

## CONTRACTS AND INTENTIONAL TORTS

### After reading this chapter, you will

- know the essential elements of a valid and enforceable contract,
- understand why contract law is important to physician–patient and hospital–patient relationships,
- appreciate how the contract principle of breach of warranty can apply to the healthcare setting, and
- grasp the basics of intentional torts and how they apply to healthcare professionals.

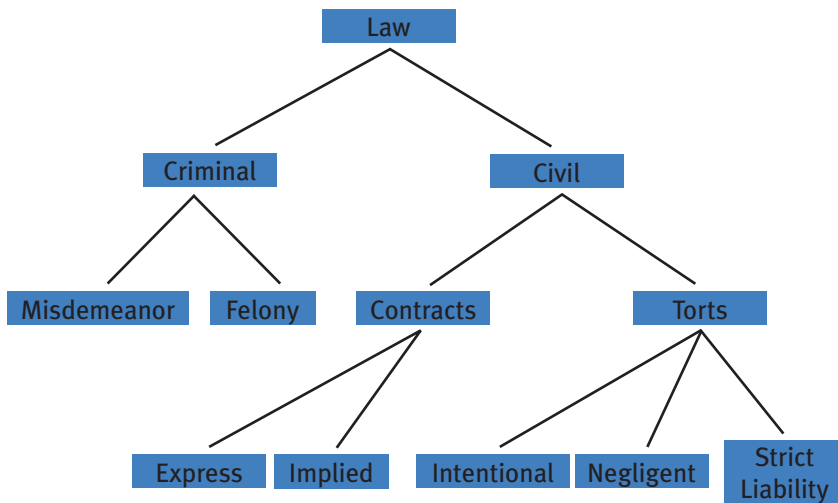
### Think Like a Lawyer

In the 1973 movie *The Paper Chase*, the Shakespearean actor John Houseman won an Academy Award for portraying Charles W. Kingsfield, a stern, intimidating contracts law professor. A highlight of the film is Kingsfield’s description of the Socratic method—a type of philosophical inquiry commonly used in law schools. To a room filled with first-year students he explains that this technique comprises a series of questions followed by the students’ answers, and that it is intended to stimulate critical thinking rather than simply convey information. The Socratic method is, essentially, *teaching by asking*.

Kingsfield struts slowly across the dais; glares at the timorous tyros before him; and announces that in his classroom there are no absolute answers, only an endless string of questions. The students are his patients on an operating table, and he is a neurosurgeon whose questions are instruments that probe their brains.

He stops. He stares. After a dramatic pause, and with a stentorian voice worthy of King Lear, he concludes: “You teach *yourselves* the law, but *I train your mind*. You come in here with a *skull full of mush*, and you leave thinking like a lawyer!” Yes, contracts law can teach you how to think like a lawyer—or at least teach you enough to know when to call on a lawyer for solid advice.

In chapter 1, you learned that law is either public or private. But law can be categorized in other ways as well—for example, there is criminal law and civil law, and civil law has subdivisions; exhibit 4.1 shows this taxonomy.

**EXHIBIT 4.1**A Taxonomy  
of Law

## Contracts and Intentional Torts as Bases of Liability

### liability

legal responsibility for one's acts or omissions

### cause of action

the basis of a lawsuit; sufficient legal grounds and alleged facts that, if proven, would constitute all the requirements for the plaintiff to prevail

When people think of **liability** in healthcare, they usually think of medical malpractice, a form of negligence. Negligence is the most common type of malpractice, but medical malpractice can also be based on breach of contract or the commission of intentional torts. In fact, many malpractice suits allege more than one **cause of action**. (The reasons for multiple allegations are discussed later in the chapter.<sup>1</sup>)

The existence of a legal duty is essential to any liability case, and the concept of duty tends to change as our society and values change. The legal duty may be imposed by constitution, legislation, common law (including negligent or intentional torts), or even contract. In healthcare, special legal duties arise from the contractual aspects of the physician–patient relationship.<sup>2</sup>

This chapter does not address the law of contracts as it relates to operational issues such as employment, materials management, facilities maintenance, and procurement. Although many of the basic principles discussed here apply to those areas, too, a full discussion of the breadth of contracts law is beyond the scope of this text; indeed, the subject of contracts occupies an entire semester course in the typical law school curriculum.

## Elements of a Contract

In simple terms, four conditions must exist for a contract to be valid:

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1. *Both parties must be legally competent to enter into the contract.*  
Contracts entered into by mentally incompetent persons are not valid—and neither are most contracts entered into by minors.
2. *There must be a meeting of the minds.* One party must make an offer—to buy or sell, for example—and the other party must accept that offer. The terms of the offer and acceptance must be identical.
3. *Consideration must be given.* **Consideration** is the price paid for the contract, but it need not be in the form of money. It may also be a promise (a) to do something you otherwise would not be required to do or (b) to refrain from doing something you otherwise would be able to do.
4. *The purpose of the contract must be legal.* A contract with a hit man to assassinate another person is void because its purpose is illegal. Likewise, many **exculpatory** (taken from the Latin words *ex* “from” and *culpa* “guilt”) contracts—those in which a party excuses the other from liability in advance—are invalid because they are against public policy.

**consideration**  
essentially, payment; something of value (not necessarily money) that is given (or promised) in return for what is received (or promised)

**exculpatory**  
absolving or clearing of blame

Contracts may be *express* (written, spoken) or *implied*. Many of our day-to-day human interchanges are implied contracts. For example, consider a patron ordering lunch in a restaurant. Implicit in the situation is this message (the offer): If you serve me what I order, I will pay the bill. By taking the order and serving the food, the restaurant accepts the patron’s offer and a contract exists. The offer and acceptance are rarely expressed as such in words, but the contract is valid nonetheless. Similarly, the doctor–patient relationship includes an offer (if you treat me, my insurance or I will pay you) and an acceptance (we’ve scheduled your appointment for next Tuesday).

## The Physician–Patient Relationship

The physician–patient relationship is based on contract principles because the physician agrees to provide treatment in return for payment. Professional liability can arise if this contract is breached. In the absence of a contract between physician and patient, the law usually imposes no duty on the physician to treat the patient, although it may impose other duties on the physician. For example, like other passersby, physicians have no legal obligation to help accident victims and although **Good Samaritan statutes** provide protection if they do, with some exceptions the statutes typically do not *require* anyone to act.<sup>3</sup>

This principle was illustrated in *Childs v. Weis*, a Texas case decided back in 1969, before better standards for emergency care were enacted.<sup>4</sup>

**Good Samaritan statutes**  
provisions of law that provide immunity from liability for persons who provide emergency care at the scene of an accident



## Legal Decision Point

You are at a beach in Florida having a picnic with your significant other. You notice a man struggling in the surf. You run to his rescue, but a minute or so later, while struggling through the waves, you notice that your companion is about to finish the last of the wine, so you abandon your effort and return to the picnic blanket before the wine is gone.

What were your legal and moral responsibilities before you began to assist the victim? Were they the same after you began? Do the answers change depending on whether you were trained in ocean rescue or CPR? What if you were an off-duty emergency medical technician? What other facts might you want to know before you answer?

Childs, a Dallas woman who was seven months pregnant, was out of town when she began to hemorrhage and suffer labor pains. At two o'clock in the morning, Childs presented herself to a small rural hospital's emergency department where a nurse examined her; called a staff physician (presumably at home); and, on the basis of what the doctor said, told her to go to her doctor in Dallas. Childs left the hospital and about an hour later gave birth in her car. Twelve hours later, the infant died. The court held that the physician had no duty to Childs because no physician-patient relationship had been established.

The hospital's and nurse's duties are a different matter, of course. As noted in chapter 10, federal law now requires emer-

gency department personnel to stabilize emergency conditions irrespective of whether a provider-patient relationship exists (see Legal Decision Point).

### Creation of the Relationship

The contract necessary to form a physician-patient relationship can be *express* (e.g., when you fill out financial responsibility forms at the doctor's office), *implied* (e.g., when you make a follow-up appointment and are seen by the doctor), or even *inferred* from the circumstances. Consider this situation: A patient is unconscious or unable to consent to treatment, but an emergency exists and the physician proceeds. The law will presume (infer) that a contract exists. Although this presumption is a legal fiction, it prevents unjust enrichment by requiring the patient to pay for services he presumably would have contracted for had he been competent. Whether express, implied, or inferred, the physician-patient contract is *bilateral*; that is, it imposes duties on both parties.

