CHAPTER 3

Tort Law

It's Your Gavel ...

THE COURT WAS APPALLED

The plaintiff, while in the custody of the defendant penal institution, alleged that because the defendant's employees failed to timely diagnose her breast cancer, her right breast had to be removed. The defendant contended that even if its employees were negligent, the plaintiff's cancer was so far developed when discovered that it would nevertheless have required removal of her breast.[1]

Pursuant to the defendant's policy of medically evaluating all new inmates, on May 26, 1989, Dr. Evans gave the plaintiff a medical examination. He testified that his physical evaluation included an examination of the plaintiff's breasts. However, he stated that his examination was very cursory.

The day following her examination, the plaintiff examined her own breasts. At that time she discovered a lump in her right breast, which she characterized as being about the size of a pea. The plaintiff then sought an additional medical evaluation at the defendant's medical clinic. Testimony indicated that fewer than half of the inmates who sign the clinic list are actually seen by medical personnel the next day. Also, those not examined on the day for which the list is signed are given no preference in being examined on the following day. Their names are simply deleted from the daily list and their only recourse is to continually sign the list until they are examined. The evidence indicated that after May 27, the plaintiff constantly signed the clinic list and provided the reason she was requesting medical care.

A nurse finally examined the plaintiff on June 21. The nurse noted in her nursing notes that the plaintiff had a "moderate large mass in right breast." The nurse recognized that the proper procedure was to measure such a mass but she testified that this was impossible because no measuring device was available. The missing measuring device to which she alluded was a simple ruler. The nurse concluded that Evans should again examine the plaintiff.

On June 28, Evans again examined the plaintiff. He recorded in the progress notes that the plaintiff had "a mass on her right wrist. Will send her to hospital and give her Benadryl for allergy she has."[2] Evans meant to write "breast" not "wrist."

He again failed to measure the size of the mass on the plaintiff's breast.

The plaintiff was transferred to the Franklin County Prerelease Center (FCPR) on September 28. On September 30, a nurse at FCPR examined the plaintiff; the nurse recorded that the plaintiff had a "golf-ball"–sized lump in her right breast. The plaintiff was transported to the hospital on October 27, where Dr. Walker treated her. The plaintiff received a mammogram examination, which indicated that the tumor was probably malignant. This diagnosis was confirmed by a biopsy performed on November 9. The plaintiff was released from confinement on November 13.

On November 16, Dr. Lidsky, a surgeon, examined the plaintiff. Lidsky noted the existence of the lump in the plaintiff's breast and determined that the size of the mass was approximately 4 to 5 centimeters and somewhat fixed. He performed a modified radical mastectomy upon the plaintiff's right breast, by which nearly the plaintiff's entire right breast was removed.

WHAT IS YOUR VERDICT?

Every instance of a man's suffering the penalty of the law is an instance of the failure of that penalty in effecting its purpose, which is to deter from transgression.

Whately

This chapter introduces the reader to the study of tort law. A *tort* is a civil wrong, other than a breach of contract, committed against a person or property (real or personal) for which a court provides a remedy in the form of an action for damages. Tort actions touch an individual both on a personal and a professional level, which is why those involved in the health care field should be armed with the knowledge necessary to make them aware of their rights and responsibilities.

The basic objectives of tort law are preservation of peace between individuals by providing a substitute for retaliation; *culpability* (to find fault for wrongdoing); deterrence to discourage the wrongdoer (tort-feasor) from committing future torts; and compensation to indemnify the injured persons of wrongdoing.

Compensation for adverse medical outcomes typically takes the form of financial damages. When finding fault, the court must determine who should bear the cost of an unfavorable outcome—the patient-plaintiff or the provider-defendant. The plaintiff must prove negligence by the defendant. Conversely, the defendant argues a case to avoid fault determination. Underlying this adversarial proceeding is the assumption that when a defendant bears the cost of a negligent act, there will be a decline in similar acts. Although professional liability insurance helps to insulate a provider from financial loss, the fear is ever present that the monetary award may exceed coverage limits, thus resulting in out-of-pocket expenses for the provider.

Incidents that raise issues of liability fall under three basic categories of tort law. In the context of the first category, patient care, negligent torts occur most commonly. The next, intentional torts, includes assault, battery, false imprisonment, invasion of privacy, and infliction of mental distress. Finally, strict liability, irrespective of fault, may be imposed in certain situations in which the activity, regardless of intentions or negligence, is so dangerous to others that public policy demands absolute responsibility on the part of the tort-feasor.

NEGLIGENCE

Negligence is a tort; a civil or personal wrong. It is the unintentional commission or omission of an act that a reasonably prudent person would or would not do under the same or similar circumstances. It is the failure to use ordinary or reasonable care. Ordinary or reasonable care is that care which persons of ordinary prudence would use.

Commission of an act would include, for example:

- Administering the wrong medication
- Administering the wrong dosage of a medication
- Administering medication to the wrong patient
- Performing a surgical procedure without patient consent
- Performing a surgical procedure on the wrong patient
- Performing the wrong surgical procedure

Omission of an act would include, for example:

- Failing to conduct a thorough history and physical examination

- Failing to assess and reassess a patient's nutritional needs
- Failing to administer medications
- Failing to order diagnostic tests
- Failing to follow up on abnormal test results

Negligence is a form of conduct caused by heedlessness or carelessness that constitutes a departure from the standard of care generally imposed on reasonable members of society. It can occur when after considering the consequences of an act, a person does not exercise the best possible judgment; where one fails to guard against a risk that should be appreciated; or where one engages in behavior expected to involve unreasonable danger to others. Negligence or carelessness of a professional person is classified as *malpractice,* whereas *criminal negligence* is the reckless disregard for the safety of another (e.g., willful indifference to an injury that could follow an act).

Malpractice suits may allege various mistakes made by doctors or other medical professionals, including misdiagnosis, mistreatment, delayed diagnosis, failure to diagnose, surgical errors, medical errors, or various types of negligence. Not all errors in medical diagnosis and treatment are necessarily malpractice, because there are certain risks and margins for error that arise inherently in the practice of medicine.[3]

Forms of Negligence

The three basic forms of negligence are:

1. *Malfeasance:* performance of an unlawful or improper act (e.g., performing an abortion in the third trimester when such is prohibited by state law)
2. *Misfeasance:* improper performance of an act, resulting in injury to another (e.g., wrong-sided surgery)
3. *Nonfeasance:* failure to act, when there is a duty to act as a reasonably prudent person would in similar circumstances (e.g., failing to order diagnostic tests or prescribe medications that should have been ordered or prescribed under the circumstances)

Degrees of Negligence

There are two degrees of negligence:

1. *Ordinary negligence:* failure to do what a reasonably prudent person would or would not do, under the circumstances of the act or omission in question
2. *Gross negligence:* intentional or wanton omission of care that would be proper to provide or the doing of that which would be improper to do

Elements of Negligence

The elements that must be present in order for a plaintiff to recover damages caused by negligence are:

1. Duty to care
   - There must be an obligation to conform to a recognized standard of care.
2. Breach of duty
   - There must be a deviation from the recognized standard of care.
   - There must be a failure to adhere to an obligation.
3. Injury
   - Actual damages must be established.
   - If there are no injuries, no damages are due.
4. Causation
   - The departure from the standard of care must be the cause of the plaintiff's injury.
   - The injury must be foreseeable.

All four elements must be present in order for a plaintiff to recover damages suffered as a result of a negligent act. When the four elements of negligence have been proven, the plaintiff is said to have presented a *prima facie case of negligence,* which will enable the plaintiff to prevail in the lawsuit.

The *burden of proof* in a negligence case is not as great as the beyond-a-reasonable-doubt standard borne by a prosecutor in a criminal case. Therefore, if a plaintiff supports a negligence claim with evidence sufficient to outweigh the evidence presented by the defendant, the defendant will be found liable for the negligent act. The defendant then will be ordered by the court, in accordance with the verdict rendered by the jury or by the court itself, to compensate the plaintiff monetarily for the harm that the plaintiff suffered. *Compensatory damages* seek to restore the injured party's financial situation to match the party's financial state before suffering harm. *Punitive damages* can also be awarded to the plaintiff for pain and suffering caused by conduct that would be considered egregious.

Duty to Care

To establish negligence, the plaintiff must first prove the existence of a legal relationship between himself or herself and the defendant. *Duty* is defined as a legal obligation of care, performance, or observance imposed on one to safeguard the rights of others. Duty may arise from a special relationship such as that between a physician and a patient.

The existence of the relationship implies that a physician-patient relationship was in effect at the time an alleged injury occurred. The duty to care can arise from a simple telephone conversation or out of a physician's voluntary act of assuming the care of a patient. Duty also can be established by statute or contract between the plaintiff and the defendant. Where there is a contractual duty of care and an injury occurs, patients have a choice of theories to use to determine which type of lawsuit to pursue—breach of contract or tort. In some jurisdictions, the statute of limitations for breach of contract is longer than for negligence actions. In such cases, the existence of a contractual duty of care may extend the liability of a health care provider for several years.

In *O'Neill v. Montefiore Hospital,*[4] the duty owed to a patient was clear. The plaintiff sought recovery against the hospital for failure to render necessary emergency treatment and against a physician for his failure and refusal to treat her spouse. The deceased, Mr. O'Neill, while experiencing pains in his chest and arms, walked with his wife to the hospital at 5:00 A.M. He claimed that he was a member of the Hospital Insurance Plan (HIP). The emergency department nurse stated that the hospital had no connection with HIP and did not take HIP patients. The nurse indicated that she would try to get a HIP physician for O'Neill. The nurse called Dr. Graig, an HIP physician, and explained the patient's symptoms to the doctor. It was suggested by Graig that O'Neill see a HIP physician at 8:00 A.M. The nurse then handed the phone to O'Neill, who said, "Well, I could be dead by 8 o'clock." O'Neill concluded his phone conversation and spoke to the nurse, indicating that he had been told to go home and come back when HIP was open. Mrs. O'Neill asked that a physician see her husband. The nurse again requested that they return at 8:00. O'Neill again commented that he could be dead by 8:00. He then left with his wife to return home, pausing occasionally to catch his breath. Shortly after arriving at home, O'Neill suddenly fell to the floor and died. Graig claimed that he had offered to come to the emergency department, but that O'Neill had said that he would wait and see another HIP physician at 8:00 that morning.

