COMMONWEALTH OF MASSACHUSETTS

Supreme Judicial Court

No. SJC-10296

PLYMOUTH COUNTY

DEAN LEAVITT,
PLAINTIFF-APPELLANT,

v.

BROCKTON HOSPITAL, INC., SHEILA SMITH AND KAREN SULLIVAN
DEFENDANTS-APPELLEES.

APPEAL FROM A JUDGMENT OF DISMISSAL OF THE
PLYMOUTH SUPERIOR COURT

BRIEF OF AMICUS CURIAE MASSACHUSETTS DEFENSE LAWYERS ASSOCIATION

MICHAEL D. RISEBERG
BBO #567771
ADLER POLLOCK & SHEEHAN, P.C.
175 Federal Street
Boston, Massachusetts 02110
(617) 482-0600

CHAD P. BROUILLARD
BBO #657419
BLOOM & BUELL
175 Federal Street, 9th Floor
Boston, Massachusetts 02110-2245
(617) 482-5700

Dated: December 12, 2008

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES:

RULES AND REGULATIONS:

MISCELLANEOUS:

STATEMENT OF THE INTEREST OF THE AMICUS

The Massachusetts Defense Lawyers Association ("MDLA"), amicus curiae, is a voluntary, non-profit, state-wide professional association of trial lawyers who defend corporations, individuals and insurance companies in civil lawsuits. Members of the MDLA do not include attorneys who, for the most part, represent claimants in personal injury litigation. The purpose of the MDLA is to improve the administration of justice, legal education, and professional standards and to promote collegiality and civility among all members of the bar. As an association of civil defense lawyers, the MDLA has a direct interest in the issues of public importance that affect MDLA members and their clients. Those interests could be affected by the issue before the Court in this appeal, including the scope of the duty of care owed by healthcare providers to third-parties. The MDLA offers its experience and perspective to the Court as an amicus curiae to assist in its resolution of the matter now before it.

ISSUE PRESENTED

Whether a hospital and its employees, who, in disregard of accepted practices, discharged a sedated patient post-colonscopy without an adult escort, owed a duty of care to a police officer who was injured in an automobile accident while en route to aid the impaired patient who had been fatally injured in a separate pedestrian-automobile accident while walking home alone.

STATEMENT OF THE CASE

The MDLA adopts by reference the Statement of the Case contained in the Brief of the Plaintiff-Appellant at pp. 1-3.

SUMMARY OF ARGUMENT

The Court should hold that the duty imposed on a physician to a nonpatient third party based on the physician's duty to warn a patient, which this Court recognized in Coombes v. Florio, 450 Mass. 182 (2007), does not extend to a physician's decisions regarding the treatment of a patient; consequently the Court should hold that the defendant hospital and its employees (collectively the "Hospital") owed no duty to the plaintiff-nonpatient. See infra at 11-17.

In Coombes, this Court carved out a narrow exception to the general rule that a physician does not owe a duty to prevent harm to a nonpatient. See infra at 11. The Court held that a physician owes a duty to a nonpatient who is foreseeably harmed by the physician's failure to warn his patient. See infra at 12-13. This holding was expressly limited to a physician's duty to warn and did not extend to a physician's decisions regarding the treatment of a patient. See infra at 12-13.

Despite the disagreement among the Justices in Coombes, they all shared (to varying degrees) a concern that imposing third-party liability on a physician presents a danger to the autonomy of the physician-patient relationship. See infra at 13-15. Based on this concern, all of the Justices in Coombes evaluated whether imposing third-party liability on a physician based on his duty to warn conflicted with the paramount duty the physician owes to warn the patient. See infra at 15-16. The Justices who advocated to establish this new duty concluded that the conflict was minimal or did not exist; while the Justices who advocated against establishing this new duty believed that a significant conflict was created.

See infra at 15-16. The majority in Coombes reasoned that the new duty it was establishing imposed only a minimal danger to the physician-patient relationship because the decision was limited to a physician's duty to warn and did not extend to a physician's decisions regarding the treatment of a patient. See infra at 17-18.

The conflict of interest analysis underlying all of the opinions in Coombes appears to derive from this Court's holding in Spinner v. Nut, 417 Mass. 549 (1994), in which the Court held that it would not find that an attorney owed a duty to a nonclient, if it raised a potential conflict with the paramount duty the attorney owes to his client. See infra at 18-19.

The Court's conflicts analysis from Coombes and Spinner were recently applied by the trial court in Dahmer v. Satlow, in dismissing a negligence case brought by the wife of a patient against his psychologist; the Court reasoned that third-party liability could not be imposed on the psychologist because of the potential conflict between the interests of the patient and his wife. See infra at 19-21.

The present case falls outside the scope of Coombes because it arises from the Hospital's decisions regarding the treatment of the patient, as opposed to a duty to warn; the plaintiff's allegations make no reference to the Hospital's failure to warn and, instead, are confined to the allegation that the Hospital improperly discharged the patient without an escort while he was still sedated from a recent surgical procedure. See infra at 21-22.

The Court should not expand the duty it established in Coombes by imposing on medical providers a duty to protect a nonpatient third party from a medical provider's decisions regarding the treatment of a patient. See infra at 22-23. Such a rule would increase health care costs. See infra at 22-23. Moreover, establishing this duty would pose dangerous consequences for the physician-patient relationship, as it would likely alter the decisions a physician makes about the treatment of a patient. See infra at 23-25. By holding that third-party liability will not be imposed over a physician's treatment decisions, the Court would provide clear guidance to the trial courts; this would prevent trial courts from having to define the parameters of when a

physician could be held liable to a third-party. See infra at 25.