Although clear enough in the abstract, these black-letter principles are often difficult to apply in practice. For example, physicians commonly and informally consult one another regarding their patients' diagnosis and treatment, and the consulted physician may not see the patient or know her name. Do these informal hallway consults create a physician-patient relationship? Generally, the answer is no.

For example, in *Oliver v. Brock*,<sup>5</sup> Dr. Whitfield was treating Anita Oliver in rural Demopolis, Alabama, for injuries sustained in an automobile accident. During a telephone conversation with Dr. Brock about another patient,

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Dr. Whitfield casually mentioned Oliver's treatment and asked for Dr. Brock's opinion. According to Dr. Whitfield's affidavit (see Legal Decision Point), Dr. Brock told him the treatment seemed to be correct under the circumstances. The conversation was apparently informal and gratuitous, and one can almost imagine Dr. Whitfield saying, "Oh, by the way, what do you think about this other situation I have?"

Dr. Brock practiced in Tuscaloosa, which is about 60 miles from Demopolis; according to his own affidavit, he never saw the patient, talked to her or her family, or even learned her name. He admitted that he occasionally talked to Dr. Whitfield by phone (apparently to discuss patients), but he continually emphasized that he did not know Oliver and had "not been employed or requested to advise anyone with regard to her medical problems." Oliver ended up suffering further injury as a result of Dr. Whitfield's course of treatment.

In her own affidavit as plaintiff, Cathy Oliver (the patient's mother) stated the following:

Dr. Whitfield told me that he would call Dr. Brock in Tuscaloosa to get some advise (sic) on how to treat my daughter's injuries. Dr. Whitfield later told me that he had talked with Dr. Brock and that Dr. Brock told him that Dr. Whitfield was treating the injuries correctly and told him to continue the same treatment.

...

I have reviewed the chart prepared by the Defendants stating the names of the doctors who treated my daughter. On a page marked "Discharge Summary," I have read that Dr. Brock was consulted and assisted in prescribing the treatment for my daughter. I sincerely believe that Dr. Brock took part in the treatment of my daughter and that he is at fault for the serious injuries suffered by my daughter as a result of this treatment.

After reviewing the evidence, such as it was, the Supreme Court of Alabama unanimously decided that there was no doctor-patient relationship between Dr. Brock and Anita Oliver, so the physician could not be held liable

## Legal Decision Point



An affidavit is a written document in which the *affiant*—the one who signs the document—swears under penalty of perjury that the facts asserted in the statement are true. Affidavits generally cannot substitute for in-court testimony because they are not subject to cross-examination. But affidavits are sometimes used to support arguments on collateral matters, especially if the opposing attorney does not object. In *Oliver v. Brock*, affidavits were used to support Dr. Brock's position that he did not have a doctor-patient relationship with Oliver, and the plaintiffs also used affidavits to support their own position.

Who do you suppose wrote the affidavits in this case? Are any of their assertions not, strictly speaking, facts? If you were opposing counsel, would you object to the use of such affidavits? If you were the judge, what weight would you give them? If you could cross-examine Dr. Whitfield (the treating physician who consulted with Dr. Brock), what questions would you ask him about his assertions?

for the injuries the patient sustained as a result of the treatment. One of the justices summarized this position clearly in a concurring opinion: “The mere discussion between professional people of hypothetical situations cannot be viewed as a basis for liability. To hold otherwise would tend to adversely affect the quality of the services they offer to members of the public. Physicians, lawyers, dentists, engineers, and other professionals, by comparing problem-solving approaches with other members of their disciplines, have the opportunity to learn from one another. Possessing this freedom, they are better positioned to bring theory into practice for the benefit of those whom they serve. Our decision in this case preserves these essential learning situations for all professional people.”<sup>6</sup>

The general rule is stated in the legal encyclopedia *American Jurisprudence* as follows:

A physician is under no obligation to engage in practice or to accept professional employment. . . . The relation is a consensual one wherein the patient knowingly seeks the assistance of a physician and the physician knowingly accepts him as a patient. The relationship between a physician and patient may result from an express or implied contract . . . and the rights and liabilities of the parties thereto are governed by the general law of contract. . . . A physician may accept a patient and thereby incur the consequent duties [even if] his services are performed gratuitously or at the solicitation and on the guaranty of a third person.<sup>7</sup>

On the other hand, a physician need not come into direct contact with a patient for a doctor–patient relationship to exist. A pathologist, for example, has a relationship with patients even though he probably never sees the people whose specimens he examines, and the patients do not know who the pathologist is or even that a pathologist is involved in their treatment.<sup>8</sup>

Another issue involves the duty of a physician who provides services to someone who is not a party to the contract. For example, a physician conducts a preemployment examination, examines an applicant for life insurance, or examines a plaintiff for a personal injuries case. In these situations, the general rule is that a typical physician–patient (i.e., treatment) relationship is not established and the physician owes no duty to the individual being examined—only to the party who contracted for the examination.

Some courts, however, have found at least a limited duty toward the plaintiff, even in the absence of a contractual relationship. In *James v. United States*, the plaintiff applied for a position at a shipyard and, as a condition of employment, was required to take a physical examination. A chest X-ray revealed an abnormality, but through a clerical error the physician never saw the X-ray or the radiologist’s report. Almost two years later, the plaintiff was diagnosed with an inoperable cancer. The defense argued that the absence of a physician–patient relationship precluded any duty of care. The court

awarded damages anyway because “having made a chest X-ray an essential part of the preemployment examination to determine an applicant’s physical fitness, however, defendant failed to use due care when . . . the report on the X-ray was not brought to the attention of the examining physician.”<sup>9</sup>

In addition, other statutes, such as the Americans with Disabilities Act and various civil rights acts, both state and federal, may limit a physician’s or even a hospital’s ability to decline to see a patient in certain circumstances.

### ***Employees’ Remedies and Workers’ Compensation Laws***

Injuries or conditions incurred on the job usually lead to physician–patient relationships for treatment. Can the employee successfully bring a lawsuit against the employer or fellow employees for the workplace injury? If treatment of the condition was rendered negligently, can the employee successfully sue the healthcare provider?

The general rule is that workers’ compensation is an employee’s *exclusive* legal remedy for a workplace injury or illness. Under that rule, employees are precluded from recovering from their employer or coworkers for negligence or other claims.<sup>10</sup> However, when an employer operates in two capacities—both as an employer and as a healthcare provider, for example—some courts have found that the second role imposes obligations outside the employment relationship and a second cause of action is possible. This exception, known as the *dual capacity doctrine*, is seen in a pair of cases.

In the 1978 case of *Guy v. Arthur H. Thomas Co.*, the plaintiff worked as a laboratory technician at the defendant hospital where she operated a blood-gas apparatus that used mercury.<sup>11</sup> In her complaint against the hospital, the plaintiff alleged that she contracted mercury poisoning from the apparatus, that the hospital’s clinical staff failed to diagnose her condition as mercury poisoning, and that her injuries were aggravated as a result of this alleged medical negligence.

The Ohio Supreme Court held that the hospital, as an employer, was liable for workers’ compensation benefits, but in its second capacity as a hospital it was also liable for the medical negligence. “Appellant’s need for protection from malpractice was neither more nor less than that of another’s employee. The . . . hospital, with respect to its treatment of the appellant, did so as a hospital, not as an employer, and its relationship with the appellant was that of hospital–patient with all the concomitant traditional obligations.”

By way of contrast, the 2000 Maryland case *Suburban Hospital v. Kirson* illustrates the approach taken by the majority of courts.<sup>12</sup> Phyllis Kirson, an operating room nurse, broke her right femur on August 6, 1993, when she slipped and fell while on the job at Suburban Hospital. The injury required surgical repair, and on August 13, while still recuperating in the hospital, she fell again and reinjured the same leg. The second fall occurred because of the negligence of a hospital employee, and it led to many complications and four additional surgeries over a 15-month period.