The New York Supreme Court for Bronx County entered a judgment dismissing the complaint, and the plaintiff appealed. The New York Supreme Court, Appellate Division, reversed the lower court and held that a physician who abandons a patient after undertaking examination or treatment can be held liable for malpractice. The proof of the record in this case indicated that the physician undertook to diagnose the ailments of the deceased by telephone, thus establishing at least the first element of negligence—duty to use due care. The finding of the trial court was reversed, and a new trial was ordered.

In a similar case, the surviving parents in *Hastings v. Baton Rouge Hospital*[5] brought a medical malpractice action for the wrongful death of their 19-year-old son. The action was brought against the hospital; the emergency department physician, Dr. Gerdes; and the thoracic surgeon on call, Dr. McCool. The patient had been brought to the emergency department at 11:56 P.M. because of two stab wounds and weak vital signs. Gerdes decided that a thoracotomy had to be performed. He was not qualified to perform the surgery and called McCool, who was on call that evening for thoracic surgery. Gerdes described the patient's condition, indicating he had been stabbed in a major blood vessel. At trial, McCool claimed that he did not recall Gerdes saying that a major blood vessel could be involved. McCool asked Gerdes to transfer the patient to the Earl K. Long Hospital. Gerdes said, "I can't transfer this patient." McCool replied, "No. Transfer him." Kelly, an emergency department nurse on duty, was not comfortable with the decision to transfer the patient and offered to accompany him in the ambulance. Gerdes reexamined the patient, who exhibited marginal vital signs, was restless, and was draining blood from his chest. The ambulance service was called at 1:03 A.M., and by 1:30 A.M. the patient had been placed in the ambulance for transfer. The patient began to fight wildly, the chest tube came out, and the bleeding increased. An attempt to revive him from a cardiac arrest was futile, and the patient died after having been moved back to the emergency department. The patient virtually bled to death.

The duty to care in this case cannot be reasonably disputed. Louisiana, by statute, imposes a duty on hospitals licensed in Louisiana to make emergency services available to all persons residing in the state regardless of insurance coverage or economic status. The hospital's own bylaws provide that patient transfer should never occur without due consideration for the patient's condition. The 19th Judicial District Court directed a verdict for the defendants, and the plaintiffs appealed. The court of appeals affirmed the district court's decision. On further appeal, the Louisiana Supreme Court held that the evidence presented to the jury could indicate the defendants were negligent in their treatment of the victim. The findings of the lower courts were reversed, and the case was remanded for trial.

As in *Hastings v. Baton Rouge Hospital,* some duties are created by statute, which occurs when a statute specifies a particular standard that must be met. Many such standards are created by administrative agencies under the provisions of a statute. To establish liability based on a defendant's failure to follow the standard of care outlined by statute, the following elements must be present:

1. the defendant must have been within the specified class of persons outlined in the statute
2. the plaintiff must have been injured in a way that the statute was designed to prevent
3. the plaintiff must show that the injury would not have occurred if the statute had not been violated

Duties may also be created by an institution through its internal rules and regulations. The courts hold that such internal rules are indicative of the organization's knowledge of the proper procedure to follow and, hence, create a duty. Thus, if

an employee fails to follow an operating rule of that organization and, as a result, a patient is injured, then the employee who violated the rule would be considered negligent.

Texas courts, for example, recognize that an employer has a duty to hire competent employees, especially if they are engaged in an occupation that could be hazardous to life and limb and requires skilled or experienced persons. For example, the appellant in *Deerings West Nursing Center v. Scott*[6] was found to have negligently hired an incompetent employee that it knew or should have known was incompetent, thereby causing unreasonable risk of harm to others. In this case, an 80-year-old visitor had gone to Deerings to visit her infirm older brother. During one visit, Nurse Hopper, a 6-foot-4-inch male employee of Deerings, confronted the visitor to prevent her from visiting. The visitor recalled that he was angry and just stared. She stated that upon his approach she had thrown up her hands to protect her face, but he hit her on the chin, slapped her down on the concrete floor, and got on top of her, pinning her to the floor.

Hopper testified that he was hired sight unseen over the telephone by Deerings' director of nursing. Even though the following day, Hopper completed an application at the nursing facility, he still maintained that he was hired over the phone. In his application, he falsely stated that he was a Texas licensed vocational nurse (LVN). Additionally, he claimed that he had never been convicted of a crime. In reality, he had been previously employed by a bar, was not a LVN, had committed more than 56 criminal offenses of theft, and was on probation at the time of his testimony.

The trial court awarded the plaintiff a judgment of $35,000 for actual damages and $200,000 in punitive damages. The court of appeals held that there was evidence supporting findings that the employee's failure to obtain a nursing license was the proximate cause of the visitor's damages and that the hiring was negligent, and also showed a heedless and reckless disregard of the rights of others.

> It is common knowledge that the bleakness and rigors of old age, drugs, and the diseases of senility can cause people to become confused . . . and cantankerous. It is predictable that elderly patients will be visited by elderly friends and family. It is reasonable to anticipate that a man of proven moral baseness would be more likely to commit a morally base act on an 80-year-old woman. Fifty-six convictions for theft is some evidence of mental aberration. Hopper was employed not only to administer medicine but also to contend with the sometimes erratic behavior of the decrepit. The investigative process necessary to the procurement of a Texas nursing license would have precluded the licensing of Hopper. In the hiring of an unlicensed and potentially mentally and morally unfit nurse, it is reasonable to anticipate that an injury would result as a natural and probable consequence of that negligent hiring.[7]

Deerings West Nursing Center v. Scott showed a clear duty of care. The appellant violated the very purpose of Texas licensing statutes by failing to verify whether Hopper held a current LVN license. The appellant then placed him in a position of authority, allowed him to dispense drugs, and made him a shift supervisor. This negligence eventually resulted in the inexcusable assault on an elderly woman.

Standard of Care

A duty of care carries with it a corresponding responsibility not only to provide care, but also to provide it in an acceptable manner. The plaintiff must show that the defendant failed to meet the prevailing standard of care. The fact that an injury is suffered is not sufficient for imposing liability without proof that the defendant deviated from the standard practice of competent fellow professionals. A nurse, for example, who assumes the care of a patient has the duty to exercise that degree of skill, care, and knowledge ordinarily possessed and exercised by other nurses. The standard of care describes the conduct expected of an individual in a given situation. The general standard of care that must be followed is that which a "reasonably prudent person" would exercise acting under the same or similar circumstances. The reasonably prudent person represents the conduct of the average person in the community under the circumstances facing the defendant at the time of the alleged negligence. The reasonableness of conduct is judged in light of the circumstances apparent at the time of injury and by reference to different characteristics of the actor (e.g., age, sex, physical condition, education, knowledge, training, mental capacity). The actual performance of an individual in a given situation will be measured against what a reasonably prudent person would or would not have done. Deviation from the standard of care will constitute negligence if there are resulting damages.

> The standard of conduct of a reasonable person may be: (a) established by a legislative enactment or administrative regulation which so provides, (b) adopted by the court from a legislative enactment or an administrative regulation which does not so provide, or (c) established by judicial decision, or, (d) applied to the facts of the case by the trial judge or jury, if there is no such enactment, regulation or decision.[8]

Traditionally, in determining how a reasonably prudent person should perform in a given situation, the courts often rely on the testimony of an expert witness as to the standard of care required in the same or similar communities. The

plaintiff's expert witness in *Stogsdill v. Manor Convalescent Home, Inc., and Hiatt, MD,*[9] who practiced about 12 miles from the convalescent home where the defendant physician treated the plaintiff, was found competent to testify. The defendant objected, stating the expert never practiced in the county where the malpractice occurred. The court overruled this objection on the grounds that locality cannot be construed so narrowly as to be determined by county lines.

Expert testimony like that in *Stogsdill v. Manor Convalescent Home, Inc., and Hiatt, MD* is necessary when the jury is not trained or qualified to determine what the reasonably prudent professional's standard of care would be under similar circumstances. Most states hold those with special skills (e.g., physicians, nurses, and dentists) to a standard of care that is reasonable in the light of their special abilities and knowledge. For example, the plaintiff, in *Kowal v. Deer Park Fire District*[10] submitted affidavits from two doctors who stated that, to a reasonable degree of medical certainty, the death of the plaintiff's decedent "was caused by severe and extensive cerebral anoxia caused by . . . incorrect intubation," that the incorrect intubation of the decedent constituted medical malpractice, and that the failure to recognize that she had been improperly intubated constituted a gross departure from good and accepted practice of what is "a common place medical technique. Assuming that the deposition testimony of the defendants established prima facie evidence that they were not grossly negligent, the sworn opinion of the plaintiff's experts established that there were issues of fact that precluded the granting of summary judgment.

The courts have been moving away from reliance on a community standard and have applied an industry or national standard. This trend has developed as a result of a more reasonable belief that the standard of care should not vary with the locale where an individual receives care. It would be unreasonable for any one health care facility and/or health care professional to set the standard simply because there is no local basis for comparison. Geographic proximity rules have increasingly given way to a national standard, with the standard in the professional's general locality becoming a factor in determining whether the professional has exercised that degree of care expected of the average practitioner in the class to which he or she belongs.

The ever-evolving advances in medicine and mass communications, the availability of medical specialists, the development of continuing education programs, and the broadening scope of government regulations continue to raise the standard of care required of health care professionals and organizations. Many courts have adopted the view that the practice of medicine should be national in scope. In *Dickinson v. Mailliard,* the court stated:

> Hospitals must now be licensed and accredited. They are subject to statutory regulation. In order to obtain approval they must meet certain standard requirements. . . . It is no longer justifiable, if indeed it ever was, to limit a hospital's liability to that degree of care which is customarily practiced in its own community. . . . [M]any communities have only one hospital. Adherence to such a rule, then, means the hospital whose conduct is assailed, is to be measured only by standards which it has set for itself.[11]

The Court of Appeals of Maryland, in *Shilkret v. Annapolis Emergency Hospital Association,* stated:

> [A] hospital is required to use that degree of care and skill which is expected of a reasonably competent hospital in the same or similar circumstances. As in cases brought against physicians, advances in the profession, availability of special facilities and specialists, together with all other relevant considerations, are to be taken into account.[12]

Evidence of the standard of care applicable to professional activities may be found in a variety of documents, such as regulations of government agencies (e.g., state licensure laws) and standards established by private organizations, such as The Joint Commission.