If the Court were to hold that it is not willing to impose third-party liability arising from a physician's treatment decisions, it would provide helpful guidance to the trial courts, and prevent them from being in the difficult position of having to determine the parameters of a physician's potential liability to nonpatient third-parties. See infra at 25.

Nor should the Court expand a medical provider's potential liability to nonpatient third parties by recognizing a special relationship between a physician and a patient. See infra at 26-38. Special relationship is an exception to the general rule that a party does not owe an affirmative duty to others to take action to rescue or protect them from conditions the party did not create. See infra at 26-27. An affirmative duty is required to hold a party liable for an omission or failure to act. In this case the Court should not even reach a special relationship analysis because the plaintiff seeks to hold the Hospital liable for an affirmative act, not a failure to act. See infra at 27-28.

If the Court concludes that an affirmative duty analysis is warranted here, it should hold that it is not willing to recognize that a special relationship exists between a physician and a patient, at least as a means of imposing on the physician a duty to prevent the patient from harming another. See infra at 32-34. Massachusetts has recognized special relationships in certain specific types of cases, but has never recognized that a special relationship, as discussed here, exists between a physician and a patient. See infra at 28-32. The physician-patient relationship lacks the element of control necessary to characterize it as a special relationship. See infra at 34-37.

ARGUMENT

I. THE COURT SHOULD HOLD THAT THE DUTY A PHYSICIAN OWES TO A NONPATIENT THIRD PARTY BASED ON THE PHYSICIAN'S DUTY TO WARN A PATIENT, WHICH THIS COURT RECENTLY ESTABLISHED IN COOMBES V. FLORIO, DOES NOT EXTEND TO A PHYSICIAN'S DECISIONS REGARDING THE TREATMENT OF A PATIENT; THE COURT, THEREFORE, SHOULD AFFIRM THE GRANT OF SUMMARY JUDGMENT FOR THE HOSPITAL AND ITS EMPLOYEES AS THEY OWED NO DUTY TO THE NON-PATIENT PLAINTIFF ARISING FROM THEIR TREATMENT DECISIONS CONCERNING THE MANNER IN WHICH THEY DISCHARGED THEIR PATIENT

A. Standard of Review

"In determining the appropriateness of a judgment dismissing a complaint, [the court] accepts as true all of the allegations of the complaint and all

reasonable inferences which may be drawn from the complaint and which are favorable to the party whose claims have been dismissed... Further a motion to dismiss a complaint ... should not be allowed unless it appears certain that the complaining party is not entitled to relief under any state of facts which could be proved in support of the claim.' Rae v. Air-Speed, Inc., 386 Mass. 187, 191 (1982)." Harvard Law School Coalition for Civil Rights v. President and Fellows of Harvard College, 413 Mass. 66, 68 (1992).

This Court recently addressed the standard of review for a motion to dismiss, and adopted the refined language set forth in the United States Supreme Court's decision in Bell Atlantic Corp. v. Twombly, 127 S.Ct. 1955 (2007), which states: "While a complaint attacked by a ... motion to dismiss does not need detailed factual allegations ... a plaintiff's obligation to provide the grounds of his entitle[ment] to relief requires more than labels and conclusions.... Factual allegations must be enough to raise a right to relief above the speculative level ... [based] on the assumption that all the allegations in the complaint are true (even if doubtful in fact)...." Iannacchino v. Ford Motor Co., 451 Mass.

623, 636 (2008), quoting Bell Atl. Corp., 127 S.Ct. 1955, 1964-1965 (internal quotations omitted). At the pleading stage, the plaintiff must present "factual allegations plausibly suggesting (not merely consistent with) an entitlement to relief, in order to reflect[ ] the threshold requirement of [Fed.R.Civ.P.] 8(a)(2) that the plain statement possess enough heft to sho[w] that the pleader is entitled to relief." Iannacchino, 451 Mass. at 636, quoting Bell Atl. Corp., 127 S.Ct. at 1966 (internal quotations omitted).

B. Duty of Care

To prevail on a negligence claim, a plaintiff must prove that the defendant owed the plaintiff a duty of reasonable care, that the defendant breached this duty, that damage resulted, and that there was a causal relation between the breach of the duty and the damage. Jupin v. Kask, 447 Mass. 141, 146 (2006). The existence of a legally recognized duty of care is a question of law for the court to decide, Wallace v. Wilson, 411 Mass. 8, 12 (1991); Peters v. Haymarket Leasing, Inc., 64 Mass.App.Ct. 767, 775 (2005), and the appropriate subject of a motion to dismiss for failure to state a claim pursuant to Rule 12(b)(6) of

the Massachusetts Rules of Civil Procedure. O'Meara v. New England Life Flight, Inc., 65 Mass.App.Ct. 543, 544 (2006). See Remy v. MacDonald, 440 Mass. 675, 677 (2004)("if not such duty exists, a claim for negligence cannot be brought").

The court determines whether a duty exists by referring to "existing social values and customs, as well as to appropriate social policy." Davis v. Westwood Group, 420 Mass. 739, 743 (1995).