For this string of injuries and lost wages, Kirson received total disability compensation from August of 1993 to May of 1995 and an additional 275 weeks' worth of permanent partial disability payments. The hospital was also ordered to pay all of her medical expenses.

Then, in July 1996, Kirson filed a negligence suit against the hospital, the employee who caused her second fall, and a few other individuals. The hospital raised the "exclusive remedy" defense, and Kirson countered with dual capacity. After reviewing the legal literature and cases from numerous other jurisdictions—including the *Guy* case from Ohio—the Maryland high court held that "dual capacity is not compatible with Maryland law."<sup>13</sup>

The court noted that it was "firmly established" in Maryland that worker's compensation applies not only to the initial workplace injury but also to any aggravation of that injury because of medical malpractice. Although the aggravation here was not the result of medical malpractice per se, it clearly resulted from the negligence of a hospital employee in causing the second fall while treating the first injury. The court disposed of Kirson's arguments as follows.

In order for the subsequent injury to be compensable, it is necessary only to show that the injury directly resulted from improper treatment of the original compensable injury. . . . It is not necessary, as Kirson contends, to split causation hairs. . . .

Fundamentally, Kirson's argument attacks the social contract on which workers' compensation is based. Suburban is obliged to pay compensation by way of disability benefits and medical expenses for the injuries sustained on August 6 and for the injuries resulting from malpractice in the treatment of the August 6 injuries. Having received compensation, Kirson wants the right to sue Suburban to recover damages which, hopefully from [her] standpoint, would exceed the amount of compensation paid. We hold, however, that, in exchange for the imposition of no fault limited liability for workplace accidents, Suburban bought peace from being considered as a third party when rendering hospital services to Kirson in fulfillment of its obligation [to provide medical care].<sup>14</sup>

This result, refusing to apply the dual capacity doctrine, puts Maryland in line with the majority of jurisdictions that have considered the argument. According to the *Kirson* opinion, Ohio and California are the only states in which dual capacity has "flourished," and since the *Guy* decision in 1978, even the Ohio court "has declined to apply dual capacity in other contexts."<sup>15</sup>

### ***Scope of the Duty Arising from the Relationship***

In the typical physician–patient relationship, the physician agrees to diagnose and treat the patient in accordance with the standards of acceptable medical practice and to continue to do so until the natural termination of the



relationship. (The standards of practice and termination of the relationship are discussed later in this chapter.) For her part, the patient agrees to pay—or have her insurance pay—for the services rendered.

On the other hand, the patient does not contractually agree to follow the doctor's orders, and failure to do so may excuse the physician from liability for untoward results. Similarly, the physician does not contractually promise to cure the patient. However, in some cases, express promises made by the physician may be deemed a guarantee of a cure. If no cure results in such cases, the physician will be liable for breach of warranty. (This topic is discussed further later in this chapter.)

The physician may limit the scope of the contract to a designated geographic area or medical specialty. In *McNamara v. Emmons*, a woman sustained a bad cut and was treated by an associate of her physician.<sup>16</sup> The next morning the patient left for a vacation in a town 20 miles away. While there, she felt she needed further treatment and asked the physician to come to the town. He refused but gave her instructions and named a local physician whom she might call. The court held that in these circumstances the defendant physician was justified in limiting his practice to his own town. In other cases, the courts have decided that, at least when no emergency exists, the physician has no obligation to make house calls but instead may require the patient to come to the office for treatment.

### ***Duties to Persons Other Than the Patient***

In many states, the contractual relationship between the patient and the physician not only allows the physician to warn certain persons that a patient has an infectious disease but also obliges the physician to do so. For example, state law may require the healthcare provider to notify the sexual partners of persons infected with HIV or diagnosed with AIDS.

Similarly, a physician might be subject to liability when a patient injures a third party. In *Freese v. Lemmon*, a pedestrian was injured by an automobile when its driver suffered a seizure.<sup>17</sup> Both the driver and his physician were sued by the injured person—the physician on the theory that he was negligent in diagnosing an earlier seizure and in advising the driver that he could operate an automobile. The trial court dismissed the case against the physician, but the Supreme Court of Iowa reversed that outcome on the theory that an unreasonable risk of harm to a third party or a class of persons (i.e., other drivers) was foreseeable. The case was remanded for a trial on the merits of the evidence.

In the famous case *Tarasoff v. Regents of the University of California* (also discussed in chapter 9), the California Supreme Court ruled that despite a confidential relationship with patients, a doctor has a duty to use reasonable care to warn persons threatened by a patient's condition.<sup>18</sup> The patient had

told his psychotherapist that he intended to kill Tarasoff, and he later made good on his threat. On these facts the court determined that the victim's parents had a valid cause of action for failure to warn.

Whether the injury to the third party is foreseeable is an important consideration in such cases. In *Brady v. Hopper*, a suit by persons injured in the assassination attempt on President Ronald Reagan in 1981, the court held that John Hinckley Jr.'s psychiatrist owed no duty to the plaintiffs because there was no evidence that Hinckley had made specific threats suggesting his intentions.<sup>19</sup>

### **Termination of the Relationship and Abandonment**

Like all contracts, the one between the physician and the patient is terminated at certain points:

- When the patient is cured or dies
- When the physician and the patient mutually consent to termination
- When the patient dismisses the physician
- When the physician withdraws from the contract

Withdrawal by a physician before the patient is cured may prompt the patient to claim abandonment. Whether abandonment is a breach of contract, an intentional tort, or negligence has been a matter of some dispute, and there might be valid claims for all three, especially when the physician thought the patient had been cured and prematurely discharged her from the hospital.<sup>20</sup>

Abandonment may be express or implied. Express abandonment occurs when a physician notifies a patient that he is withdrawing from the case but fails to give the patient enough time to secure the services of another physician. In *Norton v. Hamilton*, the plaintiff reported that she had begun labor several weeks before her baby was due.<sup>21</sup> According to the plaintiff's allegations, the physician examined her and concluded that she was not in labor. When the pains continued, the plaintiff's husband called the physician twice to say that his wife was still in pain. At that point, the physician said he was withdrawing from the case. While the husband was looking for a substitute physician, the plaintiff delivered her child alone and suffered unnecessary pain and distress. The court held that the physician's acts would be abandonment, *if proven*. (The decision only concerned the legal principle that would apply; it was not a final judgment based on evidentiary findings.)

Sometimes abandonment is inferred from the circumstances, as in the 1963 Kentucky case *Johnson v. Vaughn*.<sup>22</sup> The facts involved "a 46-year-old colored man" who had suffered a gunshot wound to the neck in the wee hours of a Saturday morning. When the patient arrived at the hospital, a nurse phoned Dr. Vaughn, who arrived a short time later; admitted the

patient; treated him somewhat (although the opinion is not clear on the extent of that treatment); and then went home, leaving word that he was to be called if the patient's condition grew worse. There is some testimony in the record that the doctor was under the influence of alcohol at the time.

Because the patient seemed dangerously injured, his son had a nurse call another doctor, Dr. Kissinger, who arrived and "gave such attention as appeared to be most urgent" but who felt he could not proceed further without a release from Dr. Vaughn. He called Dr. Vaughn, advising him that the patient was dying and needed immediate attention. At this news, Dr. Vaughn became "irate and vulgar," called Dr. Kissinger "a louse" for trying to steal his patient, and hung up. A call from the patient's son produced more verbal abuse. Finally, Dr. Vaughn said he would release the patient if he was paid \$50 by nine o'clock the next morning. Meanwhile, 30 or 40 minutes had passed before Dr. Kissinger could operate, and the patient later died.

The court held that these facts were sufficient to state a claim of abandonment against Dr. Vaughn. The opinion states, in part, "It is a rule of general acceptance that a physician is under the duty to give his patient all necessary and continued attention as long as the case requires it, and that he should not leave his patient at a critical stage without giving reasonable notice or making suitable arrangements for the attendance of another physician, unless the relationship is terminated by dismissal or assent. Failure to observe that professional obligation is a culpable dereliction."<sup>23</sup>

As this quote from the *Johnson* case implies, physicians can raise various defenses to claims of abandonment. If the patient dismisses the physician or agrees to the latter's departure, or if the physician gives notice of withdrawal early enough for the patient to find another physician of equal ability, the claim will fail. Physicians have the right to limit their practice to a certain specialty or geographic area. A physician who is too ill to treat a patient or to find a substitute also has a valid defense to an abandonment claim. If a physician obtains a substitute physician, she has a valid defense so long as the substitute is qualified and the patient has enough time to find another if the substitute is unacceptable.