While the courts tend to prefer a broader standard of care, the community standard can be extremely important in any given situation.

> Assume for a moment that the question is whether a doctor in a remote area of Alaska has placed patients at an unnecessarily high risk by receiving telephone inquiries from nurses in Eskimo villages at even more remote areas and attempting to prescribe by phone. Clearly, such conduct would violate the standard of care in San Francisco and, in San Francisco, would place his patients in an "unnecessarily" high-risk situation. For the doctor in Alaska, on the other hand, this method of consultation may be the only possible one, and thus not at all unnecessary or a gross and flagrant violation.[13]

The parents in *Wickliffe v. Sunrise Hospital*[14] sued the hospital for the wrongful death of their teenage daughter who suffered respiratory arrest while recovering from surgery. The Nevada Supreme Court held that the level of care to which the hospital must conform is a nationwide standard. The hospital's level of care is no longer subject to narrow geographic limitations under the so-called locality rule; rather, the hospital must meet a nationwide standard.

Further, the Georgia Court of Appeals in *Hodges v. Effingham*[15] held that application of the locality rule was erroneous in an action against the hospital. The alleged failure of nurses to take an accurate medical history of the patient's serious

condition and convey the information to the physician drew into question the professional judgment of the nurses. The jury should have been instructed as to the general standard of nursing required.

> There are no degrees of care in fixing responsibility for negligence, but the standard is always that care which a prudent person should use under like circumstances. The duty to exercise reasonable care is a standard designed to protect a society's members from unreasonable exposure to potentially injurious hazards; negligence is conduct that falls short of the reasonable care standard. Perfection of conduct is humanly impossible, however, and the law does not exact an unreasonable amount of care from anyone.[16]

Specialists

Specialists in particular are held to a higher standard of care than nonspecialists. Generally, the reliance of the public upon the skills of a specialist and the wealth and sources of his or her knowledge are not limited to the geographic area in which he or she practices. Rather, his or her knowledge is a specialty; a person specializes to keep abreast. Any other standard for a specialist would negate the fundamental expectations and purpose of a specialty.

Breach of Duty

Once a duty to care has been established, the plaintiff must demonstrate that the defendant breached that duty by failing to comply with the accepted standard of care. *Breach of duty* is the failure to conform to or the departure from a required duty of care owed to a person. The obligation to perform according to a standard of care may encompass either doing or refraining from doing a particular act.

The court in *Hastings v. Baton Rouge Hospital,*[17] discussed earlier, found a severe breach of duty when a patient did not receive adequate care. Hospital regulations provided that when a physician cannot be reached or refuses a call, the chief of service must be notified so that another physician can be obtained. This was not done. A plaintiff need not prove that a patient would have survived if proper treatment had been administered, but only that the patient would have had a chance of survival. As a result of Dr. Gerdes' failure to make arrangements for another physician and Dr. McCool's failure to perform the necessary surgery, the patient had no chance of survival. The duty to provide for appropriate care under the circumstances was breached.

In *Dunahoo v. Brooks,*[18] the nursing facility was found to have breached its duty when a patient tripped over an obviously ill-placed light cord. The court stated that because the defendant nursing facility operator had been aware of the 94-year-old plaintiff's infirmities and had agreed to provide her nursing care, the nursing facility assumed an obligation to exercise care commensurate with her physical condition. While the plaintiff was getting out of bed, she tripped and fell over a light cord that was loose on the floor in an area that the defendant knew the plaintiff frequently used. The cord was plugged into a socket on the floor 5 inches from the baseboard. The court was impressed with the ease with which the situation could have been corrected, noting that the cord could have been fastened down with a few nails and the outlet placed on the baseboard instead of nearly in the middle of the floor.

Another nursing facility was found negligent in *Booty v. Kentwood Manor Nursing Home, Inc.,*[19] when a 90-year-old resident wandered outside the facility, fell, and suffered a hip fracture. The resident's physical condition deteriorated and he eventually died. The staff were aware of the resident's confusion and tendency to stray. The court found that the facility was responsible for taking reasonable steps to prevent injury to a mentally confused and physically fragile resident. The facility's alarm system might have alerted the staff of unauthorized resident departures, but it had been deactivated, and the doors were propped open for the convenience of the staff. The record demonstrated that inadequate supervision of the resident had been the cause of his departure and that he probably would not have suffered injury but for the nursing facility's breach of duty owed to the resident.

Injury/Actual Damages

A defendant may be negligent and still not incur liability if no injury or actual damages result to the plaintiff. Without harm or injury, there is no liability. *Injury* includes physical harm, pain, suffering, and loss of income or reputation.

The mere occurrence of an injury "does not establish negligence for which the law imposes liability, since the injury may be the result of an unavoidable accident, or an act of God, or some cause so remote to the person sought to be held liable for negligence that he cannot be charged with responsibility for the injury."[20]

Injury was obvious in *Lucas v. HCMF Corp.,*[21] where the patient had been transferred to a nursing facility following hospitalization for several ailments, including early decubitus ulcers. The resident was returned to the hospital 24 days later. "At that time the ulcer on her hip had become three large ulcers that reached to the bone and tunneled through the skin to meet one another. The ulcer on her buttocks had grown from one inch in diameter to eight inches in diameter and extended to the bone. Additional ulcers had developed on each of her ribs, on her left arm and wrist, and on the left

side of her face."[22] The standard of care required in preventing and treating decubitus ulcers required that the resident be mobilized and turned every two hours to prevent deterioration of tissue. The treatment records reflected that the resident was not turned at all from September 22 through October 1, nor was she turned on October 4, 7, or 12. Failure to periodically turn the resident and move her to a chair had caused the deterioration in her condition.

Causation

The fourth element necessary to establish negligence requires that there be a reasonable, close, and causal connection or relationship between the defendant's negligent conduct and the resulting damages suffered by the plaintiff. In other words, the defendant's negligence must be a substantial factor causing the injury. *Proximate cause* is a term referring to the relationship between a breached duty and the injury. The breach of duty must be the proximate cause of the resulting injury. The mere departure from a proper and recognized procedure is not sufficient to enable a patient to recover damages unless the plaintiff can show that the departure was unreasonable and the proximate cause of the patient's injuries. Causation in the *Hastings v. Baton Rouge Hospital*[23] case was well established. In the ordinary course of events, Hastings would not have bled to death in a hospital emergency department over a two-hour period without some surgical intervention to save his life.

Negligent Misreading of CT Scan

On November 2, 1995, the plaintiff was admitted into the Brooklyn Hospital Center complaining of a severe headache, an inability to open her eyes, and the absence of feeling in her legs. A CT scan was administered, which the defendant conceded was misread by its staff physician as normal. After discharging the plaintiff from its care, the defendant's radiologist reviewed the CT scan and concluded it was, in fact, not normal. The defendant did not contact the plaintiff to alert her to the revised finding. After the hospital conceded that its employee's initial misreading of the CT scan and its failure to alert the plaintiff to the misreading were departures from accepted medical practice, the jury properly found that those conceded departures were the proximate causes of the plaintiff's injury. The evidence adduced at trial was legally sufficient to support the jury's verdict on causation.[24]

Failure to Refer

In *Robinson v. Group Health Association, Inc.,*[25] the District of Columbia Court of Appeals held that there was a genuine issue of material fact as to whether the failure of a group health provider to treat a patient's diabetes aggressively resulted in the amputation of his leg below the knee. The testimony of the plaintiff's expert, as it related to the issue of proximate cause, was sufficient to allow the case to go to the jury. According to the expert witness, the failure of the provider to refer the patient for vascular evaluation resulted in his below-the-knee amputation. The expert testified to a reasonable degree of medical certainty, which he equated to a greater than 50 percent chance, that if there had been an early vascular consult, followed by an angioplasty and perhaps a partial foot amputation, a below-the-knee amputation could have been avoided. Although the provider presented contrary testimony, the plaintiff's expert testimony was found sufficient to permit a reasonable juror to find that there was a direct and substantial causal relationship between the provider's breach of the standard of care and the patient's injuries.

> The primary wrong upon which a cause of action for negligence is based consists in the breach of a duty on the part of one person to protect another against injury, the proximate result of which is an injury to the person to whom the duty is owed. These elements of duty, breach, and injury are essentials of actionable negligence, and in fact most judicial definitions of the term "negligence" or "actionable negligence" are couched in those terms. In the absence of any one of them, no cause of action for negligence will lie.[26]

Eliminating Causes

Another way to establish the causal relationship between the particular conduct of a defendant and a plaintiff's injury is through the process of eliminating causes other than the defendant's conduct. For example, in *Shegog v. Zabrecky,*[27] Mr. Pereyra sought treatment for back pain from Dr. Zabrecky, a chiropractor at the Life Extension Center, in January 1987. Zabrecky ordered X-rays. The X-rays revealed that Pereyra was suffering from a fractured vertebra caused by a malignant tumor. Pereyra was referred to a surgeon who performed two surgical procedures to remove the tumor. Pereyra underwent a series of radiation treatments, which were supervised by Dr. Usas. A CT scan revealed that the cancer had spread to his lungs. Dr. Usas and other consulting physicians recommended that chemotherapy be considered following the course of radiation treatments. Pereyra was advised that his chance of survival following chemotherapy was 50 percent or better. During the summer of 1987, Pereyra consulted with a number of physicians as to the best course of treatment. Pereyra continued to see Zabrecky throughout the summer and fall of 1987. Zabrecky recommended that Pereyra reject the chemotherapy

treatments and undergo a course of treatment with neytumorin and neythymin (two compounds manufactured in Germany). The Food and Drug Administration had not approved either drug. Pereyra agreed to undergo the treatment. Zabrecky performed an initial enzyme study prior to treatment, but did not perform further tests after the course of treatment began. During the course of treatment, the cancer continued to spread. Additional radiation treatments were given. Pereyra's condition worsened, and he was admitted to the hospital. The physicians at the hospital had not been aware that Pereyra was injecting himself with drugs given to him by Zabrecky. Upon urging from his wife, Pereyra revealed this information to the physicians at the hospital. Pereyra died on December 17, 1987, approximately six weeks after he had begun treatment with neytumorin and neythymin. An autopsy revealed that Pereyra had died from necrosis of the liver caused by a toxic reaction to a foreign substance. Pereyra was taking only the drugs neytumorin and neythymin between July 1987 and his death. No cancer was found in the liver.