> The concept of "duty" ... is not sacrosanct in itself, but is only an expression of the sum total of ... considerations of policy which lead the law to say that he plaintiff is entitled to protection... No better general statement can be made than that the courts will find a duty where, in general, reasonable persons would recognize it and agree that it exists.

Luoni v. Berube, 431 Mass. 729, 735 (2000), quoting W.L. PROSSER & W.P. KEETON, TORTS § 53, at 358-359 (5th ed. 1984); see also Cremins v. Clancy, 415 Mass. 289, 292 (1993). As a general principle of law, every person has a duty to exercise reasonable care to avoid harming others. Jupin v. Kask, 447 Mass. 141, 147 (2006). A duty of care is imposed when the risk of harm is recognizable or foreseeable to the actor. Id. Otherwise stated, "to the extent a legal standard does exist for determining the existence of a tort duty

..., it is a test of the reasonable foreseeability of the harm." Id. at 148 (internal quotation and citation omitted).

In the medical malpractice context, it was generally recognized in the Commonwealth that a physician's duty of care ran only to those with whom he had a physician-patient relationship. St. Germain v. Pfeifer, 418 Mass. 511, 520 (1994); see Restatement (Third) of Torts § 41 cmt. h (Proposed Final Draft No. 1 (2008))("Unlike most duties, the physician's duty to the patient is explicitly relational: Physicians owe a duty of care to *patients*.")(emphasis in original). The existence of a physician-patient relationship, therefore, is generally an element of a medical-malpractice case. Kapp v. Ballantine, 380 Mass. 186, 193 (1980); Santos v. Kim, 429 Mass. 130, 134-135 (1999). In Coombes v. Florio, 450 Mass. 182, 190 (2007), this Court carved out a narrow exception to the general rule that a physician does not owe a duty to prevent harm to a nonpatient.

C. This Court's Decision in Coombes v. Florio

The plaintiff in Coombes was the mother and administratrix of a ten-year old boy, who was killed

when he was struck by a car driven by a patient of the defendant, Dr. Robert Florio. Id. at 183-186. The plaintiff alleged that the physician had prescribed the patient medications that caused drowsiness, dizziness, lightheadedness, fainting, altered consciousness, and sedation; that he had failed to warn the patient of these side effects; and that this failure was a proximate cause of the accident. The doctor last saw the patient two and a half months before the accident. Id. The trial court granted summary judgment for Dr. Florio on the ground that a physician owes no duty of care to anyone other than his patient. This Court, in an especially divided decision, reversed the grant of summary judgment for Dr. Florio.

The Court in Coombes held that a physician owes a duty of care to third-party nonpatients who are foreseeably put at risk by the physician's *failure to warn* a patient about the effects of prescription medications or treatment. Id. Importantly, while liability to a nonpatient third-party was found based on a physician's duty to warn a patient about the effects of his treatment, it did not extend to the physician's "very decision of what medication to

prescribe or what treatment to pursue." Id. at 191-192. Although the Court's holding in Coombes established "for the first time in this Commmonwealth a physician's duty to prevent harm to nonpatients," it was expressly limited to the physician's duty to warn. Id. at 201 (Marshall, CJ., dissenting). Justice Ireland wrote the opinion for the majority, which was joined by Justices Spina and Cowin. Justice Greaney agreed with the decision to reverse the grant of summary judgment for the physician, but disagreed with the broad scope of the duty established by the majority.[1] Chief Justice Marshall and Justice Cordy authored dissenting opinions expressing their view that a physician owes no duty to a nonpatient arising from the treatment of a patient. Id. at 202, 206-207.

Despite this disagreement, all of the Justices in Coombes shared (to varying degrees) a concern that imposing on a physician a duty to nonpatient litigants presents the danger of impinging on the autonomy of the physician-patient relationship. This concern was

---

[1] Justice Greaney believed that a physician's duty should extend to a nonpatient foreseeably harmed by a physician's failure to warn a patient about the risks of operating a motor vehicle while under the influence of a prescription medication. Id. at 196 (Greaney, J., concurring in part and dissenting in part).

voiced perhaps most strongly by Justice Cordy, who, in criticizing the new duty created by the majority, wrote:

> It would alter a physician's affirmative duty to care for his patient by introducing a new audience to which the physician must attend - everyone who might come in contact with the patient.

Id. at 207 (Cordy, J., dissenting). Similarly, Chief Justice Marshall in expressing her objection to the duty established by the majority, observed:

> The physician's concern for a patient's ability to assess information about needed and appropriate treatment would be forced to compete with concern for an amorphous, but widespread, group of third parties whom a jury might one day determine to be "foreseeable" plaintiffs. The physician would be forever looking over his shoulder.

Id. at 203. Justice Greaney, in advocating for a narrower duty than the majority, stated:

> A physician should not, in ordinary circumstances, be held legally responsible for the safety of others on the highway, or elsewhere, based on the medical treatment afforded a patient. To a physician, it is the patient (not a third party with whom the physician has no direct contact) who must always come first.

Id. at 197. Finally, Justice Ireland recognized in the majority opinion the "harmful consequences" that would result from a rule that "could create a fear of litigation that would intrude into a doctor's very

decision of what medication to prescribe or what treatment to pursue." Id. at 191-192.