Two California cases exemplify purposeful termination of the doctor-patient relationship when a patient is uncooperative or disagreeable. In *Payton v. Weaver*, the patient was Payton, a 35-year-old indigent woman with end-stage renal disease and a history of drug and alcohol abuse. Her physician, Dr. Weaver, informed her that he would no longer continue to treat her because of her intensely uncooperative behavior, antisocial conduct, and refusal to follow instructions.<sup>24</sup> Payton tried without success to find alternative treatment and petitioned the court to compel the doctor to continue treating her. The parties agreed that the physician would continue if she met reasonable conditions of cooperation. When she did not keep her part of the



## Legal Decision Point

End-stage renal disease (ESRD) is chronic kidney failure that has progressed to the point of requiring kidney dialysis or transplant. An ESRD patient needs to undergo dialysis every three or four days but lives a somewhat normal existence between treatments (subject to contributing conditions, such as high blood pressure and diabetes).

The *Payton* court stated that “there was no emergency” in Payton’s case. Do you agree? Was she a patient with a chronic disease, or was she a patient who was bound to have serial emergencies? Instead of seeing Dr. Weaver as scheduled (which she did not), what if she had been taken to the emergency department every few days in extremis and in need of dialysis? If you were a hospital administrator, how would you advise the emergency department to deal with a patient such as Payton?

bargain, Dr. Weaver again notified her that he was withdrawing, and she again sought a court order. This time, the trial court found that she had violated the previous conditions and in the process had adversely affected other dialysis patients. The court also found that there was no emergency requiring treatment under a California statute,<sup>25</sup> that the physician’s notice was sufficient to end the relationship, and that the doctor was not responsible for the fact that no other dialysis unit would accept her (see Legal Decision Point). The appellate court sustained the trial court decision, and Payton died pending appeal.<sup>26</sup>

In another case, the court decided that a medical group and hospital must provide nonemergency care to a husband and wife. In *Leach v. Drummond Medical Group, Inc.*, the plaintiffs, who were regular patients of the group practice, had

written to a state agency commenting adversely on the performance of the group’s physicians.<sup>27</sup> The practice told the couple that, because they complained to the medical board, “a proper physician–patient relationship” could not be maintained and they would receive only 30 days of care, after which they would be treated only for emergencies. The couple sued to compel continued treatment of their many health problems. (The practice was the only medical group available within 100 miles.) The trial court denied relief, but the appellate court reversed the decision and allowed the suit to continue. The court decided that although one physician may not be required to treat a patient she does not like, the group as a whole can be ordered to do so.<sup>28</sup> Because the patients had not publicly criticized the doctor but only discreetly contacted the appropriate state agency, the court held that denying services to them was not justified.

Some cases have extended the physician’s duty to the patient even after the doctor–patient relationship has ended. In *Tresemmer v. Barke*, the physician had implanted an intrauterine device (IUD) in the plaintiff in 1972.<sup>29</sup> The physician had seen the patient only on that one occasion. The plaintiff later suffered injury from the device (a Dalkon Shield) and filed suit against the physician. She alleged that he knew the risks of using the IUD but failed to warn her. The court held that the defendant had a duty to warn the plaintiff, noting that a physician is in the best position to alert a patient and that death or great bodily harm might be prevented as a result.<sup>30</sup>

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## Liability for Breach of Contract

In the typical physician–patient contract, the physician agrees (or implies agreement) to perform a service. Failure to perform the service with reasonable skill and care may give the patient a basis for filing a claim, not only for negligence but also for breach of contract. The previous paragraphs illustrate breach-of-contract cases based on abandonment; *Alexandridis v. Jewett* offers an example of a different kind of contractual breach.<sup>31</sup>

In *Alexandridis*, two obstetricians agreed that one of them would personally deliver the patient’s second child. When the time came, however, the patient’s labor progressed rapidly and the obstetrician whose night it was to take call could not arrive at the hospital in time. The baby was delivered by a first-year resident, who performed an episiotomy during the process and damaged the patient’s anal sphincter as a result. Because the partners had contractually agreed to deliver the patient’s child and were more skilled than the resident in training who delivered the child, the court found that the partners would be liable for breach of contract if their greater skill would have protected the patient from injury.

A physician who uses a procedure that is different from the one he promised to use may also be liable for breach of contract. In *Stewart v. Rudner*, the physician promised to arrange for an obstetrician to deliver a child by cesarean section.<sup>32</sup> The patient, a 37-year-old woman who had suffered two stillbirths, was extremely eager to have a “sound, healthy baby.” While the patient was in labor, the physician told another obstetrician to “take care of this case” but did not tell him about the promise to perform a cesarean section. At the end of a lengthy labor, the baby was stillborn. The appellate court upheld a jury verdict for the patient on the ground that the physician breached his promise that a cesarean operation would be used to deliver the baby.

## Liability for Breach of Warranty

Physicians are susceptible to liability not only if they promise but fail to perform a certain *service* but also especially if they promise that their treatment will yield a specific *result* but does not. A physician who guarantees a result gives the patient a contractual basis for a lawsuit if the treatment is not successful, even if it was performed skillfully. In *Sullivan v. O’Conner*, a professional entertainer thought her nose was too long.<sup>33</sup> She contracted with a physician to have cosmetic surgery. The physician promised that the surgery would “enhance her beauty and improve her appearance.” The surgery was unsuccessful, however, and after two more operations the nose looked worse than before.

Physicians do not guarantee results simply by agreeing to perform an operation, and drawing the line between an opinion and a guarantee is

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## Legal Brief

*Sullivan v. O'Conner* is a good example of the roles juries and appellate courts play in our legal system. The jury decides what the facts are, and the appellate court must accept those facts as true unless they are indisputably wrong.

In some respects, this rule is analogous to the instant replay rule in football. Unless the review clearly shows the decision was wrong, the call “on the field” stands.

often difficult. The jury decided in this case, however, that there was a guarantee, and the appellate court affirmed the jury’s verdict for the plaintiff (see Legal Brief).

*Guilmet v. Campbell* is well known in health law circles. The plaintiff had a bleeding ulcer and talked with a surgeon about a possible operation. He testified that the surgeon said:

Once you have an operation it takes care of all your troubles. You can eat as you want to, you can drink as you want to, you can go as you

### tort

a civil offense not founded on contract; a failure to conduct oneself in a manner considered proper under the given circumstances

### intentional tort

a category of torts that describes a civil wrong resulting from an intentional act on the part of the **tortfeasor**

### tortfeasor

a wrongdoer; a person who commits a tort

### negligence

failure to comply with established standards for the protection of others; departure from the conduct expected of a reasonably prudent person acting under the same or similar circumstances

please. Dr. Arena and I are specialists; there is nothing to it at all—it’s a very simple operation. You’ll be out of work three to four weeks at the most. There is no danger at all in this operation. After the operation you can throw away your pill box. In twenty years if you figure out what you spent for Maalox pills and doctor calls, you could buy an awful lot. Weigh [that cost] against an operation.<sup>34</sup>

With this assurance, the plaintiff underwent the operation, during which his esophagus ruptured. As a result, his weight dropped from 170 to 88 pounds, and he developed hepatitis and numerous other complications. He sued the physician on both a negligence theory and a warranty (guarantee) theory. The jury decided that the physicians were not negligent but had breached their promise to cure. The Michigan Supreme Court affirmed the decision. In response to *Guilmet*, and presumably after some heavy lobbying by the medical profession, the state legislature later passed a statute requiring that any alleged promise or guarantee of a cure will be void unless it is in writing and signed by the physician alleged to have made it.<sup>35</sup>

## Intentional Torts

Another basis for professional liability is intentional tort. A **tort** (Latin for “wrong”) is a civil wrong, not based on contract, that results in injury to another person or another person’s property or reputation.<sup>36</sup> Torts are usually divided into three categories, each of which involves a different type of proof (see again exhibit 4.1):

- **Intentional tort**, as the name implies, is a wrongful, premeditated action that causes injury.
- **Negligence** is unintentional failure to do what a reasonably careful person would do under the circumstances.