A lawsuit was filed against the defendants, seeking damages for negligent treatment. The alleged negligent acts included:

- Administering drugs statutorily prohibited for use
- Withholding information from treating physicians
- Failing to follow patient's blood work
- Advising the patient to use drugs that had expired
- Engaging in the unlicensed practice of medicine
- Inducing the patient to forgo appropriate therapy

The jury delivered a verdict for the plaintiff. The defendants appealed, claiming that the evidence introduced at trial did not support the jury's finding as to causation.

The appellate court held that Zabrecky's grossly negligent actions and the circumstantial evidence introduced supported the jury's finding of causation. Zabrecky violated a recognized standard of care by prescribing statutorily prohibited drugs. No evidence was presented that would have supported another cause of the patient's liver failure. Reports from treating physicians indicate that the plaintiff died of liver failure and not from cancer. The defendant's expert testified that necrosis of the liver can be caused by the injection of foreign substances. He also testified that the normal reaction time of the human liver to a foreign protein is, on average, six weeks. "One of the ways to establish the causal relationship between particular conduct of a defendant and a plaintiff's injury is the expert's deduction, by the process of eliminating causes other than the conduct, that the conduct was the cause of injury. . . . The submitted reports indicate that each physician deduced that the German drugs were the most probable cause of Pereyra's liver failure, even without analysis of the drugs."[28]

Foreseeability

Foreseeability is the reasonable anticipation that harm or injury is likely to result from an act or an omission to act. The test for foreseeability is whether a person of ordinary prudence and intelligence should have anticipated the danger to others caused by a negligent act. "The test is not what the wrongdoer believed would occur; it is whether he or she ought reasonably to have foreseen that the event in question, or some similar event, would occur."[29]

When a defendant's actions fail to meet the standard of care, negligence has occurred and the jury must make two determinations. First, was it foreseeable that harm would occur from the failure to meet the standard of care? Second, was the carelessness or negligence the proximate or immediate cause of the harm or injury to the plaintiff? "The broad test of negligence is what a reasonably prudent person would foresee and would do in the light of this foresight under the circumstances."[30]

There is no expectation that the actor can guard against events that cannot reasonably be foreseen or that are so unlikely to occur that they would be disregarded. For example, in *Haynes v. Hoffman,*[31] the plaintiff brought a medical malpractice action against the defendant physician for his alleged negligence in prescribing a medication to which the plaintiff suffered an allergic reaction. The trial court returned a verdict in favor of the defendant, and the plaintiff appealed. The evidence at trial revealed that the plaintiff had not disclosed her history of allergies to the physician. The physician testified that, at the time of the physical examination of the plaintiff, she denied having any allergies. The physician testified that he would not have prescribed the drug had he known the plaintiff's complete history. By failing to disclose her allergies to the physician, the plaintiff was contributorily negligent. Foreseeability involves guarding against that which is probable and likely to happen, not against that which is only remotely and slightly possible.

The question of foreseeability was an issue in *Ferguson v. Dr. McCarthy's Rest Home.*[32] In this case, the plaintiff, a resident in the defendant's nursing facility, suffered from paralysis of the left side but was able to roll toward the left side in bed. The defendant had knowledge of this ability. A radiator, which was approximately the same height as the bed, was next to the plaintiff's bed on the left side. During the night, the plaintiff's left foot came in contact with the radiator and she suffered third-degree burns. The court held that this type of accident was foreseeable with respect to a person in the plaintiff's condition, particularly because the defendant had knowledge of the plaintiff's condition. The defendant should have shielded the radiator or not placed the plaintiff next to it.

Generally, the issue of foreseeability is for the trial court to decide. A duty to prevent a wrongful act by a third party will be imposed only where those wrongful acts can be reasonably anticipated.

SUMMARY CASE

All the elements necessary to establish negligence were well established in *Niles v. City of San Rafael*.[33] On June 26, 1973, at approximately 3:30 P.M., Kelly Niles, a young boy, got into an argument with another boy on a ball field and he was hit on the right side of his head. He rode home on his bicycle and waited for his father, who was to pick him up for the weekend. At approximately 5:00 P.M., his father arrived to pick him up. By the time they arrived in San Francisco, Kelly appeared to be in a great deal of pain. His father then decided to take him to Mount Zion Hospital, which was a short distance away. He arrived at the hospital emergency department at approximately 5:45 P.M. On admission to the emergency department, Kelly was taken to a treatment room by a registered nurse. The nurse obtained a history of the injury and took Kelly's pulse and blood pressure. During his stay in the emergency department, he was irritable, vomited several times, and complained that his head hurt. An intern who had seen Kelly wrote, "pale, diaphoretic, and groggy," on the patient's chart. Skull X-rays were ordered and found to be negative except for soft tissue swelling that was not noted until later. The intern then decided to admit the patient. A second-year resident was called, and he agreed with the intern's decision. An admitting clerk called the intern and indicated that the patient had to be admitted by an attending physician. The resident went as far as to write "admit" on the chart and later crossed it out. A pediatrician who was in the emergency department at the time was asked to look at Kelly. The pediatrician was also the paid director of the Mount Zion Pediatric Out-Patient Clinic. The pediatrician asked Kelly a few questions and then decided to send him home. The physician could not recall what instructions he gave the patient's father, but he did give the father his business card.

The pediatrician could not recall giving the father a copy of the emergency department's head injury instructions, an information sheet that had been prepared for distribution to patients with head injuries. The sheet explained that an individual should be returned to the emergency department should any of the following signs appear: a large, soft lump on the head; unusual drowsiness (cannot be awakened); forceful or repeated vomiting; a fit or convulsion (jerking or spells); clumsy walking; bad headache; and/or one pupil larger than the other.

Kelly was taken back to his father's apartment at about 7:00 P.M. A psychiatrist friend stopped by at approximately 8:45 P.M. He examined Kelly and noted that one pupil was larger than the other. Because the pediatrician could not be reached, the patient was taken back to the emergency department. A physician on duty noted an epidural hematoma during his examination and ordered that a neurosurgeon be called.

Today, Kelly can move only his eyes and neck. A lawsuit against Mount Zion and the pediatrician for $5 million was instituted. The city of San Rafael and the public school district also were included in the lawsuit as defendants. Expert testimony by two neurosurgeons during the trial indicated that the patient's chances of recovery would have been very good if he had been admitted promptly. This testimony placed the proximate cause of the injury with the hospital. The final judgment was $4 million against the medical defendants, $2.5 million for compensatory damages, and another $1.5 million for pain and suffering.

Case Lessons

Each case presented in this textbook illustrates actual experiences of plaintiffs and defendants, enabling the reader to apply the lessons learned to real-life situations. The many lessons in *Niles v. City of San Rafael* include the following:

- An organization can improve the quality of patient care rendered in the facility by establishing and adhering to policies, procedures, and protocols that facilitate the delivery of quality care across all disciplines.
- The provision of quality health care requires collaboration across disciplines.
- A physician must conduct a thorough and responsible examination and order the appropriate tests for each patient, evaluating the results of those tests, and providing appropriate treatment prior to discharging the patient.
- A patient's vital signs must be monitored closely and documented in the medical record.
- Corrective measures must be taken when a patient's medical condition signals a medical problem.
- A complete review of a patient's medical record must be accomplished before discharging a patient. Review of the record must include review of test results, nurses' notes, residents' and interns' notes, and the notes of any other physician or consultant who may have attended the patient.
- An erroneous diagnosis leading to the premature dismissal of a case can result in liability for both the organization and physician.

FAILURE TO ADMINISTER PROPER NOURISHMENT

Citation: *Caruso v. Pine Manor Nursing Ctr.,* 538 N.E.2d 722 (Ill. App. Ct. 1989)

Facts

In Illinois, a nursing facility by statute has a duty to provide its residents with proper nutrition. Under

the Nursing Home Care Reform Act, the owner and licensee of a nursing home are liable to a resident for any intentional or negligent act or omission of their agents or employees that injures a resident. The act defines *neglect* as a failure in a facility to provide adequate medical or personal care or maintenance, when failure results in physical or mental injury to a resident or in the deterioration of the resident's condition. Personal care and maintenance include providing food, water, and assistance with meals necessary to sustain a healthy life.

The nursing facility in this case maintained no records of the resident's fluid intake and output. A nurse testified that such a record was a required nursing facility procedure that should have been followed for a person in the resident's condition but was not. The resident's condition deteriorated after staying six and a half days at the facility. Upon leaving the facility and entering a hospital emergency department, the resident was diagnosed by the treating physician as suffering from severe dehydration caused by an inadequate intake of fluids. The nursing facility offered no alternative explanation for the resident's dehydrated condition. As a result of the facility's failure to maintain adequate records, the resident suffered severe dehydration that required hospital treatment.

The evidence demonstrated that the proximate cause of the resident's dehydration was the nursing facility's failure to administer proper nourishment. The trial court found that the record supported a finding that the resident had suffered from dehydration as a result of the nursing facility's negligence. The defendant appealed the jury verdict.

Issue

Did the nursing facility resident suffer harm as a result of the facility's negligence?

Holding

The Illinois Appellate Court upheld the trial court's finding that the resident suffered dehydration due to the nursing facility's negligence.

Reason

The evidence demonstrated that the proximate cause of the resident's dehydration was the nursing facility's failure to administer proper nourishment. The jury reasonably concluded that the resident suffered dehydration and that the nursing facility's treatment caused the dehydration.

Discussion

1. Discuss the element of foreseeability as applied in this case.
2. Discuss the importance of timely nutritional screenings and assessments.
3. What is the mechanism for screening and assessing the nutritional needs of patients in your

INTENTIONAL TORTS

There are two main differences between intentional and negligent wrongs. The first is intent, which is present in intentional but not in negligent wrongs. For a tort to be considered intentional, the act must be committed intentionally, and the wrongdoer must realize to a substantial certainty that harm would result. The second difference is less obvious. While a negligent wrong may simply be the failure to act when there is a legal duty to act, an intentional wrong always involves a willful act that violates another's interests. Intentional wrongs include such acts as assault, battery, false imprisonment, defamation of character, fraud, invasion of privacy, and infliction of emotional distress.