Based on this concern for the autonomy of the physician-patient relationship, all of the Justices in Coombes examined whether imposing a duty to nonpatients in the context of the plaintiff's case would conflict with the paramount duty the physician owes to his patient. In performing this analysis, both Justice Ireland and Justice Greaney concluded that the duty they each proposed would not impose a heavy cost on the physician-patient relationship, because existing tort law already imposed on a doctor a duty to warn a patient of the adverse side effects of medications. Id. at 191, 198 citing Cottam v. CVS Pharmacy, 436 Mass. 316, 321 (2002). Accordingly, Justice Ireland wrote that the duty would require "nothing from a doctor that [was] not already required by his duty to his patient." Id. at 191. Justice Ireland and Justice Greaney also shared the view that a duty to nonpatients was warranted, in part, because it served to protect the patient and the nonpatient from the same harm, the foreseeable risk that side effects of a drug would impair the patient's ability to drive. Id. at 191, 198-199. Thus, the Justices

who elected to extend a physician's duty to warn to nonpatients concluded that the duty they established would not conflict with the paramount duty that the physician owes to the patient and it would not alter the physician's decisions with respect to the patient.

In contrast, Chief Justice Marshall and Justice Cordy advocated against establishing a duty to third parties based, in a large part, on their belief that it would alter a physician's decisions within the physician-patient relationship. Id. at 203-205, 211-212. These Justices observed that extending liability to nonpatients based on a physician's duty to warn would alter the substance and extent of the warnings that a physician would otherwise provide to a patient. Id. at 203-205, 211-212. The Justices reasoned that to protect themselves from possible third-party lawsuits, physicians would inundate patients with excessive and unnecessary warnings. And these would replace the more meaningful warnings that physicians give to patients based on the physician's professional judgment regarding what information is in the best interest of the patient given the patient's particular circumstances. Id.

Importantly, although the majority in Coombes was willing to impose a duty to third-parties based on a physician's duty to warn, Justice Ireland stated that the Court might not be willing to do so based on a physician's "very decision of what medication to prescribe or what treatment to pursue." Id. at 191-192. Justice Ireland recognized that the intrusion on the doctor-patient relationship was more limited based on a doctor's duty to warn than it would be with respect to a doctor's treatment decisions. Id. A doctor's duty to warn, according to Justice Ireland, "is narrower than a doctor's duty to use due care when deciding to prescribe a particular drug or pursue a particular course of treatment." Id.; see also Restatement (Third) of Torts: Liability for Physical Harm, § 41 comment h (Proposed Final Draft No. 1, 2008) (duty to warn is "more limited" than duty to use reasonable care). Accordingly, Justice Ireland stated that he did not "need to address whether a nonpatient could base a negligence claim on a doctor's negligent prescribing decision, although [he] recognize[d] that protecting the doctor-patient relationship may provide a sound policy reason for limiting such a duty to the patient." Id. citing McKenzie v. Hawai'i Permanente

Med. Group, Inc., 98 Haw. 296, 307-309, 47 P.3d 1209 (2002); Burroughs v. Magee, 118 S.W.3d 323, 331 (Tenn. 2003).

D. The Conflict of Interest Analysis Underlying Coombes

The conflict of interest analysis that underlies all of the opinions in Coombes appears to derive from this Court's reasoning in Spinner v. Nutt, 417 Mass. 549 (1994). See Coombes, 450 Mass. at 198 (Greaney, J., concurring in part and dissenting in part)(applying Spinner). In Spinner this Court held that an attorney did not owe a duty of care to a nonclient where it potentially conflicted with the paramount duty the attorney owed to his client. Id. at 544-545. The plaintiffs in Spinner were the beneficiaries of a trust who brought a negligence claim against the attorney for the trustees. The Court noted that the interests of beneficiaries and trustees generally present a potential for conflict. The Court, therefore, concluded that if it were to find that the attorney owed a duty to both the trustees and the beneficiaries, "conflicting loyalties could impermissibly interfere with the attorney's task of advising the trustee." Id. at 554. Importantly,

the Court reasoned that it is the potential for conflict, and not necessarily an actual conflict, that prevents the imposition of a duty on attorneys to non-clients. Spinner, at 554 citing DaRoza v. Arter, 416 Mass. 337, 383-384 (1993); Robertson v. Gatson Snow & Ely Bartlett, 404 Mass. 515, 524 (1989); Page v. Frazier, 388 Mass. 55, 65 (1983). This Court in Spinner reasoned, therefore, that "an isolated instance of identity of interests between the trustees and the beneficiaries would not support the imposition of a duty" on the trustee's attorney to the beneficiaries. Spinner, 417 Mass. at 554.

E. The Trial Court's Application of Coombes in Dhamer v. Satlow

The conflict of interest analysis from Spinner and Coombes was recently applied by the Superior Court in dismissing a negligence case brought by a wife against her husband's psychologist. Dahmer v. Satlow, 23 Mass.L.Rptr. 373, 2007 WL 4510212 (Mass.Super. December 19, 2007)(Billings, J.). The plaintiff alleged that the psychologist's improper counseling of the plaintiff's husband, which was supposed to strengthen and preserve their marriage, caused it to fail. Applying this Court's reasoning in Coombes and

Spinner, Judge Billings concluded that the psychologist owed no duty of care to the patient's spouse, because it would have raised a potential conflict with the psychologist's paramount duty to the patient. Judge Billings reasoned that the case before him posed what the "Coombes case, as the majority saw it, did not": a real possibility that if the plaintiff's claim were allowed to proceed, the psychologist would find herself subject to conflicting duties, to her patient on the one hand and to his spouse on the other. Judge Billings reasoned that while the husband and wife may, in fact, have shared an interest in preserving their marriage, he could not rule out the possibility that the patient's needs might conflict with the goal of saving the marriage. The Judge noted, for example, that if the relationship was abusive (though he saw no evidence of that in the case), it seemed at least conceivable that a responsible psychologist might discuss with her patient the possibility of leaving the marriage. Applying this Court's holding in Spinner, Judge Billings held that it was the potential for conflicting duties, regardless of whether an actual

conflict existed, that required him to conclude that the psychologist owed no duty to her patient's spouse.