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- **Strict liability** is incurred when a person commits a wrongful act that poses high risk of harm to others, but did not do so intentionally or out of negligence.

As noted earlier, most malpractice cases are based on negligence. Strict liability is uncommon in healthcare administration, but it surfaces in relation to defective drugs and medical devices.

In healthcare, lawsuits based on intentional tort are less common than negligence cases, but they are important because they give plaintiffs some flexibility they would not have otherwise. There may also be multiple consequences for the healthcare provider who commits an intentional tort. Because intent is usually an essential element in proving both an intentional tort and a crime, many intentional torts, such as assault and battery, entail both criminal and civil liability. This point is significant because commission of a criminal act could result in revocation of one's license to practice.

### Assault and Battery

“Assault and battery” is actually two intentional torts. An *assault* is conduct that places a person in apprehension of being touched in a way that is insulting, provoking, or physically harmful. *Battery* is the actual touching (see Legal Brief). Both assault and battery are acts done without legal authority or permission. A move to kiss someone without consent is an assault, and the act of kissing without consent is both assault and battery. If the person were asleep when kissed, the perpetrator would not be committing assault because the person was not apprehensive. He would, however, be committing battery. (Obviously, kissing someone with permission is neither assault nor battery but is normally an enjoyable experience.)

The question of consent to medical or surgical treatment is complex; chapter 11 features a detailed discussion of the topic. For present purposes, assault and battery cases can be grouped into three categories:

1. Those in which no consent for the touching was obtained
2. Those in which the physician exceeded the scope of the consent given
3. Those in which the consent was “uninformed”

First are the intentional acts committed by a healthcare provider with no patient consent whatsoever. In *Burton v. Leftwich*, for example, a physician who was having trouble removing sutures from the toe of a four-year-old child (whose parents were

**strict liability**  
automatic  
responsibility  
(without having to  
prove negligence)  
for damages  
as a result of  
possession or  
use of inherently  
dangerous  
equipment, such  
as explosives, wild  
and poisonous  
animals, or assault  
weapons

#### Legal Brief



We accept the incidental touching that accompanies everyday life, but there are certain boundaries. For example, jostling others on a crowded subway train is not battery, but groping others is.

Battery is sometimes characterized by the aphorism, “Your right to swing your arm ends where my nose begins.” (But the swing might be an assault if you see it coming.)

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apparently not much help) smacked the tot's thigh several times with his open hand, leaving bruises that were visible for three weeks.<sup>37</sup> An appellate court upheld a jury verdict for the plaintiffs on the grounds that the physician had committed battery.

Compare that case with *Mattocks v. Bell*, in which a 23-month-old girl—whom a medical student was treating for a lacerated tongue—clamped her teeth on the student's finger and would not let go.<sup>38</sup> After a failed attempt to free his finger by forcing a tongue depressor into the child's mouth, the student slapped her on the cheek. The parents lost the battery suit. The force the student used was judged to be proper under the circumstances.

In the often-cited case *Schloendorff v. Society of New York Hospital* (discussed in more detail in chapter 11), a doctor was liable for battery after he operated on a patient who had consented only to an examination under anesthesia but not to an operation.<sup>39</sup> In another case, a patient signed a consent form to have his kidney stones removed by a certain urologist. After the surgery, the patient discovered that the operation had been performed not by the urologist he requested but by two other members of the urologist's medical group. He sued all three physicians for malpractice and failure to obtain **informed consent**. After the jury found for the defendants, the Supreme Court of New Jersey reversed the decision. It held that the plaintiff had claims for battery and malpractice and that even if no physical injury occurred, the defendants could be liable for mental anguish and perhaps even punitive damages.<sup>40</sup> The court stated: "Even more private than the decision who may touch one's body is the decision who may cut it open and invade it with hands and instruments. Absent an emergency, patients have the right to determine not only whether surgery is to be performed on them, but who shall perform it."<sup>41</sup>

The second and third categories of assault and battery cases will be discussed in more detail in chapter 11. For now it is sufficient to note that a case fitting either the second or third category can support a negligence theory in addition to the intentional tort of assault and battery. Negligence is the more common allegation, but liability on assault and battery is also possible.

*Mohr v. Williams* is illustrative of this point.<sup>42</sup> The plaintiff consented to an operation on her right ear. After she was anesthetized, the surgeon discovered that her left ear needed surgery more than the right one, so he operated on the left ear instead. On the ground, among others, that the surgeon's conduct amounted to assault and battery, the appellate court upheld a trial court's decision to let the case proceed.

Although the surgeon in *Mohr* should have consulted the patient before operating on the other ear and probably should have discussed that possibility before beginning the surgery, a surgeon may be justified in operating beyond the scope of the original consent when an emergency makes



obtaining the patient's further consent impossible or dangerous. In *Barnett v. Bachrach*, a surgeon operating on a patient for an ectopic pregnancy (a pregnancy outside the uterus) discovered that the pregnancy was normal but that the patient had acute appendicitis.<sup>43</sup> He removed the appendix and later sued the patient for not paying the medical bill. The patient defended the collection suit by alleging that the appendix was removed without her consent. In holding for the surgeon, the court noted that if he had not taken out the appendix, both the patient and child might have been endangered.

These cases of extending the scope of surgery can be extremely complicated, and the outcome can depend on small factual differences. Generalizing about the proper course of action to take is difficult. For this reason, most hospital risk management departments have detailed surgical consent forms that anticipate all possible intraoperative complications and document the patient's permission for the medical team to make prudential judgments should those complications arise during the surgery.

### Defamation

**Defamation** is wrongful injury to another person's reputation. Written defamation is *libel*, and oral defamation is *slander*.<sup>44</sup> To be actionable, the defamatory statement must be "published"—that is, the defendant must have made the statement to a third party, not just to the plaintiff. In *Shoemaker v. Friedberg*,<sup>45</sup> a physician wrote a letter to a patient, stating that she had a venereal disease. The patient showed the letter to two or three other women and later, in the presence of a friend, discussed the diagnosis with the physician. In suing him she alleged a breach of confidentiality, but the court held that no recovery should be allowed because the patient had published the diagnosis herself. (This result is an example of what could be called the "it's your own dumb fault" rule.)

**defamation**  
the act of making untrue statements about another that damages the person's reputation

Physicians have several defenses available to them in defamation suits:

- *The truth of a statement is an absolute defense.* Even a true statement, however, can lead to liability for invasion of privacy or breach of confidentiality. (See further discussion on this point later in the chapter and in the discussion of the Health Insurance Portability and Accountability Act [HIPAA] in chapter 9.)
- *Statements made in good faith to protect a private interest of the physician, the patient, or a third party are usually entitled to a qualified privilege.* An example is a false but good-faith report of a sexually transmitted disease diagnosis to a state health department, as required by law.
- *Some statements, such as those made during a judicial proceeding or by one physician to another in discussing a patient's treatment, are privileged*

*and provide a defense.* In *Thornburg v. Long*, for example, a specialist advised a patient's family physician on the basis of an erroneous lab report that the patient had syphilis.<sup>46</sup> When the patient sued the specialist for libel, the court held that the statement was privileged because the specialist had a duty to communicate the information to the other physician and had done so with reasonable skill even though it turned out that the information was incorrect.

### **False Imprisonment**

False imprisonment arises from unlawful restriction of a person's freedom. Many false imprisonment cases involve patients who have been involuntarily committed to a mental hospital. In *Stowers v. Wolodzko*, a psychiatrist was held liable for his treatment of a patient who had been forcibly committed against her will.<sup>47</sup> Although this type of commitment was allowed under state law, for many days the psychiatrist held the woman incommunicado and prevented her from calling an attorney or a relative. His actions amounted to false imprisonment because her freedom was unlawfully restrained. (The unusual facts of this case are laid out in *The Court Decides* at the end of this chapter.)