Assault and Battery

It has long been recognized by law that a person possesses a right to be free from aggression and the threat of actual aggression against one's person. The right to expect others to respect the integrity of one's body has roots in both common and statutory law. The distinguishing feature between assault and battery is that assault effectuates an infringement on the mental security or tranquility of another whereas battery constitutes a violation of another's physical integrity.

Assault

An *assault* is defined as the deliberate threat, coupled with the apparent present ability, to do physical harm to another. No actual contact is necessary. To commit the tort of assault, two conditions must exist: First, the person attempting to touch another unlawfully must possess the apparent present ability to commit the battery; second, the person threatened must be aware of or have actual knowledge of and fear of an immediate threat of a battery.

Battery

Battery is the intentional touching of another's person in a socially impermissible manner, without that person's consent. The law provides a remedy if consent to a touching has not been obtained or if the act goes beyond the consent given. Therefore, the injured person may initiate a lawsuit against the wrongdoer for damages suffered. In *Peete v. Blackwell,*[34] punitive damages in the amount of $10,000 were awarded to a nurse in her action against a physician for assault and battery. Evidence showed that the physician struck the assisting nurse on the arm and cursed at her when the physician ordered her to turn on the suction. Although there were no injuries, $1 in compensatory damages and $10,000 in punitive damages were awarded by the jury.

In the health care context, the principle of law concerning battery and the requirement of consent to medical and surgical procedures is critically important. Liability of organizations and health care professionals for acts of battery is most common in situations involving lack of patient consent to medical and surgical procedures.

It is of no legal importance that a procedure constituting a battery has improved a patient's health. If the patient did not consent to the touching, the patient may be entitled to such damages as can be proved to have resulted from commission of the battery. In *Perna v. Pirozzi,*[35] the New Jersey Supreme Court held that a patient who consents to surgery by one surgeon and is actually operated on by another has an action for medical malpractice or battery. Proof of unauthorized invasion of the plaintiff's person, even if harmless, entitles one to nominal damages.

Not only must individual staff members be aware of potential assault and battery hazards by fellow employees, as well as themselves, but they also must be alert to potential problems between patients (e.g., problems caused by smoking, racial or religious bias, and emotional conflicts). A health care facility has a particular duty to closely supervise those patients whose mental conditions make it probable that they will injure themselves or others.

False Imprisonment

False imprisonment is the unlawful restraint of an individual's personal liberty or the unlawful restraint or confinement of an individual. The personal right to move freely and without hindrance is basic to the legal system. Any intentional infringement on this right may constitute false imprisonment. Actual physical force is not necessary to constitute false imprisonment; false imprisonment may occur when an individual who is physically confined to a given area reasonably fears detainment or intimidation without legal justification. Both intimidation and forced detainment may be implied by words, threats, or gestures. Excessive force used to restrain a patient may produce liability for both false imprisonment and battery.

To recover for damages for false imprisonment, a plaintiff must be aware of the confinement and have no reasonable means of escape. Availability of a reasonable means of escape may bar recovery. To lock a door when another is reasonably available to pass through is not imprisonment. However, if the only other door provides a way of escape that is dangerous, the law may consider it an unreasonable way of escape and, therefore, false imprisonment may be a cause of action. Whether false imprisonment has taken place will be a matter for the courts to decide. No actual damage need be shown for liability to be imposed.

Where legal justification is absent and an arrest or imprisonment is false, the person denied free movement will be permitted to seek a remedy at law for any injury. Some occasions and circumstances allow for a person's confinement, such as when a person presents a self-danger or a danger to others. Criminals are incarcerated, as are sometimes the mentally ill who may present a danger to themselves or others. Long-term care residents are sometimes restrained to prevent falls. Children are retained after school for disciplinary reasons. In these examples, the right to move about freely has been violated, but the infringement occurs for reasons that are justifiable under the law.

False Arrest

In *Desai v. SSM Healthcare,*[36] Dr. Desai was walking across a hospital parking lot, a shortcut to the St. Louis University Medical School's Institute of Molecular Virology, where Desai worked as part of his graduate studies. Two security guards, Mr. Mealey and Mr. Windam, stopped Desai and asked him for identification. Desai said that he was a doctor and that he did not have his identification with him. Following an argument, the two security guards grabbed Desai's arms and Windam slammed Desai's head against the trunk of a car. After handcuffing him, the security guards escorted Desai back to the security office where they were joined by the security

guards' supervisor. The handcuffs were eventually removed after the security guards received verification that Desai was affiliated with the institute and confirmation from a nurse supervisor that he was a physician. Shortly thereafter, the university campus police arrived. One of the officers asked Desai to apologize to Mealey. Desai refused and said that he wanted the St. Louis City police called, as he wanted to file an official complaint of assault. At the request of the security guards, Desai was rehandcuffed and arrested by the St. Louis police for trespassing. The security guards later admitted that they had Desai arrested to avoid trouble for themselves. Desai was not released from jail until noon the following day. While in jail, he suffered headaches and seizures. Desai brought suit against the hospital and security guards for false imprisonment, battery, and malicious prosecution.

The defendants moved to have the malicious prosecution count dismissed, and the motion was granted. The jury had returned a verdict totaling $75,000 in damages for the false imprisonment claim and found in favor of the defendants on the battery claim. The trial court sustained the defendants' motions for judgment notwithstanding the verdict and the plaintiff appealed.

Did the plaintiff meet his burden of establishing his case by substantial evidence? The Missouri Court of Appeals held that the evidence supported a finding that the security guards falsely imprisoned the physician, and that the physician was entitled to punitive damages on the false imprisonment claim. The defendants' testimony provided the jury with sufficient evidence to establish that the plaintiff had been held against his will. The testimony supported a finding that the arrest was self-serving and resulted in the false imprisonment. The trial court erred in dismissing the punitive damages as to the false imprisonment claim and, therefore, prevented its submission to the jury.

Physically Violent Persons

In *Celestine v. United States,*[37] the right to move about freely had been violated; however, the infringement was permissible for reasons justifiable under the law. In this case, the plaintiff had brought an action alleging battery and false imprisonment because security guards had placed him in restraints. The plaintiff-appellant sought psychiatric care at a veterans administration (VA) hospital. He became physically violent while waiting to be seen by a physician. The VA security guards placed him in restraints until a psychiatrist could examine him. The U.S. Court of Appeals for the Eighth Circuit held that the record supported a finding that the hospital was justified in placing the patient under restraint. Under Missouri law, no false imprisonment or battery occurred in view of the common-law principle that a person believed to be mentally ill could be restrained lawfully if such was considered necessary to prevent immediate injury to that person or others.

Contagious Diseases

Protocols should be instituted for handling patients diagnosed as having contracted a highly contagious disease. Detaining such patients, without statutory protection, constitutes false imprisonment. State health codes generally provide guidelines for caring for such patients. Statutes in many states allow mentally ill and intoxicated individuals to be detained if they are found to be dangerous to themselves or others. Those who are mentally ill, however, can be restrained only to the degree necessary to prevent them from harming themselves or others. If a mentally ill patient cannot be released, procedures should be followed to provide commitment to an appropriate institution for the patient's care.

Intoxicated Persons

The patient in *Davis v. Charter by the Sea*[38] was found not entitled to a directed verdict on a false-imprisonment claim. The claim arose from her overnight, involuntary detention at a hospital. Evidence that the patient was highly intoxicated, confused, incoherent, and experiencing a low diastolic blood pressure raised a jury question as to the existence of a medical emergency authorizing her detention.

Restraints

Restraints generally are used to control behavior when patients are disoriented or may cause harm to themselves (e.g., from falling, contaminating wounds, or pulling out intravenous lines) or to others. The use of restraints raises many questions of a patient's rights in the areas of autonomy, freedom of movement, and the accompanying health problems that can result from continued immobility. In general, a patient has a right to be free from any physical restraints imposed or psychoactive drugs administered for purposes of discipline or convenience and that are not required to treat a patient's medical symptoms.

Although the motivations for using restraints appear sound, there has been a tendency toward overuse. The fear of litigation over injuries sustained because of the failure to apply restraints further compounds the problem of overuse. As a result, regulations governing the use of restraints under the Omnibus Budget Reconciliation Act of 1987 make it clear that restraints are to be applied as a last resort rather than as a first option in the control of a resident's behavior.

Because prescription drugs are sometimes used to restrain behavior, the regulations represent the first time that prescription drugs must by law "be justified by indications documented in the medical chart."[39]

To avoid legal problems, health care organizations should implement policies aimed at eliminating or reducing the use of restraints. Programs for the effective use of restraints should include the following:

- Written policies that conform to federal and state guidelines (e.g., a policy prescribing that the least-restrictive device will be utilized to maintain the safety of the patient, a policy requiring the periodic review of patients under restraint, and a policy requiring physician orders for restraints)
- Procedures for implementing organizational policies (e.g., alternatives to follow before restraining a patient may include family counseling to encourage increased visitations, environmental change, activity therapies, and patient counseling)
- Periodic review of policies and procedures, with revision as necessary
- Education and orientation programs for the staff to be conducted inside and outside the organization
- Education programs for patients and their families
- A sound appraisal of each patient's needs
- Informed consent from the patient or legal guardian
- The application of the least-restrictive restraints
- Constant monitoring of the patient to determine the continuing need for restraints, injury to the patient, and complaints by the patient
- Documentation that includes:
  - the need for restraints—time-limited orders ("as needed" PRN orders are not acceptable)
  - consents for the application of restraints—patient monitoring—reappraisal of the continuing need for restraints

In *Big Town Nursing Home, Inc. v. Newman,*[40] the court held there was sufficient evidence to support a finding that a 67-year-old male resident had been falsely imprisoned in a facility against his will. He had attempted to leave the facility three days after he arrived at the facility but was caught by the facility's employees and forcibly returned. He was placed in a wing with persons who were addicted to drugs and alcohol and those who were mentally disturbed. He asked during the ensuing weeks that he be permitted to leave and attempted to leave five or six times. He was eventually confined to a restraint chair, his clothes taken, and he was not permitted to use the telephone. The actions of the staff were described as being in utter disregard of the resident's legal rights. There was no court order for his commitment and the agreement for his admission stated that he was not to be kept against his will. The court stated that the staff acted recklessly, willfully, and maliciously by unlawfully detaining him.