F. This Case Falls Outside Coombes Because It Is Based On The Hospital's Treatment Decision, Not A Duty To Warn

Unlike Coombes, which was based on a doctor's failure to warn, the plaintiff here seeks to impose a duty on the Hospital based on its decisions regarding the treatment of its patient. The plaintiff claims the Hospital was negligent for discharging the Patient post-colonscopy without an escort, while he was still under the effects of the drugs he was administered. The plaintiff claims that the Hospital knew these drugs caused tiredness, weakness, problems with coordination, and an inability to think clearly. The plaintiff claims that sound medical practice required the Hospital not to discharge him without an escort to ensure he would not have to drive or otherwise get himself home while under the influence of these drugs. Nowhere does the plaintiff allege that the Hospital was negligent for failing to warn the Patient about the side effects of the drugs or of the danger of proceeding home without an escort, or failing to provide any other warning. Shortly after being

discharged, the Patient was struck and killed by a car on the side of the road while he was walking home from the Hospital. The plaintiff was an active-duty police officer who was responding to the accident involving the Patient when he was struck by a negligently driven vehicle.

G. The Court Should Not Impose On Medical Providers A Duty to Protect Nonpatient Third Parties From A Medical Provider's Decisions Regarding the Treatment of a Patient

If the plaintiff's claim were allowed to proceed, it would broaden the scope of potential tort liability for medical professionals in Massachusetts. It would be the first time this Court has recognized that a medical provider owes a duty to a nonpatient third-party arising out of the medical provider's decisions regarding the treatment of a patient. Accordingly, it would expand the scope of potential tort liability for medical providers beyond the duty to warn that this Court established in Coombes. Sound policy would not be advanced by imposing on physicians such an expanded duty of care. Such an expansion would increase health care costs by expanding the potential liability of physicians. Increased medical malpractice payments

drive up malpractice premiums, which in turn increases health care costs to patients.

Moreover, this expansion of physician liability is unwarranted because of the danger it poses to the physician-patient relationship. As the Court acknowledged in Coombes, these harmful consequences are greater when the intrusion is upon the doctor's "very decision of what medication to prescribe or what treatment to pursue," as opposed to the duty to warn. Coombes, 450 Mass. at 192-193.[2] Individual treatment decisions are best left to patients and their physicians, where the "doctor's concern is focused

[2] The plaintiff contends that this case presents a much easier liability question than Coombes, because there liability arose from a patient taking prescription medication at a remote time and place (more than two months after last seeing the doctor). Here, the plaintiff argues that the patient's accident occurred shortly after he was discharged from the hospital and while he was still sedated. The plaintiff relies on Justice Cordy's dissent in Coombes to argue that the duty here "rests squarely on the present control" the hospital had over its patient. Coombes, 450 Mass. at 213 n.6 (Cordy, J., dissenting). Importantly, however, the critical distinction between this case and Coombes, is not the proximity in time or place between the alleged negligence and the accident, but the fact that Coombes involved a medical provider's duty to warn, while this case involves a medical provider's treatment decisions. Notably, the cases that Justice Cordy was distinguishing on the control issue were duty to warn cases. Id. (discussing Hardee v. Bio-Med Applications of S.C., Inc., 370 S.C. 511, 516 (2006); Joy v. Eastern Me. Med. Ctr., 529 A.2d 1364 (Me. 1987)).

solely on what, in his or her judgment, the patient's own situation requires." Coombes, 450 Mass. at 211 (Cordy, J., dissenting). Treatment decisions "must take into account complicated issues concerning the potential benefits and risks to individual patients." McKenzie v. Hawai'i Permanente Medical Group, Inc., 47 P.3d 1209, 1216 (Hawai'i 2002). With the imposition of potential third-party liability, a physician may understandably make decisions, at times, that are not based on the best interest of the patient, but the physician's concern with protecting himself from potential liability to nonpatient third-parties. For example, where a physician might otherwise discharge a patient believing it is in the patient's best interests, a concern for potential third-party liability may lead the physician to delay the discharge. Delayed discharges also increase health care costs. Likewise, an expansion of liability may discourage a physician from prescribing certain medications because of a risk of a side effect, such as a seizure or other behavioral effects. Potential third-party liability could also alter a physician's willingness to encourage a person with a disability to play sports or return to work. It could also lead

physicians to practice defensive medicine, ordering tests or procedures that are medically unnecessary, not out of a concern for the patient, but to protect themselves from potential third-party liability.

