).
74. See, e.g., Lonzrick v. Republic Steel Corp., 1 Ohio App. 2d 374, 205 N.E.2d 92, 93 (1965); see also R. POSNER, ECONOMIC ANALYSIS OF LAW § 3.6-.7 (1st ed. 1973).
75. U.C.C. § 1-106 (1976) comment 3 states: "'Consequential' or 'special' damages and 'penal' damages are not defined in terms in the Code, but are used in the sense given them by the leading cases on the subject."
tal-provided product had not been answered by a Texas court prior to the Truly decision.\textsuperscript{76} That problem was, however, addressed by the court in Foster v. Memorial Hospital Association:\textsuperscript{77}

The hospital has not undertaken to be an insurer in this type of situation and the Court finds that holding the hospital liable today would encourage a gradual expansion of the doctrine of warranty to permit recovery in situations totally outside the intent of the warranty provisions of the Uniform Commercial Code which have historically required negligence.\textsuperscript{78}

A similar response was delivered by the court in Cheshire v. Southampton Hospital Association,\textsuperscript{79} which stated: "[A] warranty theory [is] not available to a patient complaining of an isolated part of his treatment as being a warranted sale."\textsuperscript{80} These leading decisions indicate that personal injury cases arising from products provided by medical professionals are not compensable as consequential damages under warranty law.

Thus courts in other jurisdictions, as well as the Uniform Commercial Code, indicate that economic contract interests and remedies are not relevant to the fact situations that arise when personal injuries are sustained as a result of defective products provided by medical professionals.\textsuperscript{81} If liability without fault is expanded to hold health care providers liable for personal injuries caused by products, it should be based instead on the policy considerations underlying strict tort liability. The economic considerations underlying that doctrine are more clearly directed toward remedying such injuries. Even in this latter area, however, accomplishment of underlying economic purposes may be slight and detriments to the public as patients may be great.

\textsuperscript{76} Courts in the jurisdiction in which Truly and Thomas were decided have commented on the inapplicability of warranty law to the provision of goods related to medical services, but have not rendered a decision directly on the question of consequential damages. In Shivers v. Good Shepherd Hosp., Inc., 427 S.W.2d 104 (Tex. Civ. App.—Tyler 1968, writ ref'd n.r.e.), the court declined to impose negligence on the hospital because of charitable immunity, which was then still viable. It went on to discuss the hospital's liability if charitable immunity had not been protective:

It will . . . be noted that the two cases . . . [Jacob E. Decker & Sons v. Capps and McKisson v. Sales Affiliates, Inc.] apply the rule of strict liability and implied warranty to the manufacturer and distributor of a product. If this is to be the extent of the rule, then the appellee [hospital] will not be liable under the strict liability and implied warranty rule applied in those cases.

\textit{Id.} at 107. A more recent case, Potts v. W.Q. Richards Memorial Hosp., 558 S.W.2d 939 (Tex. Civ. App.—Amarillo 1977, no writ), decided that the hospital could not seek contract damages under the UCC for remaining fees merely because goods had been provided incident to the patient's stay in the hospital. The hospital was attempting to bring the cause of action under the four-year statute of limitations applicable to sales of goods. \textit{Id.} at 946.

\textsuperscript{77} 219 S.E.2d 916 (W. Va. 1975).

\textsuperscript{78} \textit{Id.} at 920.

\textsuperscript{79} 53 Misc. 2d 355, 278 N.Y.S.2d 531 (N.Y. Sup. Ct. 1967); see also La Rossa v. Scientific Design Co., 402 F.2d 937, 942-43 (3d Cir. 1968) ("professional services form a marked contrast to consumer products cases").

\textsuperscript{80} 53 Misc. 2d at 356, 278 N.Y.S.2d at 532.

\textsuperscript{81} See supra note 32 (regarding court decisions); supra note 72 (regarding the UCC).
B. Strict Tort Liability

The fundamental purpose underlying the doctrine of strict tort liability is to further public safety in the use of consumer products. In such a situation an economist would say that injuries are an externality, a cost or benefit external to the market system, causing prices if used alone, to misallocate resources. Even the most firm supporters of the market recognize the appropriateness of government intervention in response to serious externalities when such externalities can be addressed in a cost-effective manner. A pricing remedy, such as requiring compensation for damages, is often preferable to regulation by standards or prohibitions. However, the remedy should not itself distort the allocation of resources more seriously than the externality to which it is directed.