Discharge Against Medical Advice

Patients who decide to leave a facility against medical advice should be requested to sign a discharge against advice form. Should a patient refuse to sign such a form, such refusal should be noted in the patient's record.

Defamation of Character

Another type of intentional tort comes in the form of defamation of character. *Defamation of character* is a communication to someone about another person that tends to hold that person's reputation up to scorn and ridicule. To be an actionable wrong, defamation must be communicated to a third person; defamatory statements communicated only to the injured party are not grounds for an action. *Libel* is the written form of defamation and may be presented in such forms as signs, photographs, letters, and cartoons. *Slander* is the verbal form of defamation and tends to form prejudices against a person in the eyes of third persons.

In a libel or slander *per se* (on its face) action, a court will presume that certain words and accusations cause injury to a person's reputation without proof of damages. Words or accusations that require no proof of actual harm to one's reputation are: (1) accusing someone of a crime, (2) accusing someone of having a loathsome disease, (3) using words that affect a person's profession or business, and (4) calling a woman unchaste. Health care professionals are, however, legally protected against libel when complying with a law that requires the reporting of venereal or other diseases. Damages typically consist of economic losses, such as loss of business or employment.

Libel

Performance Appraisals Not for General Publication. A statement in a hospital newsletter regarding the discharge of a nursing supervisor constituted libel per se in *Kraus v. Brandsletter.*[41] The newsletter indicated that the hospital's medical board had discharged the nursing supervisor after a unanimous vote of no confidence. Couching the board's determination in terms of a vote gave the impression that the

board's determination had been based on facts that justified the board's opinion. The statement tended to injure the nurse's reputation as a professional because it did not refer to specifics of her performance but rather to her abilities as a professional in general. The reasonable interpretation of the statement in the newsletter was that the supervisor was incompetent in her professional capacity, thus giving rise to a cause of action for libel per se.

On the flip side in the same case, an alleged statement that a physician said, "You nurses will receive your Christmas bonus early, your boss is going to get fired," was not slander per se in that it did not injure the nurse in her professional capacity.[42] In addition, the statement that she was going to be fired was true.

Performance Appraisal Statements Not Libelous. In *Schauer v. Memorial Care System,*[43] the plaintiff applied for and was given a supervisory position at Memorial Hospital's new catheterization laboratory. In March 1989, she received an employment appraisal for the period June 1988 through December 1988. At that time, Schauer's supervisor rated her performance as "commendable" in two categories and "fair" in eight categories, with an overall rating of "fair." Although Schauer did not lose her job as a result of the appraisal, she brought an action against the hospital and her former supervisor for libel and emotional distress as a result of the appraisal. The hospital moved for summary judgment on the grounds that the employment appraisal was not defamatory as a matter of law, the hospital had qualified privilege to write the performance appraisal, and the claim for emotional distress did not reach the level of severity required for a claim for intentional infliction of emotional distress. The trial court granted the hospital's motion for summary judgment, and Schauer appealed.

The Texas Court of Appeals held that the statements contained in the performance appraisal were not libelous and that the appraisal was subject to qualified privilege. Moreover, the hospital's conduct and the statements contained in the appraisal did not support the claim for intentional infliction of emotional distress.

To sustain her claim of defamation, Schauer had to show that the hospital published her appraisal in a defamatory manner that injured her reputation in some way. A statement can be unpleasant and objectionable to the plaintiff without being defamatory. The hospital argued that the statements contained in the appraisal were truthful, permissible expressions of opinion and not capable of a defamatory meaning. Schauer's supervisor prepared the appraisal as part of her supervisory duties. The appraisal was not published outside the hospital and was prepared in compliance with the hospital policy for all employees. Schauer disputed her overall rating of "fair" as being libelous. "Clearly, this is a statement of her supervisor's opinion and is not defamatory as a matter of law."[44]

In her performance appraisal, Schauer objected to the statement, "Ms. Schauer was not sensitive to employee relations."[45] Schauer conceded in her deposition that there were a number of interpersonal problems in the catheterization laboratory and that she did not get along with everyone. The court found that given these admissions, the statement was not defamatory.

As to the plaintiff's claim of emotional distress, the plaintiff failed to show that the hospital acted intentionally and recklessly. The Restatement of Torts, Second, § 46 (1977) provides:

> Liability has been found only where the conduct has been so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community. . . . The liability clearly does not extend to mere insults, indignities, threats, annoyances, petty oppressions, or other trivialities. Complete emotional tranquility is seldom attainable in this world, and some degree of transient and trivial emotional distress is part of the price of living among people. The law intervenes only where the distress is so severe that no reasonable man could be expected to endure it.

Newspaper Articles. A libel suit was brought against the Miami Herald Publishing Company more than two years after its publication of an editorial cartoon depicting a nursing facility in a distasteful manner.[46] The cartoon was described in the following manner:

> On October 29, 1980, *The Herald* published an editorial cartoon which depicted three men in a dilapidated room. On the back wall was written "Krest View Nursing Home," and on the side wall there was a board which read "Closed by Order of the State of Florida." The room itself was in a state of total disrepair. There were holes in the floor and ceiling, leaking water pipes, and exposed wiring. The men in the room were dressed in outfits resembling those commonly appearing in caricatures of gangsters. Each man carried a sack with a dollar sign on it. One of the men was larger than the other two and was more in the forefront of the picture. One of the others addressed him. The caption read: "Don't Worry, Boss, We Can Always Reopen It As a Haunted House for the Kiddies."[47]

The court held that the newspaper's editorial cartoon depicting persons resembling gangsters in a dilapidated building, identified as a particular nursing facility that had been closed by state order, was an expression of pure opinion and was protected by the First Amendment against the libel suit alleging that the cartoon defamed the owner of the facility.

In another newspaper libel case, the court in *Wisconsin Association of Nursing Homes*[48] would not compel the newspapers to accept and print an advertisement in the exact form submitted by the Wisconsin Association of Nursing Homes and various individual homes.

> Plaintiffs allege in their complaint that the defendants published a series of "investigative reports" in the *Milwaukee Journal* which dealt with the quality of care and services in several nursing homes. Plaintiffs further characterized the conclusions of the article as being false and erroneous. As a result, the plaintiffs prepared a full-page advertisement which purported to respond to and refute the allegations set out in the above mentioned "reports." The defendant newspaper refused to publish the advertisement in the form presented, and referred the question of possibly libelous matter to the attention of plaintiffs' attorneys.[49]

The court held that it was within the newspaper's journalistic discretion to reject the advertisement on the ground that it contained possibly libelous material. "[T]he clear weight of authority has not sanctioned any enforceable right of access to the press. In sum, a court can no more dictate what a privately owned newspaper can print than what it cannot print."[50]

> Unlike broadcasting, the publication of a newspaper is not a government-conferred privilege. As we have said, the press and the government have had a history of disassociation. We can find nothing in the United States Constitution, any federal statute, or any controlling precedent that allows us to compel a private newspaper to publish advertisements without editorial control merely because such advertisements are not legally obscene or unlawful.[51]

In a very different suit, the appellee in *Stevens v. Morris Communications Corp.*[52] alleged that a newspaper article, which identified her as a representative of a convalescent center at a city council meeting, had defamed her. She claims that the article implies that she has responsibility for the convalescent center's problems of maintenance and disrepair. The court held that the appellee was not defamed by the article. Using the reasonable person test, the court found that it was highly unlikely that a reasonable person could have read the newspaper article as being defamatory.

Slander

Slander lawsuits are rare because of the difficulty in proving defamation, the small awards, and the high legal fees. With slander, the person who brings suit generally must prove special damages; however, when any allegedly defamatory words refer to a person in a professional capacity, the professional need not show that the words caused damage. It is presumed that any slanderous reference to someone's professional capacity is damaging. The Georgia case of *Barry v. Baugh,*[53] however, presented a unique situation. The case involved a nurse who brought a defamation action, charging that a physician slandered her in the course of a consultation concerning the commitment of her husband to a mental institution. The nurse requested damages for mental pain, shock, fright, humiliation, and embarrassment. The nurse alleged that if the physician's statement were made known to the public, her job and reputation would be affected adversely. The court held that the physician's statement concerning the nurse did not constitute slander because the physician was not referring to the nurse in a professional capacity.[54] In this case, because the court held that the physician's statement did not refer to the nurse in her professional capacity, the plaintiff had to demonstrate damages in order to recover. The plaintiff was unable to show damages.

Professionals who are called incompetent in front of others have a right to sue to defend their reputation. However, it is difficult to prove that an individual comment was injurious. If the person making an injurious comment cannot prove that the comment is true, then that person can be held liable for damages.

ACCUSATORY STATEMENTS NOT DEFAMATORY

Citation: *Chowdhry v. North Las Vegas Hospital, Inc.,* 851 P.2d 459 (Nev. 1993)

Facts

On October 2, 1985, a young woman entered the emergency department of a hospital complaining of chest pain and shortness of breath. Dr. Lapica, the emergency physician on duty, saw her. Lapica diagnosed the patient as suffering from a possible pneumo-hemothorax, which required the placement of a chest tube to drain accumulated fluids. Lapica contacted Dr. Chowdhry, a physician who had recently performed surgery on the young woman and who was also the on-call thoracic surgeon at the hospital, and informed Chowdhry that his services were required at the hospital. The record

revealed that Chowdhry refused to return to the hospital to treat the patient because he had recently left there and would treat her only if she were transferred to University Medical Center (UMC). Chowdhry testified that he could not return to the hospital because of a conflicting emergency at UMC.

Lapica then contacted the hospital's chief of staff, Dr. Wilchins, and told him that Chowdhry refused to come to the hospital and attend to the patient. Both physicians concluded that if the patient could be safely transported to UMC, the transfer should be affected so that Chowdhry could treat her.