Additionally, if the Court were to hold that third-party liability cannot be imposed over a medical provider's treatment decisions, this would provide needed guidance to the trial court. This would prevent trial court judges, such as Judge Billings in Dahmer, from having to undertake a conflicts analysis to determine whether the plaintiff's claim should be allowed to proceed. Although Judge Billings reached the correct result, a conflicts of interest analysis is not a science, and it is likely that judges will reach different outcomes on whether to allow a plaintiff's claim to proceed. In the absence of a clear rule, trial judges are left the difficult task of trying to identify the outer limits of this novel duty that a medical provider may owe to a nonpatient third-party. Coombes, 450 Mass. at 206 (Marshall, CJ., dissenting). The Court, therefore, should decline the plaintiff's request to expand the scope of potential tort liability of medical providers in the Commonwealth.

II. THE COURT SHOULD NOT EXPAND A MEDICAL PROVIDER'S POTENTIAL LIABILITY TO NONPATIENT THIRD PARTIES BY RECOGNIZING A SPECIAL RELATIONSHIP BETWEEN A PHYSICIAN AND A PATIENT

A. A MEDICAL PROVIDER DOES NOT OWE AN AFFIRMATIVE DUTY TO THIRD PARTIES WHEN DISCHARGING A PATIENT

1. Plaintiff Alleges a Negligent Act, Not That the Hospital Failed to Act, So No Affirmative Duty Exists

The special relationship doctrine, which is discussed further below, is an exception to the general rule that parties "do not owe others a duty to take action to rescue or protect them from conditions [the parties] have not created." Cremins v. Clancy, 415 Mass. 289, 296-97 (1993) (Greaney, J., concurring). See Kavanagh v. Trustees of Boston Univ., 440 Mass. 195, 202-203(2003); see also, Restatement (Second) of Torts § 314 (1965) ("The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action.") While everyone has a duty to act reasonably, an affirmative duty is required to hold one liable for their omission or failure to act. See, e.g., Restatement (Second) of Torts § 314, note (c) ("The origin of the [affirmative duty] rule lay in

the early common law distinction between action and inaction, or "misfeasance" and "non-feasance."). In addressing the plaintiff's special relationship argument in Coombes, Justice Ireland reasoned that the Court did not need to "resort to imposing" an affirmative duty on the physician, as the plaintiff's case was based on the physician's own act of prescribing the medication (as opposed to a failure to act) and the accompanying duty to warn. 450 Mass. at 194 citing McKenzie, 98 Haw. at 299-300 (special relationship argument inapplicable where defendant's own act created foreseeable risk).

Applying this reasoning here, the Court should find that a special-relationship analysis is not warranted here because this is not a case in which an affirmative duty is at issue. Like the physician's decision to prescribe medications at issue in Coombes, the plaintiff's negligence claim here is based on the Hospital's act in the way it discharged the patient, not a failure to act. Coombes, 450 Mass. at 187, 193-196. Even the plaintiff's allegation that the Hospital "failed to provide an escort" refers to the manner in which the hospital carried out the act of discharging the patient. Therefore, a special

relationship analysis is not warranted here. Nevertheless, if the Court somehow concludes that an affirmative duty should be considered, the Court should hold that a special relationship does not exist between a physician and a patient for the purpose of holding a physician liable to a nonpatient third party.

B. THE PHYSICIAN-PATIENT RELATIONSHIP LACKS THE ELEMENT OF CONTROL NEEDED TO CONSIDER IT A SPECIAL RELATIONSHIP FOR THE PURPOSE OF IMPOSING THIRD PARTY LIABILITY ON THE PHYSICIAN

1. Special Relationships Recognized in Massachusetts

In accord with the Restatement Second of Torts § 315 (1965), this Court has recognized a "special relationship" exception to the general rule that actors do not owe third parties an affirmative duty. "There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another unless ... a special relationship exists between the actor or the third person which imposes a duty upon the actor to control the third person's conduct..." See Coombes, at 193-196 (2007); Kavanagh at 202-203; Luoni at 731 (2000). See generally, Restatement (Third) of Torts: Liab. Physical Harm § 41

(P.F.D. No. 1, 2005).[3] This Court has recognized that a special relationship exists in several categories of cases.

First, this Court has recognized a special relationship when a statute creates an affirmative duty of care to foreseeable third persons as contemplated in the liquor liability cases. Adamian v. Three Sons Inc., 353 Mass. 498 (1968) (bar owner held liable to those injured by intoxicated patron.) Physicians do not have a statutory duty to the general public in discharging a patient so this exclusion does not apply in this case. Second, this Court has recognized a special relationship when the defendant

---

[3] The Restatement draft, in relevant part, provides:

> (a) An actor in a special relationship with another owes a duty of reasonable care to third persons with regard to risks posed by the other that arise within the scope of the relationship.
>
> (b) Special relationships giving rise to the duty provided in Subsection (a) include:
>
> (1) a parent with dependent children,
> (2) a custodian with those in its custody,
> (3) an employer with employees when the employment facilitates the employee's causing harm to third parties, and
> (4) a mental-health professional with patients.