The basic purpose of remedying the externality of injuries without having losses exceed gains is arguably achieved by imposing liability without fault upon entities that have the ability to satisfy three class requirements: adequate compensation of the injured party, distribution of the risk of loss, and deterrence from production of defective products. The appropriateness of applying strict liability to a medical professional thus depends upon the professional’s ability to satisfy these three class requirements.


83. R. DORFMAN, PRICES AND MARKETS 141-43 (1967); P. SAMUELSON, ECONOMICS 159, 465-66 (6th ed. 1964). Externalities are factors that are external to the price system, for which the system does not provide adequate countervailing incentives. A classic example of an externality is air or water pollution. Although a manufacturer may design a system to produce a product efficiently and inexpensively, and consumers may be induced by the price system to purchase this good, consumers might prefer to pay more and reduce pollution. Governmentally imposed requirements for pollution control equipment may thus add to costs in a manner that increases economic efficiency. See R. POSNER, supra note 72, § 13.5.

84. The pricing remedy aspect of tort liability allows the promoter of products, some of which may have caused injury due to defectiveness, to sustain the costs of court judgments, but to continue producing valuable products. It induces him to balance the benefit of the product as produced and the cost of injuries exactly as society values these factors. In this sense, a damage remedy may be more economically efficient than regulations imposed as safety standards. See R. POSNER, supra note 72, ch. 13 (entitled The Choice Between Regulation and the Common Law) for an analysis of the comparison between pricing and standards remedies.

85. Posner, for this reason, avoids use of the term “externality” and labels it misleading. The real issue, for him, is who should be made to bear the cost. The factor controlling that issue, in turn, is the balance of costs and benefits:

If the joint value of railroading and farming would be maximized by the discontinuance of crop production, the substitution of a more fire-resistant crop, or the removal of the crop to some distance from the railroad right-of-way, then placing liability on the railroad [for fire damage due to sparks] would be inappropriate.

Moreover, “if transaction costs are low, the market may operate efficiently despite the presence of externalities.” R. POSNER, supra note 72, at 52. Posner’s analysis is equivalent to that of other economists, such as Samuelson, who do not avoid reference to externalities, but it avoids the misleading implication that legal intervention of any particular kind is required.

86. See Restatement (Second) of Torts § 402A comment c (1965).
Although the decisions in Truly and Thomas were concerned with hospitals, the implications of their holdings extend to entities such as clinics, partnerships, and individual practitioners. These entities may not be able to spread risk effectively and are not necessarily the most appropriate persons upon whom to place the burden of compensation.\(^8\) Furthermore, the reasoning does not depend upon the health service provider’s control over non-negligently created defects, and it therefore may not square with the deterrence rationale.\(^8\) Thus the misallocation of resources brought about by strict liability might amount to a cure that is worse than the disease.

**Compensation to the Injured Party.** Strict liability is premised in part upon the assumption that the injured consumer is less able to absorb the risk of catastrophic loss than the business that provided the injury-causing product.\(^8\) As between a non-negligent individual physician and his patients as a group, this assumption may not be as readily accepted. The courts generally impose liability upon each step in the distributive chain from manufacturer to retailer.\(^9\) Three reasons have been stated for imposing strict liability on intermediaries due to compensation goals.\(^9\) First, because identification of the product manufacturer or distributor may be difficult, the consumer is left with no definite party to name in a suit. A second concern is that the party, once identified, may be a foreign corporation not amenable to jurisdiction. Finally, some links in the distributive chain may be financially unable to satisfy a judgment. In light of these concerns the question remains whether the health service provider is an appropriate link in the distributive chain upon which to impose the needs of compensation.

Considering the extensive recordkeeping required by state and federal

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\(^8\) Strict liability of manufacturers and promoters may also be economically unjustified if the common law regime for its imposition is not congruent with underlying economic purposes. For example, Posner concludes that unless contributory negligence is a defense (in many states it is not), strict liability may create diseconomies. R. POSNER, *supra* note 72, at 139. An economic critique of strict liability law as applied to the manufacturer would be valuable, but is beyond the scope of this Article.