The patient was ultimately transported to UMC where Lapica and Ms. Crow, the supervising nurse at the hospital, prepared incident reports detailing the events and submitted them to the hospital administrator, Mr. Moore.

On October 3, 1985, Moore informed Dr. Silver, UMC's chief of surgery, that Chowdhry had refused to come to the hospital emergency department to treat the patient. The matter was directed to the hospital's surgery committee, which recommended summary suspension of Chowdhry's staff privileges.

On November 1, 1985, in response to Chowdhry's request, a hearing was held before the medical executive committee. As a result of the hearing, Chowdhry's staff privileges were reinstated, but a reprimand was placed in his file for jeopardizing himself, the patient, and the hospital. The hospital denied Chowdhry's subsequent request to have the reprimand expunged from his record, thus prompting Chowdhry to file an action against the hospital, Silver, Moore, Wilchins, and Lapica.

Chowdhry's complaint alleged theories of liability based upon negligence, breach of contract, conspiracy, defamation, and negligent and intentional infliction of emotional distress. The district court concluded that Chowdhry had no reasonable basis for bringing the action and awarded attorneys' fees and costs to the hospital, Silver, Moore, Wilchins, and Lapica; Chowdhry appealed.

Issue

Did the district court err in dismissing the claims of defamation and infliction of emotional distress?

Holding

The Nevada Supreme Court held that the district court did not err in dismissing the claims of defamation and infliction of emotional distress.

Reason

Chowdhry's emotional distress claims are premised upon respondents' accusations of patient abandonment. Chowdhry testified that as a result, "he was very upset" and could not sleep. Insomnia and general physical or emotional discomfort are insufficient to satisfy the physical impact requirement for emotional distress. Thus, Chowdhry failed, as a matter of law, to present sufficient evidence to sustain verdicts for negligent or intentional infliction of emotional distress.

To establish a prima facie case of defamation, a plaintiff must prove: (1) a false and defamatory statement by defendant concerning the plaintiff, (2) an unprivileged publication to a third person, (3) fault amounting to at least negligence, and (4) actual or presumed damages. The actual statements made by the various respondents were not that Chowdhry "abandoned" his patient, but that he "failed to respond" or "would not come" to the hospital to treat his patient. The record reflected that the respondents made the statements to hospital personnel and other interested parties (e.g., the patient's mother) in the context of reporting what was reasonably perceived to be Chowdhry's refusal to treat the patient at the hospital. The statements attributable to the respondents, taken in context, are not reasonably capable of a defamatory construction.

Discussion

1. Explain what a plaintiff must prove in order to establish an action for defamation.
2. How does libel differ from slander?

Defenses to a Defamation Action

Essentially, the two defenses to a defamation action are truth and privilege. When a person has said something that is damaging to another person's reputation, the person making the statement will not be liable for defamation if it can be shown that the statement is true. A privileged communication differs from a defamatory statement in that the person making the communication has a responsibility to do so. For example, many states have statutes providing immunity to physicians and health care institutions in connection with peer review proceedings. The person making the communication must do so in good faith, on the proper occasion, in the proper manner, and to persons who have a legitimate reason to receive the information.

An administrator's statements made to a physician's supervisor regarding the physician's alleged professional misconduct is not grounds for a defamation action as long as the statements are made in good faith. A hospital administrator has a duty to report complaints about alleged professional misconduct of physicians working in the hospital. The administrator has qualified privilege to report such complaints to the physician's supervisor and other hospital officials as necessary.[55]

Two types of privilege may provide a defense to an action for defamation: absolute privilege and qualified privilege. *Absolute privilege* attaches to statements made during judicial and legislative proceedings as well as to confidential communications between spouses. *Qualified privilege* attaches to statements such as those made as a result of a legal or moral duty to speak in the interests of third persons and may provide a successful defense only when such statements are made in the absence of malice. If it can be shown that a speaker made a statement out of monetary gain, hatred, or ill will, the law will not permit the speaker to hide behind the shield of privilege to avoid liability for defamation.

The defense of privilege is illustrated in the case of *Judge v. Rockford Memorial Hospital,*[56] whereby a nurse brought an action for libel. The action was based on a letter written to a nurses' professional registry by the director of nurses at the hospital to which the nurse had been assigned by the registry. In the letter, the director of nurses stated that the hospital did not wish to have the nurse's services available to them because of certain losses of narcotics during times when this particular nurse was on duty. The court refused the nurse recovery. Because the director of nurses had a legal duty to make the communication in the interests of society, the director's letter constituted a privileged communication. Therefore, the court held that the letter did not constitute libel because it was privileged.

It is important to note that public figures have more difficulty in pursuing defamation litigation than the average individual. One who occupies a position of considerable public responsibility is considered a public figure for the purposes of the law of defamation and is generally more vulnerable to public scrutiny. Legal action against a public figure generally will be denied in the absence of any showing of actual malice in connection with alleged defamatory references to a plaintiff. Actual malice applies only in cases involving public figures and encompasses knowledge of falsity or recklessness as to truth.

The chairman of a publicly owned and operated county hospital in *Drew v. KATV Television*[57] brought a suit against a television station for defamation. The station reported during a news broadcast that the board chairman had been charged with a felony when he had been charged with two misdemeanor counts of solicitation to tamper with evidence (both of which were dismissed at trial). The second news report implied that the plaintiff was involved in a drug investigation being conducted at the hospital where he served as chairman of the board. The plaintiff occupied a position of considerable public responsibility, and he was considered a public figure for the purposes of the law of defamation. The circuit court dismissed the case on the defendant's motion for summary judgment, and the plaintiff appealed. The Arkansas Supreme Court held that the trial court properly ordered summary dismissal of the plaintiff's action against the television station in the absence of any showing of malice in connection with the allegedly defamatory references to the plaintiff during the news broadcasts.

Fraud

The intentional tort of *fraud* is defined as willful and intentional misrepresentation that could cause harm or loss to a person or property. Fraud includes any cunning, deception, or artifice used, in violation of legal or equitable duty, to circumvent, cheat, or deceive another. The forms it may assume and the means by which it may be practiced are as multifarious as human ingenuity can devise, and the courts consider it unwise or impossible to formulate an exact, definite, and all-inclusive definition of the action.

To prove fraud, the following facts must be shown:

- An untrue statement known to be untrue by the party making it and made with the intent to deceive
- Justifiable reliance by the victim on the truth of the statement
- Damages as a result of that reliance

Concealment of Information from Patient

The plaintiff in *Robinson v. Shah*[58] was a long-time patient of defendant, Dr. Shah, from 1975 to 1986. During that period of time, the defendant treated the plaintiff for various gynecological disorders. On November 9, 1983, the defendant performed a total abdominal hysterectomy and bilateral

salpingo-oophorectomy on the plaintiff. Approximately one week following surgery, the plaintiff was discharged from the hospital and was assured that there were no complications or potential problems that might arise as a result of the surgery. On the day after the plaintiff was discharged from the hospital, she began to experience abdominal distress. She consulted the defendant about these symptoms, and the defendant ordered X-rays to be taken of the plaintiff's kidneys, ureter, and bladder in an effort to explain her discomfort.

The X-rays were taken at St. Joseph Memorial Hospital and were read and interpreted by Dr. Cavanaugh, presumably a radiologist associated with that facility. After reading the X-rays, Cavanaugh called the defendant and reported that the slides showed the presence of surgical sponges that had been left in the plaintiff's abdomen after surgery. Cavanaugh also sent the defendant a copy of a written report that reflected the findings.

The defendant fraudulently concealed from the plaintiff the findings of the X-rays. Instead of being truthful, the defendant intentionally lied to the plaintiff and told her the X-rays were negative and that there were no apparent or unusual complications from the recent abdominal surgery, and she assured the plaintiff that she did not require further treatment. At no time did the defendant reveal to the plaintiff the fact that she had left surgical sponges in the plaintiff's abdomen after the most recent surgery.

Over the next several years, the plaintiff continued to see the defendant for gynecological checkups. She continued to experience abdominal pain and discomfort. The defendant, however, continued to conceal from the plaintiff the existence of the surgical sponges left in the plaintiff's abdomen. The plaintiff ceased seeing the defendant as her physician in 1986. However, she consulted other physicians and continued to experience frequent pain and discomfort in her abdomen as well as intestinal, urological, and gynecological problems. Although the plaintiff brought her complaints to the attention of other physicians, no one was able to diagnose the source of her problems.

In 1993, one of the physicians attending to the plaintiff's problems diagnosed a pelvic mass, which he felt could be causing some discomfort. The plaintiff underwent pelvic sonograms and X-rays, which revealed the existence of retained surgical sponges. The plaintiff contended that the defendant, from and after November 18, 1983, had knowledge of the presence of retained surgical sponges in her abdomen and knew the potential of future complications that could arise from this condition. Despite this knowledge, the plaintiff contended, the defendant fraudulently concealed the existence of this condition from the plaintiff.

The trial court found that the plaintiff was unable to discover the fact that the defendant negligently left surgical sponges in her abdomen and that this fact was fraudulently concealed from the plaintiff, who did not discover the defendant's fraud until August 11, 1993.

The appeals court held that although the action in this case was filed more than ten years after the fraud was perpetrated, the statute of limitations was not tolled because of the defendant's fraudulent concealment of information from the patient. The court decided that a physician may not blunt a malpractice cause of action by misrepresenting facts to a patient. Allowing such misrepresentation would serve only to encourage such behavior.

Invasion of Privacy

The *right to privacy* is implied in the Constitution. It is recognized by the law as the right to be left alone—the right to be free from unwarranted publicity and exposure to public view, as well as the right to live one's life without having one's name, picture, or private affairs made public against one's will. Health care organizations and professionals may become liable for invasion of privacy if, for example, they divulge information from a patient's medical record to improper sources or if they commit unwarranted intrusions into a patient's personal affairs.

Patients have a right to personal privacy and a right to the confidentiality of their personal and clinical records. The information in a patient's medical record is confidential and should not be disclosed without the patient's permission, with the exception of occasions when there is a legal obligation or duty to disclose the information (i.e., reporting of communicable diseases, gunshot wounds, and child abuse). Those who come into possession of the most intimate personal information about patients have both a legal and an ethical duty not to reveal confidential communications.