Restatement (Third) of Torts: Liab. Physical Harm, § 41 (P.F.D. No. 1, 2005).

owes a duty to an identifiable limited class of persons that includes the plaintiff, then the defendant may owe a duty to the plaintiff to protect him from the dangerous or unlawful acts of a third person. See Mullins v. Pine Manor College, 389 Mass. 47 (1983) (holding a college owes a duty to its students to take reasonable steps to protect them from harm from foreseeable criminal acts). Here, the Hospital had no preexisting relationship with an identifiable class of persons like students on a campus, so this exception does not apply. Third, this Court has recognized "special relationships" where one party has control over another's conduct (discussed in detail below.) The Court has recognized a special relationship based on the element of control in certain specific types of relationships, including a parent and child, a landowner and licensee, a police officer and prisoner, and a parole officer and parolee. See Irwin v. Ware, 392 Mass. 745 (1984) (special relationship when police released intoxicated motorist into driver); Jean W. v. Commonwealth, 414 Mass. 496 (1993) (special relationship between parole officer and parolee). See generally, Coombes v.

Florio, at 193-196 (2007); Restatement (Second) of Torts § 316-318.

One Massachusetts trial court has also recognized an important sub-category of special relationships that exist between a mental-healthcare provider and patient while the patient is in that provider's custody. See Carr v. Howard, 5 Mass. L. Rep. 63, 1996 Mass.Super. LEXIS 602 (Norfolk Super. Ct.1996) (J. Cowin) (holding a special relationship between psychiatrist and a psychiatric hospital that have custody over patients who are dangerous to themselves and others). Plaintiff cites to Carr v. Howard, to support the proposition that regular healthcare providers have a special relationship with their patients. The instant case can be immediately distinguished from Carr which involved mental health professionals who had actual custody of a committed patient with dangerous propensities. The plaintiff in Carr had a stronger claim given that the mental health professionals were authorized to exert physical control over a committed patient. This holding is in accord with the analysis found within the Restatement (Third) of Torts: Liab. Physical Harm § 41, Comments (g)-(h), which suggests that a black letter special

relationship should be specifically recognized for mental healthcare providers, but notably not extended to regular healthcare providers.

2. Massachusetts Has Not Recognized a Special Relationship Between a Medical Provider and Patient

This Court has not recognized that a "special relationship" exists between a medical provider and a patient. See Coombes at 193-196. Plaintiff is asking this Court to expand the law on special relationships to include the physician-patient relationship. Such an expansion is not warranted.

In Coombes, the plaintiff argued a special relationship existed and yet Justice Ireland explicitly concluded that a special relationship theory did not apply. Justice Ireland's reasoning was based on his conclusion that the case lacked an affirmative duty theory, and so could be resolved strictly under general negligence principles regarding the duty to warn. Id. at 187, 193-195. ("The plaintiff's special relationship and assumed duty theories are inapplicable in this case.") Admittedly, in his concurring opinion, Justice Greaney did believe there was a narrow special relationship for the "duty

to warn" only. "In the usual case, so long as a physician provides his patient with an appropriate warning (cautioning the patient about the possible danger of driving) the applicable standard of care has been met, and a physician has no further duty." Coombes at 197-198. None of the other justices found a special relationship in Coombes. Even Justice Greaney reasoned, however, that the limited special relationship he proposed would not extend beyond a physician's duty to warn because of the physician's lack of control over the patient.[4] In making this distinction, Justice Greaney wrote:

---

[4] Plaintiff refers to a Superior Court decision, Arsenault v. McConarty, 21 Mass. L. Rep. 500; 2006 Mass. Super. LEXIS 454 (2006), as persuasive grounds for recognizing a special relationship between health providers and patient on the basis of control. The Arsenault case however specifically dealt with a physician's failure to warn about the effects of medication and cannot be distinguished from Coombes. Judge Agnes reasoning follows Justice Greaney in Coombes regarding the limited special relationship created by the duty to warn:

> "This court fully appreciates that doctors cannot be insurers of highway safety, and that there is no basis in our existing social values, customs, and considerations of public policy to impose such an unreasonable burden on physicians. Rather, in a case like this, as long as a physician provides his patient with an appropriate warning in accordance with the applicable standard of care, the doctor's duty to the

> A physician's advice may not be followed, of course, and a physician has no ability physically to prevent a patient from driving (or engaging in any behavior) once that patient departs from the physician's office ... By informing (or otherwise counseling or advising) a patient of known potential side effects of prescribed medications that might affect the patient's ability to drive a motor vehicle safely, and where appropriate, warning the patient not to drive at all, a physician may effectively avoid any risk of danger to the patient and others."

Coombes at 199-200. This Court should likewise decline to find a broad special relationship between a medical provider and patient based on the medical provider's decisions regarding the treatment of the patient.

3. A Physician Does Not Control the Patient

Unlike a parent or police officer, a healthcare provider does not exert control over a patient's conduct. Id. See Restatement (Third) of Torts: Liab. Physical Harm § 41 ("Patients who are not in custody cannot be "controlled" in the classic sense, and the duty imposed is only one of reasonable care.") Comment (g). The physician-patient relationship lacks the

---

> public, including any injured third party such as the plaintiff in this case, would be discharged."

Id.

element of control necessary to be considered a special relationship.

First, a physician-patient relationship does not entail reciprocating obligations. The physician is under an exclusive duty to the patient to provide sound medical advice and treatment; the patient is under no obligation to follow that advice. Consequently, the patient is unlike the motorist pulled over by the police officer, or the parent and child. Whatever advice a physician provides to a patient, the patient is free to ignore. Therefore without any obligation to adhere to the advice given, the control required for the imposition of a special relationship is lacking.