Further, the vast body of malpractice law, presumably an expression of the public policy involved in this area of health care, imposes upon a dentist or physician liability only for negligent performance of his services—negligent deviation from the standards of his profession. In the performance of his professional skill he has control of what he does. As to the instrument he uses, he has no control with respect to a latent defect therein. Why, then, should he be held strictly liable for the instruments he uses, as to which he has no control over latent defects, and liable only for negligence in the performance of his professional services, which he does control?

227 A.2d at 546.

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\(^8\) See infra notes 115-21.


\(^9\) *Id.* at 100 (identification), 218 (jurisdiction); see infra note 102 (financial reserve).
laws,\textsuperscript{92} state dangerous drug acts,\textsuperscript{93} and state or local controlled substances acts,\textsuperscript{94} incidents in which the medical professional will be the only identifiable party in the marketing process should be few. The Joint Commission on Accreditation of Hospitals further demands considerable detail in inventory and accounting procedures covering both consumable and non-consumable goods.\textsuperscript{95} These statutes and regulations require specific identification of a high percentage of goods that are likely to be defective and cause injury. Thus, when a hospital or other health care provider dispenses an injury-producing product, the product can usually be traced to its manufacturer or supplier. Requiring compensation from that entity will, almost without fail, be more appropriate for the effectuation of the economic purposes underlying strict liability.\textsuperscript{96}

Having identified a party or group of parties from whom to seek compensation, an injured consumer must establish jurisdiction over these parties. Application of a long-arm statute\textsuperscript{97} requires that the plaintiff demonstrate that the defendant supplier has the requisite contacts with the state.\textsuperscript{98} This determination is facilitated by the extensive recordkeeping required by legal and accreditation standards.\textsuperscript{99} Even if the entire volume of transactions can not be traced, jurisdiction can be established by inferring regular sales.\textsuperscript{100} A single purposeful transaction related to the injury is likely to be enough.\textsuperscript{101} If stringent jurisdictional requirements of the past would have supported an argument for holding medical professionals liable, today's liberal service of process requirements do not.

The most important concern to the injured party who seeks compensation is finding a source with adequate financial reserve, or a "deep pocket." Resources available to members of the distributive chain range from the abundant for giant drug and chemical companies to the marginal for smaller concerns that provide items such as laundered goods on a local


\textsuperscript{93} Indeed, in \textit{Truly}, plaintiff sued the manufacturers and distributors and settled with them before trial for more than the amount the jury fixed as her damages. See supra notes 6-13 and accompanying text. In \textit{Thomas} plaintiff experienced the rare situation in which her claim failed for inability to identify the manufacturer, because the hospital bought similar gowns from several suppliers and disposed of the burned article after the incident.

\textsuperscript{94} E.g., \textit{TEX. REV. CIV. STAT. ANN.} art. 4476-14, §§ 5-6 (Vernon 1976 & Supp. 1982).

\textsuperscript{95} \textit{ACCREDITATION MANUAL FOR HOSPITALS--Pharmaceutical Services} 137 (1981).

\textsuperscript{96} See infra text accompanying notes 115-21 (regarding distribution of losses); infra notes 122-24 (regarding deterrence).

\textsuperscript{97} \textit{E.g.}, \textit{TEX. REV. CIV. STAT. ANN.} art. 2031b (Vernon 1964 & Supp. 1982).


\textsuperscript{99} See supra notes 92-95.

\textsuperscript{100} See, e.g., Gray v. American Radiator & Standard Sanitary Corp., 22 Ill. 2d 432, 176 N.E.2d 761 (1961) (malfunction of foreign-manufactured valve, bought in Illinois, supported inference that sale of valve was part of larger volume of commercial transactions affecting Illinois, even in absence of proof of individual transactions).

basis. However uncertain the financial picture may be for manufacturers and suppliers, the fact that a high percentage of even nonpublic hospitals operates on a not-for-profit basis is an argument for searching for other financial alternatives. Although circumstances could arise in which the hospital has a deeper pocket than some small manufacturer or supplier, the consequences to health care providers in sustaining such awards could be devastating. Since manufacturers or distributors of medical goods can usually be identified, service of process can be obtained, and sources of financial reserve that are comparable to or greater than most entities in the health care field can generally be located, the additional imposition of liability without fault on the service provider does not advance the compensation purpose as significantly as might appear at first blush.