### **Invasion of Privacy and Breach of Confidentiality**

Although truth is a defense in defamation cases, there are two other bases for possible liability: (1) invasion of privacy and (2) wrongful disclosure of confidential information. Invasion of privacy occurs when a patient is subjected to unwanted publicity. For example, in *Vassiliades v. Garfinckel's, Brooks Bros.*, the defendants (a physician and the famous department store) used "before" and "after" photographs of the plaintiff's cosmetic surgery without her permission. This action was sufficient to support a verdict for invasion of privacy and breach of **fiduciary** duty.<sup>48</sup> Similarly, a Michigan physician was held liable for invasion of privacy when he allowed a lay friend to observe the delivery of a baby in his patient's home. Clearly, a patient's expectation of privacy should be respected.

A suit for wrongful disclosure of confidential information was brought on behalf of a man who had been a patient at the Holyoke Geriatric and Convalescent Center.<sup>49</sup> His family had sought the court's permission to remove him from the kidney dialysis treatments that were sustaining his life. The court granted the petition, but several nurses and aides from the center, with the approval of the center's administrator, wrote a letter to a local newspaper protesting the decision. The letter appeared on the front page of the paper. A jury awarded the plaintiff's widow and estate \$1 million for violation of a statute that prohibits release of personal information. The case clearly shows the danger of disclosing confidential patient information without proper

#### **fiduciary**

an individual or entity (e.g., a bank or a trust company) that has the power and duty to act for another (the beneficiary) under circumstances that require trust, good faith, and honesty

authority, and it was decided in 1985—11 years before HIPAA brought further attention to the subject of privacy and stricter enforcement activity.

In many situations, state or federal law requires disclosure of confidential information. For example, confidential information from a patient's medical record may be disclosed for purposes of quality assurance and peer review activities and to state authorities in cases of suspected child abuse. Other reporting requirements include those relating to communicable disease, abortion, birth defect, injury or death resulting from use of a medical device, environmental illness and injury, injuries (such as knife or gunshot wounds) resulting from suspected criminal activities, and conditions (such as epilepsy) affecting one's ability to drive safely or operate heavy machinery.

Disclosures made in conformity with the law are not wrongful, and no liability will attach. Similarly, there is no liability for disclosing patient information when the patient (or the patient's guardian) has given permission or when a search warrant or other legal procedure requires it. Healthcare facilities must be aware of the federal and state requirements regarding confidentiality of medical records and must have policies and procedures in place to protect the information contained in them. (All of these requirements are discussed in more detail in chapter 9.)

### **Misrepresentation**

Misrepresentation is another intentional tort for which physicians can be held liable. Misrepresentation is either intentional (fraudulent or deceitful) or negligent. Either way, the person claiming injury must show that a fact was falsely represented and that he based decisions on the misrepresentation. Misrepresentation cases involving physicians are of two types: (1) misrepresentation to persuade a patient to submit to treatment and (2) misrepresentation of a prior treatment or its results.

Physicians who misrepresent the nature or results of treatment they have given are liable for fraud even if the treatment was done carefully. In *Johnson v. McMurray*,<sup>50</sup> Dr. McMurray had performed surgery on Lavid Johnson and had left a surgical sponge in his body. Johnson specifically asked that Dr. McMurray not participate in the follow-up surgery needed to remove the sponge, and he sought out Dr. Griffith to operate. Unknown to Johnson, Dr. Griffith intended to have Dr. McMurray assist in the surgery anyway, which he did. More complications arose, and the patient eventually lost his leg. The court decided that the two doctors had fraudulently concealed a significant fact and a jury could award damages.

Misrepresentation sometimes allows a patient to bring suit after the **statute of limitation** expires. In *Hundley v. Martinez*, the patient suffered vision problems for a number of months after cataract surgery. On numerous

#### **statute of limitation**

a law setting the maximum period one can wait before filing a lawsuit, depending on the type of case or claim

occasions he returned to his ophthalmologist for follow-up and was repeatedly assured that his “eye was all right, getting along fine.”<sup>51</sup> Eventually, the patient (an attorney) became virtually blind in the affected eye. More than two years later, he consulted another ophthalmologist about cataract formation in the other eye. Only then did he learn that the first eye had been permanently damaged by the earlier surgery. The court held that the two-year limitation period should be disregarded if the jury found that the physician had obstructed the plaintiff’s case by fraud or in other ways. Accordingly, a new trial was ordered.

### Outrage

The tort of outrage—sometimes called “intentional infliction of emotional distress”—arises from extreme and offensive conduct by the defendant. *Rockhill v. Pollard* is a graphic example of a case involving outrage.<sup>52</sup> The plaintiff, her mother-in-law, and her ten-month-old daughter were injured in an automobile accident on a wintry evening in Oregon shortly before Christmas; the accident knocked the baby unconscious. A passing motorist picked them up and arranged for a physician to meet them at the doctor’s office. Here is a portion of the court’s opinion describing the encounter with the defendant, Dr. Pollard:

Both plaintiff and [her mother-in-law] Christine Rockhill testified that defendant was rude to them from the moment they met him. Plaintiff testified:

“And the first thing, he looked at us, and he had a real mean look on his face, and this is what he said. He said, ‘My God, women, what are you doing out on a night like this?’ . . . and my mother-in-law tried to explain to him why we were on the road, and her and I both pleaded to him.”

Without making any examination, defendant told them there was nothing wrong with any of them. [The baby] was still unconscious at this time. According to plaintiff:

“She was very lifeless. I was saying her name, and she wouldn’t respond at all. Her eyelids were a light blue. She was clammy, very cold.

“In fact, I thought she was dead at the time.”<sup>53</sup>

After repeated requests to do so, the doctor finally gave the child a cursory examination and said there was nothing wrong with her. The baby had vomited, and both the adults had blood and vomit on them. The opinion states that the doctor told the mother-in-law, “Get in there and clean yourself up. You are a mess.” The opinion continues, quoting from the transcript:

“The doctor was out of the room, and I told her [Christine Rockhill, the mother-in-law], I says, ‘We have got to get help for this baby,’ and she said, ‘Well, what are we going to do?’

“And the doctor came back in the room, and she asked the doctor, she says, ‘What are we going to do?’ And he just shrugged his shoulders and said he didn’t know.”

When Christine Rockhill suggested that her brother would pick them up at defendant’s office, defendant said, “My God, woman, I can’t stay here until somebody comes and gets you.” Although the temperature was below freezing and [the baby’s] clothing and blanket were wet with vomit, he told them to wait outside by a nearby street light while someone came . . . to get them.

After a 20-minute wait in the cold, the group was taken to a hospital. By the time they arrived, the baby was apparently semiconscious and suffering from shock. The women were given emergency treatment and released. The child had surgery to repair a depressed skull fracture and was released after a week in the hospital.

The trial court had dismissed the lawsuit, thinking that the plaintiff had not presented a **prima facie** case (enough evidence to win unless the defendant presents contradictory evidence). The Supreme Court of Oregon disagreed, stating, “We think the issue should have been submitted to the jury.”<sup>54</sup>

It is not hard to see why a jury could find that the defendant’s conduct was “outrageous” and thus an intentional tort.

**prima facie**  
containing  
enough evidence  
to win unless  
the defendant  
presents  
contradictory  
evidence

### Violation of Civil Rights

For 50 years now, courts have recognized causes of action for violations of patients’ civil rights. Violation of federal civil rights statutes—such as committing discrimination on the basis of race, religion, ethnicity, and other protected categories—is an obvious example.<sup>55</sup> Less apparent discrimination is shown in *Widgeon v. Eastern Shore Hospital Center*.<sup>56</sup> In this unusual case, the plaintiff was involuntarily committed to a Maryland hospital after an **ex parte hearing** (one in which only one party is present), in which the plaintiff’s wife testified that he had exhibited abnormal and violent behavior.

**ex parte hearing**  
hearing in which  
only one party is  
present

Two physicians examined the plaintiff on his arrival at the hospital, and although he showed no outward signs of mental illness, the doctors ordered that he be held at the hospital. The plaintiff maintained that his wife lied about his behavior because she wanted to be free to join her male friend in Florida. As soon as she met up with her “friend,” the hospital released the plaintiff. He promptly sued his wife, the physicians, and the hospital for violation of federal and state civil rights statutes, negligence, false imprisonment, false arrest, defamation, intentional infliction of emotional distress, and conspiracy to commit these wrongs. The court held that the complaint stated a valid cause of action under federal law and the Maryland Declaration of Rights: “That no man ought to be taken or imprisoned or disseized of

his freehold, liberties or privileges, or outlawed, or exiled, or, in any manner, destroyed, or deprived of his life, liberty or property, but by the judgment of his peers, or by the Law of the land.”<sup>57</sup>

## Summary

This chapter addresses the essential elements of a valid contract (competent parties, a “meeting of the minds,” consideration, legality of purpose) and the importance of contracts law in the relationships between patients and their physicians and between patients and hospitals. The chapter also briefly discusses issues relating to workers’ compensation and intentional tort, pointing out that both can affect doctor–patient and hospital–patient relationships.