Indeed, the "informed consent" laws are designed to put the patient in a position to make their *own* medical decisions. The physician's judgment does not typically substitute for the patients where patient risk is involved. The physician normally owes the patient a duty to explain the necessary medical facts so the patient can make informed treatment decisions with an appreciation for foreseeable risks. Harnish v. Children's Hosp. Medical Center, 387 Mass. 152 (1982); ("Every competent adult has a right "to forego

treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession.") (quoting Wilkinson v. Vesey, 110 R.I. 606, 624, 295 A.2d 676 (1972)); See also, Lubanes v. George, 386 Mass. 320, 325(1982). Thus a physician cannot be said to normally exert the same kind of direct control we recognize in special relationships.

The clearest example of a physician's lack of control over the patient has to be that a physician lacks the ability to exert physical control over a patient. Patients in the modern healthcare setting have rights which protect them from physical or chemical control exerted by their providers. During treatment, healthcare providers only take physical custody of their patients in heavily regulated circumstances that invoke the immediate physical safety of the patient or when the patient has been deemed incompetent.[5] If a competent, adult patient chooses to disregard warnings or instructions, physicians usually do not have recourse to correct the

[5] "Restraint or seclusion may only be imposed to ensure the *immediate physical safety* of the patient, a staff member, or others and must be discontinued at the earliest possible time." 42 C.F.R. § 482.13 (e) (emphasis added).

patient's conduct the way a parent or police officer might. As a result, a healthcare provider may give warnings, recommendations and instructions to a patient, but cannot otherwise directly control the patient's conduct. Consequently, the relationship between a medical provider and a patient lacks the element of control necessary to consider it a special relationship for the purpose of imposing potential third-party liability on the medical provider.

4. Extending the special relationship doctrine to the physician-patient relationship for the purpose of imposing potential third party liability on a physician would be contrary to sound public policy

The Court should not expand the potential tort liability of medical providers by finding that a special relationship exists between a medical provider and a patient. If medical providers were deemed to have a "special relationship" towards their patients during discharge, they would be under an affirmative legal obligation to exert control of their patient's conduct for the benefit of third parties. See Coombes at 193-196, 2007); Kavanagh at 202-203. For the reasons discussed earlier, imposing such a duty on a medical provider would place it in the untenable

position of having potentially conflicting duties, to the patient on the one hand and nonpatient third parties on the other. Such an expansion of a medical provider's potential tort liability is unwarranted as it would increase health care costs and intrude dangerously, and in unprecedented fashion, on the autonomy of the physician-patient relationship.

CONCLUSION

For the foregoing reasons, the Court should hold that a medical provider's potential liability to a nonpatient third-party is limited to the medical provider's duty to warn a patient, and does not extend to the medical provider's decisions regarding the treatment of a patient. Likewise, the Court should not expand a medical provider's potential liability to a nonpatient third party by recognizing a special relationship between a physician and a patient. The Court, therefore, should affirm the judgment of dismissal for the Hospital and decline the plaintiff's proposal to expand the scope of potential tort liability for medical providers in the Commonwealth.

Respectfully submitted,

THE MASSACHUSETTS DEFENSE LAWYERS ASSOCIATION

By its attorneys,

MICHAEL D. RISEBERG
BBO #567771
ADLER POLLOCK & SHEEHAN, P.C.
175 Federal Street
Boston, Massachusetts 02110
(617) 482-0600

CHAD P. BROUILLARD
BBO #657419
BLOOM & BUELL
175 Federal Street, 9th Floor
Boston, Massachusetts 02110-2245
(617) 482-5700

Dated: December 12, 2008

PROOF OF SERVICE

I, Michael D. Riseberg, do hereby certify that on December 12, 2008, I caused two copies of the foregoing Brief of Amicus Curiae Massachusetts Defense Lawyers Association to be served by Priority Class U.S. Mail upon Jeffrey S. Beeler, Esq., Heilein & Beeler, P.C., 207 Union Street, S. Natick, MA 01760; Daniel J. Buoniconti, Esq., Foster & Eldridge, LLP, One Canal Park, Cambridge, MA 02141; and John J. Barter, Esq., Law Office of John J. Barter, 83 Atlantic Avenue, 3rd Floor, Boston, MA 02110-3711.

/s/ Michael D. Riseberg
Michael D. Riseberg

CERTIFICATE OF RULE 16(k) COMPLIANCE

I, Michael D. Riseberg, do hereby certify that the foregoing Brief of Amicus Curiae Massachusetts Defense Lawyers Association complies with the Rules of Court that pertain to the filing of appellate briefs, including, but not limited to, Mass. R. App. P. 16(a)(6), 16(e), 16(f), 16(h), 18 and 20.

/s/ Michael D. Riseberg
Michael D. Riseberg

No. SJC-10296

DEAN LEAVITT,
PLAINTIFF-APPELLANT,

v.

BROCKTON HOSPITAL, INC., SHEILA SMITH
AND KAREN SULLIVAN
DEFENDANTS-APPELLEES.

APPEAL FROM A JUDGMENT OF DISMISSAL OF THE
PLYMOUTH SUPERIOR COURT

BRIEF OF AMICUS CURIAE MASSACHUSETTS DEFENSE LAWYERS ASSOCIATION

PLYMOUTH COUNTY

BATEMAN & SLADE, INC. BOSTON, MASSACHUSETTS