**Distribution of the Risk of Loss.** The shifting of the risk of loss from the consumer to the manufacturer or promoter so that it may be distributed better is an arguable economic policy objective. Such a shift is advantageous if dangerousness is an externality not reflected in price and if the risk-distribution benefits of such a shift can fairly be said to exceed detriments. The question is whether creating such liability for a health service provider who furnishes a product incidental to the rendering of medical services, in addition to imposing liability upon the manufacturer and distributor, is appropriate. In declining to do so, several courts have cited as authority the rationale of riskspreading stated in the *Restatement (Second) of Torts:*

On whatever theory, the justification for strict liability has been said to be that the seller, by *marketing* his product for use and consumption, has undertaken and assumed a special responsibility toward any member of the consuming public who may be injured by it; that the public has the right to and does expect, in the case of products which it needs and for which it is forced to rely upon the seller, that reputable sellers will stand behind their goods; that public policy demands that the burden of accidental injuries caused by products intended for consumption be placed upon those who market them, and be treated as a *cost of production* against which liability insurance can be ob-

102. [1981] *Health-United States* 183. The report indicates that of a total 6525 hospitals, 3436 are voluntary, nonprofit institutions.
103. *See infra* text accompanying notes 114-21.
104. *See supra* note 83 and accompanying text.

tained; and that the consumer of such products is entitled to the maximum of protection at the hands of someone, and that the proper persons to afford it are those who market the products.\textsuperscript{106}

The emphasis is thus upon "marketing" in the sense of promotion, upon the treatment of the externality as a "cost of production," and upon the availability of indemnity (insurance) against loss. This latter concept presupposes a relatively large number of similar claims. These criteria fit the health service provider's incidental use of products only with difficulty.

The first characteristic stated by the comment implies that the burden of risk-spreading should be placed upon the enterprise producing the product, the manufacturer, or upon the entity marketing the product, the distributor. Many courts have decided that a medical professional can not be regarded as having marketed an incidentally used product in the sense of promoting it.\textsuperscript{107} For example, in applying the essence test to hold a dentist not liable as a matter of law for use of a needle with latent defects, one court stated:\textsuperscript{108} "It is further very clear that strict liability was imposed in our New Jersey cases for the essentially basic reason that those so held liable put the product 'in the stream of trade and promote its purchase by the public.'"\textsuperscript{109} A medical professional does not advertise, merchandise, or make medical products available for discrete sales to the public. Indeed, the interpretation that health care providers do not market the products they supply is so widely accepted\textsuperscript{110} that it has been endorsed by the very court system\textsuperscript{111} that produced \textit{Truly} and \textit{Thomas}.

Furthermore, this marketing analysis includes an element of identification between a product and its promoter. The comment's language that the seller "stand behind his goods" strongly implies this conclusion.\textsuperscript{112} The distinction between active promotion of a product on the open market and mere furnishing of the identical product in connection with medical treatment is evident in the case law. The courts of several jurisdictions have imposed liability upon blood banks selling contaminated blood under a warranty theory; but these same courts have held that hospitals providing such blood as part of a service transaction were not liable under the same theory.\textsuperscript{113} Such an analysis would result in the conclusion that Burlington Mills is a manufacturer of fabrics, and Levi Strauss is a supplier of clothes, but St. Joseph Hospital is not a seller of gowns.