## Discussion Questions

1. In *Oliver v. Brock*, what factors did the court consider most significant in determining whether Dr. Brock had a contractual relationship with Oliver?
2. Why are workers’ compensation benefits the sole remedies for workplace injuries of employees, as discussed in *Guy v. Arthur H. Thomas Co.* and *Suburban Hospital v. Kirson*? What is the “social contract” referred to in the latter opinion?
3. Explain why a case alleging a breach of contract, such as *Guilmet v. Campbell*, might be easier to prove than a standard case alleging negligence.
4. In what ways can intentional torts occur in the healthcare field?

## The Court Decides



***Stowers v. Wolodzko***  
**386 Mich. 119, 191 N.W.2d 355 (1971)**

**Swainson, J.**

*[In court opinions a jurist's position is often given by the addition of "J" or "CJ" behind the name. The initials stand for Judge or Justice, or Chief Judge or Chief Justice, depending on the title of the position in the particular jurisdiction. Members of the Michigan Supreme Court are known as "justices," thus the Stowers decision was written by Justice Swainson.]*

This case presents complicated issues concerning the liability of a doctor for actions taken subsequent to a person's confinement in a private mental hospital pursuant to a valid court order. . . .

Plaintiff, a housewife, resided in Livonia, Michigan, with her husband and children. She and her husband had been experiencing a great deal of marital difficulties and she testified that she had informed her husband . . . that she intended to file for a divorce.

On December 6, 1963, defendant appeared at plaintiff's home and introduced himself as "Dr. Wolodzko." Dr. Wolodzko had never met either plaintiff or her husband before he came to the house. He stated that he had been called by the husband, who had asked him to examine plaintiff. Plaintiff testified that defendant told her that he was there to ask about her husband's back. She testified that she told him to ask her husband, and that she had no further conversation with him or her husband. She testified that he never told her that he was a psychiatrist.

Dr. Wolodzko stated in his deposition . . . that he told plaintiff he was there to examine her. However, upon being questioned upon this point, he stated that he

could "not specifically" recollect having told plaintiff that he was there to examine her. He stated in his deposition that he was sure that the fact he was a psychiatrist would have come out, but that he couldn't remember if he had told plaintiff that he was a psychiatrist.

Plaintiff subsequently spoke to Dr. Wolodzko at the suggestion of a Livonia policewoman, following a domestic quarrel with her husband. He did inform her at that time that he was a psychiatrist.

On December 30, 1963, defendant Wolodzko and Dr. Anthony Smyk, apparently at the request of plaintiff's husband and without the authorization, knowledge, or consent of plaintiff, signed a sworn statement certifying that they had examined plaintiff and found her to be mentally ill. Such certificate was filed with the Wayne County Probate Court on January 3, 1964, and on the same date an order was entered by the probate court for the temporary hospitalization of plaintiff until a sanity hearing could be held. The Judge ordered plaintiff committed to Ardmore Acres, a privately operated institution, pursuant to the provisions of [Michigan law].

Plaintiff was transported to Ardmore Acres on January 4, 1964. . . .

. . .

The parties are in substantial agreement as to what occurred at Ardmore Acres. Defendant requested permission to treat the plaintiff on several different occasions, and she refused. For six days, she was placed in the "security room," which was a bare room except for the bed. The windows of the room were covered with wire mesh. During five of

*(continued)*



*(continued from previous page)*

the six days, plaintiff refused to eat, and at all times refused medication. Defendant telephoned orders to the hospital and prescribed certain medication. He visited her often during her stay.

When plaintiff arrived at the hospital she was refused permission to receive or place telephone calls, or to receive or write letters. Dr. Wolodzko conceded at the trial that plaintiff wished to contact her brother in Texas by telephone and that he forbade her to do so. After nine days, she was allowed to call her family, but no one else. Plaintiff testified on direct examination that once during her hospitalization she asked one of her children to call her relatives in Texas and that defendant took her to her room and told her, "Mrs. Stowers, don't try that again. If you do, you will never see your children again." It is undisputed that plaintiff repeatedly requested permission to call an attorney and that Dr. Wolodzko refused such permission.

At one point when plaintiff refused medication, on the written orders of defendant, she was held by three nurses and an attendant and was forcibly injected with the medication. Hospital personnel testified at the trial that the orders concerning medication and deprivation of communication were pursuant to defendant's instructions.

Plaintiff, by chance, found an unlocked telephone near the end of her hospitalization and made a call to her relatives in Texas. She was released by court order on January 27, 1964.

Plaintiff filed suit alleging false imprisonment, assault and battery, and malpractice, against defendant Wolodzko, Anthony Smyk and Ardmore Acres. Defendants Ardmore Acres and Smyk were dismissed prior to trial. At the close of plaintiff's proofs, defendant moved for a directed verdict. The court granted the motion as to the count of malpractice only, but allowed the counts of assault and battery and false imprisonment to go to the jury. At the Conclusion of the

trial, the jury returned a verdict for plaintiff in the sum of \$40,000. . . .

Defendant has raised five issues on appeal. . . .

. . .

The second issue involves whether or not there was evidence from which a jury could find false imprisonment.

"False imprisonment is the unlawful restraint of an individual's personal liberty or freedom of locomotion." [Citation omitted.] It is clear that plaintiff was restrained against her will. Defendant, however, contends that because the detention was pursuant to court order (and hence not unlawful), there can be no liability for false imprisonment. However, defendant was not found liable for admitting or keeping plaintiff in Ardmore Acres. His liability stems from the fact that after plaintiff was taken to Ardmore Acres, defendant held her incommunicado and prevented her from attempting to obtain her release, pursuant to law. Holding a person incommunicado is clearly a restraint of one's freedom, sufficient to allow a jury to find false imprisonment.

Defendant contends that it was proper for him to restrict plaintiff's communication with the outside world. Defendant's witness, Dr. Sidney Bolter, testified that orders restricting communications and visitors are customary in cases of this type. Hence, defendant contends these orders were lawful and could not constitute the basis for an action of false imprisonment. However, the testimony of Dr. Bolter is not conclusive on this point.

. . . Psychiatrists have a great deal of power over their patients. In the case of a person confined to an institution, this power is virtually unlimited. All professions (including the legal profession) contain unscrupulous individuals who use their position to injure others. The law must provide protection against the torts committed by these individuals. In the case of mental patients, in order to have this protection, they must be able to communicate with the outside world.





In our country, even a person who has committed the most abominable crime has the right to consult with an attorney.

Our Court and the courts of our sister States have recognized that interference with attempts of persons incarcerated to obtain their freedom may constitute false imprisonment. Further, we have jealously protected the individual's rights by providing that a circuit Judge "who willfully or corruptly refuses or neglects to consider an application, action, or motion for, habeas corpus is guilty of malfeasance in office." [Citation omitted.]

. . . [P]laintiff was . . . attempting to communicate with a lawyer or relative in order to obtain her release. Defendant prevented her from doing so. We . . . hold that the actions on the part of defendant constitute false imprisonment. . . .

A person temporarily committed to an institution pursuant to statute certainly must have the right to make telephone calls to an attorney or relatives. We realize that it may be necessary to restrict visits to a patient confined to a mental institution. However, the same does not apply to the right of a

patient to call an attorney or relative for aid in obtaining his release. This does not mean that an individual has an unlimited right to make numerous telephone calls, once he is confined pursuant to statute. Rather, it does mean that such an individual does have a right to communicate with an attorney and/or a relative in attempt to obtain his release.