\begin{notes}
\item[106] See supra note 105.
\item[107] RESTATEMENT (SECOND) OF TORTS § 402A comment c (1965) (emphasis added).
\item[108] See authorities cited supra note 105.
\item[110] 227 A.2d at 543 (emphasis in original).
\item[111] See supra note 105.
\item[112] See supra note 105.
\end{notes}
The second characteristic of an entity marketing products susceptible to strict liability is its ability to distribute the risk of losses as part of the cost of production. Hospitals have been subjected to substantially greater liability by the erosion of the doctrines of charitable immunity, the "captain of the ship" rule, the development of liability under administrative and corporate negligence, and a number of other recently created duties.\(^{114}\) If liability without fault is added in a manner inapplicable to other service providers, the cumulative weight of risk-distribution could exceed benefits.\(^{115}\) Furthermore, the risk-distribution feature of the strict liability rationale assumes that such costs can be distributed over a large market. Although they are ultimately passed on, the point at which costs are distributed can make a substantial difference in impact upon the consumer. For example, a million dollar judgment against a manufacturer that produces ten million needles a year would increase consumer costs only ten cents. The same judgment levied against a small rural hospital serving one thousand patients annually would increase the cost to each patient by one thousand dollars.\(^{116}\) But even that difference is not the end of the point; the cost of defense is often greater than the award in medical malpractice cases. Imposition of strict liability on the health service provider would not only spread those costs over a smaller public,\(^{117}\) but would, if all potentially liable defendants were joined, require multiplication of legal costs without increasing awards.\(^{118}\) Assuming that the same multiplier will apply to insurance brokerage, loss management programs, and other expenditures that imposition of liability is likely, indeed is intended, to induce, it


\(^{115}\) The United States Senate noted its concern over rising hospital costs in hearings related to health legislation and antitrust. S. REP. No. 1285, 93d Cong., 2d Sess., reprinted in [1974] U.S. CODE CONG. & AD. NEWS 7842, 7895. The committee stated: "Although recognizing the increase in costs experienced by health care providers attributable to general inflation, the Committee wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services." Id.

\(^{116}\) For similar reasons, the health service provider will be inefficient at purchasing insurance. Cf. P. Samuelson, supra note 83, at 422.

\(^{117}\) The mere spreading of risks, without lower transaction and insurance costs, is not a rational objective in economic terms. See R. Posner, supra note 74, at 93-94 & n.3. But cf. P. Samuelson, supra note 83, at 421-22.

\(^{118}\) Even if the health service provider is indemnified, so that he loses nothing related to the plaintiff's actual damage recovery, the health service provider has, indeed, lost something—the cost of defense of the claim against him and of recovering on the indemnity claim made by him. In many malpractice cases this cost far exceeds the amount paid the plaintiff. Of course, legal costs are a part of a necessary system of recovery to address safety externalities. But if benefits (i.e., the increase in damages paid plaintiffs) are exceeded by detriments (i.e., the increase in, and redundancy of, payments to lawyers), the liability may be bad policy.
becomes apparent that the costs of the remedy may exceed its benefits. These costs represent net losses to the consuming public even if the health service provider recovers contribution or indemnity. In fact, the prosecution and defense of such third-party claims will occasion additional dead-weight losses.

The third feature of the loss-distribution rationale concerns the optimal party to obtain liability insurance for accidental injuries caused by defective products. The manufacturer or distributor who handles a specific line of products can do so efficiently. Insurance policies can be drawn to cover reasonably anticipated areas of liability for a narrow range of products. A health care provider, however, is not in a position to obtain insurance as readily for the wide range of products it uses.\textsuperscript{119} An effort to do so would be particularly inefficient in view of the absence of precedent for products liability in this context.\textsuperscript{120} Claims history is lacking, future developments are relatively unpredictable, and uncertainty would increase premiums. Reasonable reliance on established law would mean that many health service providers would face novel liability for which they had sensibly not purchased insurance, since it would have been wasteful to do so. Furthermore, while the requirement of product insurance seems a sensible requirement for the enterprise marketing the good, an entity providing a service, such as a hospital, already insures itself against defects in service by obtaining the coverage for professional negligence.\textsuperscript{121}

Deterrence. One of the recognized purposes of tort law is to deter individuals or entities from injuring people or acting in other ways that are detrimental to the interests of society. One of the strongest reasons for imposing liability, therefore, is to make such individuals conform their conduct to the standard required by the law. Arguably, this policy supports the imposition of liability upon manufacturers of defective products, since they are in a position to control the uniformity and quality of their products. They are also the only parties likely to be in a position to know whether a product has qualities that make it so inherently unsafe that it should not be marketed.
The deterrence rationale, if applied to health care providers, would imply that looking to them for the detection of latent defects in the broad range of products they use is rational. But the typical hospital, clinic, or individual physician cannot economically undertake universal product testing. These entities are consumers of products; they must rely on manufacturers and distributors to avoid latent manufacturing, design, or warning defects just as the individual consumer does. Apart from the instance in which a reasonably alert doctor or nurse would notice that a vial’s contents are not the usual color or consistency (in which event strict liability is unnecessary because a negligence claim would lie), medical professionals are not themselves qualified and do not employ others to test a drug, needle, or instrument to ascertain its fitness. The court in *Bichler v. Willing* recognized that:

“In today’s world, it is often *only the manufacturer* who can fairly be said to know and to understand when an article is . . . safely made for its intended purpose. Once floated on the market, many articles . . . defy detection of defect. . . . *[T]he manufacturer . . . alone . . . has the practical opportunity . . . to turn out useful . . . but safe products.”

Since this ability is lacking in health service providers, the deterrence rationale loses much of its force.

After one recognizes that medical professionals customarily do not have the facility for detecting product defects, the question that remains is whether such a capability should be initiated. Inducing such a professional to employ the range of technical experts that would be necessary to evaluate each variety of pill, needle, valve, or bandage he administers would not be appropriate. The result would be an increase in the cost of health care disproportionate to any probable improvement. The alternative reaction for a health care provider would be that of a distributor who carries a limited range of products—namely, to discontinue providing sensitive products and require the patient to purchase them from another source. Such a policy would not serve patients well, and it can hardly be considered as representing the intent of the courts or legislatures that have adopted strict liability.

### IV. Conclusion

With rare unanimity the courts have historically refused to impose strict liability upon health service providers for miscarriages of products incidentally used by them. This approach has not been peculiar to the medical

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123. *Id.* at 59 (emphasis and ellipses in original) (quoting *Codling v. Paglia*, 32 N.Y.2d 330, 340-41, 298 N.E.2d 622, 627, 345 N.Y.S.2d 461, 468 (1973)).
124. *See supra* note 115 and accompanying text.
125. Strict liability “prevents the consumer who is a risk preferrer from trading on his taste.” R. *Posner, supra* note 72, at 137. In common-sense terms a patient might desire to be treated by use of a product entailing significant risk because the alternative is less effective treatment, but *Truly* and *Thomas* may prevent this choice.
profession; it is a manifestation of the general rule that while product promoters, including manufacturers, wholesalers, or retailers, may be liable without fault for injuries caused by product defects, service providers who incidentally use products may not. The courts have fashioned the "essence of the transaction" test to ensure simple characterization of an entire relationship as either a sale or a service—but not both. The purpose of this rule is to avoid inappropriate imposition of strict liability upon service providers who inevitably use products to some degree.

The promoter of a product sold at a discrete instant may justly be subjected to expectations of uniformity. Arguments for strict liability are therefore stronger in the context of such a sale. Services, however, require adaptation to varying circumstances and are rendered over a duration of time; hence, negligence analysis is more appropriate. The essence test respects this difference by a distinction that is as crisp and clear as can be expected of the common law. The two cases analyzed here, Thomas and Truly, signal a significant departure from this approach without appropriate analysis of its history or purpose.

The result in Thomas and Truly is liability at variance with its economic policy foundations. Warranty theory presupposes consumer expectations as to quality that are related to price by the law of supply and demand. This assumption is inapplicable to products incidentally used by physicians, because a consumer market is unlikely, and independent price-quality negotiations are not customarily conducted between physician and patient as buyer and seller. Arguably, the policies underlying strict tort liability do apply to medical accidents. Although these policies may support imposition of liability on promoters, whether they do so with respect to health service providers is doubtful. The compensation purpose is not significantly advanced by adding physician liability to that imposed upon manufacturers and distributors. Neither does the medical professional provide a cost-effective point at which to ensure distribution of the risk of loss. Deterrence of the externality of unsafe product distribution cannot be significantly enhanced by imposing strict liability on medical professionals, since they are consumers of the myriad products they incidentally use and cannot test each one as a manufacturer would. Thus the two decisions examined here cannot be justified by reference to either principle or policy. They should not be followed in the future.