Dr. Bolter was unable to give any valid reason why a person should not be allowed to consult with an attorney. We do not believe there is such a reason. While problems may be caused in a few cases because of this requirement, the facts in the instant case provide cogent reasons as to why such a rule is necessary. Mrs. Stowers was able to obtain her release after she made the telephone call to her relatives and they, in turn, obtained an attorney for her. Prior to this, because of the order of no communications, she was virtually held a prisoner with no chance of redress. We, therefore, agree with the Court of Appeals that there was sufficient evidence from which a jury could find that Dr. Wolodzko had committed false imprisonment.

The Court of Appeals is affirmed. ■

### Discussion Questions

1. Note that this case was decided in 1971 on facts that occurred in the early 1960s. The case may remind readers of the classic movie *One Flew Over the Cuckoo's Nest*. At the time, laws addressing involuntary psychiatric commitment were not common or were nonexistent in some jurisdictions. Research your state's standards for involuntary commitment and determine how these cases would be handled today.
2. What other information would you like to have to fully consider this case?
3. According to the opinion, Stowers was committed on the strength of the statement of two physicians that she was "mentally ill." What additional evidence would be sufficient today to have someone committed involuntarily? What would the evidence have to prove? Why?
4. What are the procedural steps to follow under the commitment laws of your state?



## Notes

1. Some physicians and hospitals believe they have full professional liability coverage under their malpractice insurance policies, but in fact they are covered only for negligent acts. For example, in *Security Ins. Group v. Wilkinson*, 297 So. 2d 113 (Fla. App. 1974), the court held that a hospital's professional liability policy did not cover a breach of contract to treat the plaintiff's wife.
2. Courts can and often do find legal duties where none existed previously. In *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976), the court found that a psychiatrist had a duty to warn the person whom the patient had threatened to kill, even though there was no relationship between the doctor and the threatened person and in spite of the fact that doctor-patient communications are normally confidential. This case is discussed further in chapter 9.
3. For example, in *Hurley v. Eddingsfield*, 156 Ind. 416, 59 N.E. 1058 (1901), the only physician available to aid a critically ill person refused to assist, for no apparent reason. The court stated that, unless some special contract or other commitment exists, physicians have no legal duty to treat people. Vermont and Minnesota have statutes that require a bystander to render aid in an emergency and provide a measure of immunity for doing so. See Vt. Stat. Ann. Tit. 12, § 519 (1968) and Minn. Stat. Ann. § 604A.01 (2010).
4. 440 S.W.2d 104 (Tex. Civ. App. 1969). This case is discussed in greater detail in chapter 10.
5. 342 So. 2d 1 (Ala. 1976).
6. *Id.* at 5.
7. AM. JUR. 2d, *Physicians, Surgeons, and Other Healers*, § 96.
8. ANGELA R. HOLDER, *MEDICAL MALPRACTICE LAW* at 6 (2nd ed. 1978).
9. 483 F. Supp. 581 (1980).
10. See, e.g., *Young v. St. Elizabeth Hosp.*, 131 Ill. App. 3d 193, 475 N.E.2d 603 (1985) (the plaintiff alleged negligent treatment of injuries sustained on the job; suit dismissed); *McAlister v. Methodist Hosp. of Memphis*, 550 S.W.2d 240 (Tenn. Sup. Ct. 1977) (a hospital employee alleged negligent treatment of work-related back injury).
11. 55 Ohio St. 2d 183, 378 N.E.2d 488 (1978).
12. 362 Md. 140, 763 A.2d 185 (2000).
13. 763 A.2d at 202.
14. *Id.* at 195-96.

15. *Id.* at 198.
16. 36 Cal. App. 2d 199, 97 P.2d 503 (1939).
17. 210 N.W.2d 576 (Iowa 1973). *See also* Kaiser v. Suburban Transp. Sys., 65 Wash. 2d 461, 398 P.2d 14 (1965), *amended by* 65 Wash. 2d 461, 401 P.2d 350 (1965) (passengers on a patient bus were allowed to recover damages from the defendant physician); Duvall v. Goldin, 139 Mich. App. 342, 362 N.W.2d 275 (1984) (physician owed a duty to third persons injured in an auto accident after the physician failed to warn his patient not to operate a motor vehicle).
18. *Supra* note 2. *See also* Davis v. Lhim, 124 Mich. App. 291, 335 N.W.2d 481 (1983) (a psychiatrist was held liable for discharging a patient who subsequently killed his mother and for failing to warn the patient's mother). *But see* Soto v. Frankford Hosp., 478 F. Supp. 1134 (E.D. Pa. 1979).
19. 751 F.2d 329 (10th Cir. 1984).
20. DAVID W. LOUISELL & HAROLD WILLIAMS, *MEDICAL MALPRACTICE* § 8.08 at 219 (1973).
21. 92 Ga. App. 727, 89 S.E.2d 809 (1955).
22. 370 S.W.2d 591 (Ky. 1963).
23. *Id.* at 596.
24. 131 Cal. App. 3d 38, 182 Cal Rptr. 225 (1982).
25. Cal. Health & Safety Code § 1317 (West 1979).
26. *See* Sallie T. Sanford, *What Scribner Wrought: How the Invention of Modern Dialysis Shaped Health Law and Policy*, 13 RICH. J. L. & PUB. INT. 337 (2010). A 2009 case involving Grady Memorial Hospital in Atlanta raises a larger issue in the context of undocumented immigrants with ESRD who are not eligible for Medicare or Medicaid and whose clinic at Grady had closed. *See* Kevin Sack, *Hospital Falters as Refuge for Illegal Immigrants* (published November 21, 2009), at <http://www.nytimes.com/2009/11/21/health/policy/21grady.html>.
27. 144 Cal. App. 3d 362, 192 Cal. Rptr. 650 (1983).
28. Cal. Civ. Code § 51.
29. 86 Cal. App. 3d 656, 150 Cal. Rptr. 384 (1978).
30. *Id.* at 672, 150 Cal. Rptr. at 394.
31. 388 F.2d 829 (1st Cir. 1968).
32. 349 Mich. 459, 84 N.W.2d 816 (1957).
33. 363 Mass. 579, 296 N.E.2d 183 (1973).
34. 385 Mich. 57, 68, 188 N.W.2d 601, 606 (1971).
35. Mich. Comp. Laws Ann. § 566.132(1)(g) (2009).

36. For the subject of torts generally, *see* RESTATEMENT (SECOND) OF TORTS. For intentional torts specifically, *see* RESTATEMENT §§ 13–62.
37. 123 So. 2d 766 (La. Ct. App. 1960).
38. 194 A.2d 307 (D.C. Ct. App. 1963).
39. 211 N.Y. 125, 105 N.E. 92 (1914).
40. *Perna v. Pirozzi*, 92 N.J. 446, 438, 457, A.2d 431, 461 (1983).  
Against the urologist, the plaintiff had a cause of action for breach of contract, breach of fiduciary duty, and malpractice.
41. *Id.* at 461, 457 A.2d at 439.
42. 95 Minn. 261, 104 N.W. 12 (1905).
43. 34 A.2d 626 (D.C. Mun. Ct. App. 1943).
44. *See generally* 53 C.J.S., Libel & Slander §§ 1–9.
45. 80 Cal. App. 2d 911, 916, 183 P.2d 318, 322 (1947).
46. 178 N.C. 589, 101 S.E. 99 (1919).
47. 386 Mich. 119, 191 N.W.2d 355 (1971). The court also held the psychiatrist liable for assault and battery for giving the patient involuntary medication beyond what was permitted by the statute.
48. 492 A.2d 580 (D.C. App. 1985). The department store was not liable because it had obtained assurances from the physician that the plaintiff had given her consent.
49. *Spring v. Geriatric Authority of Holyoke*, 394 Mass. 274, 475 N.E.2d 727 (1985).
50. 461 So. 2d 775 (Ala. 1984).
51. 151 W. Va. 977, 158 S.E.2d 159 (1967).
52. 259 Or. 54, 485 P.2d 28 (1971).
53. 259 Or. at 55, 485 P.2d at 29.
54. *Id.*
55. *See, e.g.*, *Washington v. Blampin*, 226 Cal. App. 2d 604, 38 Cal. Rptr. 235 (1964).
56. 479 A.2d 921 (Md. 1984).
57. MD. DECLARATION OF RIGHTS, ART. 24.