Unfortunately, familiarity with an organization's health care environment tends to diminish the conscious concern personnel should have for the protection of patient privacy. The plaintiff, a former hospital employee, in *Vernuil v. Poirie*[59] was awarded $15,000 in a legal action against her supervisor and hospital for invasion of privacy. The plaintiff claimed that while she was a patient and in the postoperative recovery room, her supervisor lifted her sheet in an attempt to view her abdominal incision. The court of appeals held that evidence sustained a finding of invasion of privacy. Because the supervisor's conduct occurred during the time and place of his employment, the hospital was jointly liable for damages. "Ensuring a patient's well-being from all others, including staff, while the patient is helpless under the effects of anesthesia is part of its normal business."[60]

Intentional Infliction of Mental Distress

The intentional or reckless infliction of mental distress is characterized by conduct that is so outrageous that it goes beyond the bounds tolerated by a decent society. *Mental distress* includes mental suffering resulting from painful

emotions such as grief, public humiliation, despair, shame, and wounded pride. Liability for the wrongful infliction of mental distress may be based on either intentional or negligent misconduct. A plaintiff may recover damages if he or she can show that the defendant intended to inflict mental distress and knew or should have known that his or her actions would give rise to it.

The mother of a premature infant who died shortly after birth went to her physician for a six week check-up. She noticed a report in her medical chart that stated that the child was past the fifth month in development and that hospital rules and state law prohibited disposal of the infant as a surgical specimen. The mother questioned her physician regarding the infant. The physician requested that his nurse take the mother to the hospital. An employee at the hospital took the mother to a freezer. The freezer was opened and the mother was handed a jar containing her premature infant. The circuit court found that the hospital, through its employees, committed intentional infliction of emotional distress. On appeal, the court of appeals held that the jury could find that the hospital's conduct in displaying the infant was outrageous conduct.[61]

In another mental distress case, an action in *Greer v. Medders*[62] was brought by a patient and his wife against a physician. The defendant physician had been covering for the attending physician who was on vacation. When the hospitalized plaintiff had not seen the covering physician for several days, he called the physician's office to complain. The physician later entered the patient's room in an agitated manner and became verbally abusive in the presence of the patient's wife and a nurse. He said to the patient, "Let me tell you one damn thing, don't nobody call over to my office raising hell with my secretary. . . . I don't have to be here every damn day checking on you because I check with physical therapy. . . . I don't have to be your damn doctor."[63] When the physician left the room, the plaintiff's wife began to cry, and the plaintiff experienced episodes of uncontrollable shaking for which he received psychiatric treatment. The superior court entered summary judgment for the physician, and the plaintiff appealed. The Georgia Court of Appeals held that the physician's abusive language willfully caused emotional upset and precluded summary judgment for the defendant.

STRICT/PRODUCTS LIABILITY

Strict liability is a legal doctrine that makes some persons or entity responsible for damages their actions or products cause, regardless of "fault" on their part. Strict liability often applies when people engage in inherently hazardous activities, such as blasting in a city. If the blasting injures a person, no matter how careful the blasting company was, it can be liable for any injuries suffered. Strict liability also applies in the case of manufactured products such as drugs. This section focuses on products liability.

Products liability is the accountability of a manufacturer, seller, or supplier of chattels to a buyer or other third party for injuries sustained because of a defect in a product. An injured party may proceed with a lawsuit against a seller, manufacturer, or supplier on three legal theories: (1) negligence, (2) breach of warranty (express or implied), and (3) strict liability. Many states have enacted comprehensive products liability statutes. These statutory provisions can be very diverse such that the United States Department of Commerce has promulgated a Model Uniform Products Liability Act (MUPLA) for voluntary use by the states. Three types of product defects that incur liability are design defects, manufacturing defects, and defects in marketing (e.g., providing improper instructions for the product's use).

Negligence

Negligence, as applied to products liability, requires the plaintiff to establish duty, breach, injury, and causation. The manufacturer of a product is not liable for injuries suffered by a patient if they are the result of negligent use by the user. Product users must conform to the safety standards provided by the manufacturers of supplies and equipment. Failure to follow proper safety instructions can prevent recovery in a negligence suit if injury results from improper use.

Because manufacturers are liable for injuries that result from unsafe product design, they generally provide detailed safety instructions to the users of their products. Failure to provide such instructions could be considered negligence on the part of the manufacturer.

An action in *Airco v. Simmons National Bank, Guardian, et al.*[64] was brought against a physician partnership that provided anesthesia services to the hospital and Airco, Inc., the manufacturer of an artificial breathing machine used in the administration of anesthesia. It was alleged that the patient suffered irreversible brain damage because of the negligent use of the equipment and its unsafe design. The machine had been marketed despite prior reports of a foreseeable danger of human error brought about by the presence of several identical black hoses and the necessity of connecting them correctly to three ports of identical size placed closely together. The machine lacked adequate labels and warnings, according to the reports. The jury awarded $1,070,000 in compensatory damages against the physician partnership and Airco, Inc. Punitive damages in the amount of $3 million were awarded against Airco, Inc. On appeal of the punitive damages award, the Arkansas Supreme Court held that the evidence for punitive damages was sufficient for the jury. The manufacturer acted in a persistent reckless disregard of the foreseeable dangers in the machine by continuing to sell it with the known hazardous design.

Negligence, as well as breach of warranty and strict liability, was not established in the well-publicized case of the 1980s involving a woman who died after ingesting Tylenol capsules tainted with potassium cyanide. The decedent's estate in *Elsroth v. Johnson & Johnson*[65] sued the manufacturer and the retail grocery store that sold the over-the-counter drug. The defendants moved for a summary judgment. The U.S. district court held that the retailer did not have a duty to protect the decedent from acts of tampering by an unknown third party. The manufacturer was not liable under an inadequate warning theory. Manufacturers are under a duty to warn of the dangers that may be associated with the normal and lawful use of their products, but they need not warn that their products may be susceptible to criminal misuse.

Negligent use of a product, however, may lead to liability. In *Monk v. Doctors Hospital,* the negligent use of a Bovie plate led to liability.[66] The patient was admitted to the hospital for abdominal surgery. Before surgery, the patient asked the surgeon also to remove three moles from the right arm and one from the right leg. The surgeon instructed a hospital nurse to prepare a Bovie machine, but was not present while the machine was set up. The nurse placed the contact plate of the Bovie machine under the patient's right calf in a negligent manner, and the patient suffered burns. Manufacturer instruction manuals supported the claim that the plate was placed improperly on the patient. These manuals were available to the hospital. The trial court directed a verdict in favor of the hospital and the physician. The appellate court found that there was sufficient evidence from which the jury could conclude that the Bovie plate was applied in a negligent manner. There also was sufficient evidence, including the manufacturer's manual and expert testimony, from which the jury could find that the physician was independently negligent.[67]

This case demonstrates the necessity for an organization to require conformity to the safety standards provided by the manufacturers of supplies and equipment. As evidenced in the previous case, such failure can cause an organization and its staff to be held liable for negligence. This case should alert manufacturers of the necessity to provide appropriate safety instructions to the users of their products. It can be assumed that failure to provide such instructions could be considered negligence on the part of the supplier.

Defective Packaging

Cotita, a registered nurse, was stuck by a syringe manufactured by the defendant-appellee, PharmaPlast. The syringe, although still in its sterile packaging, was missing the protective cap that normally covers the tip of the needle. This improper packaging allowed the needle to pierce its sterile plastic covering and penetrate the protective gloves Cotita was wearing. Because of the presence of the patient's blood on his gloves at the time of the needle stick, Cotita feared that he had been exposed to the human immunodeficiency virus (HIV). Subsequent tests revealed that Cotita was not HIV-positive; nevertheless, he sued PharmaPlast, seeking damages for mental anguish stemming from his fear of contracting AIDS.

PharmaPlast admitted defective packaging, and the district court granted summary judgment for the plaintiff on the issue of the defective state of the syringe. PharmaPlast asserted Cotita was negligent in his use of the syringe. Cotita objected to the introduction of evidence concerning his negligence.

The damage issue was tried before a jury that returned a verdict for $150,000 in Cotita's favor. This amount was reduced by 30 percent, a figure that the jury found reflected his negligence. Cotita maintained that the issue of his negligence should not have been considered by the jury, nor used to reduce the amount of his award.

The U.S. Court of Appeals found no error in the district court's application of comparative fault. PharmaPlast presented evidence that the procedures used by the nurse were in violation of the universal precautions and procedures that are standard in the health care field. The district court here was entitled to determine that the application of comparative fault would ultimately encourage workers in the health care field to follow the established procedures for handling syringes.[68]

Failure to Warn

Merck pulled Vioxx off pharmacy shelves, a drug it manufactures for the treatment of arthritis, after participants in a study experienced adverse cardiovascular events compared to those taking a placebo. Approximately 20 million people have used Vioxx. Since the recall of Vioxx, approximately 4,200 product liability lawsuits representing about 7,500 plaintiff groups have been filed against Merck. Lawsuits have already been filed in Texas, New Jersey, and California. Merck has vowed to fight each case.

The first Vioxx trial took place in Texas, where Mrs. Ernst claims that if her husband had known of the true risks of Vioxx, he would not have taken the drug. The plaintiff's lawyers argued that Merck was aware of the problems with Vioxx for several years, concealed the negative information, and continued to sell the drug to the public. On a jury verdict, Merck was held liable for the death in May 2001 of Mr. Ernst, a marathon runner, who died eight months after he started using Vioxx. He died of a heart attack and was taking Vioxx at the time of his death. The jury awarded the plaintiff $253 million in damages. Because of malpractice caps in Texas, Mrs. Ernst will receive a substantially lesser amount for damages. Nevertheless, the ultimate financial impact on

Merck is expected to be in the billions. Merck is expected to appeal the jury's decision claiming that Ernst's arrhythmia had not been linked to Vioxx in the studies conducted.

Breach of Warranty

A *warranty* is a particular type of guarantee (a pledge or assurance of something) concerning goods or services provided by a seller to a buyer. Nearly everything purchased is covered by a warranty. To recover under a cause of action based on a breach of warranty theory, the plaintiff must establish whether there was an express or implied warranty.

Express Warranty

An *express warranty* includes specific promises or affirmations made by the seller to the buyer, such as "X" drug is not subject to addiction. If the product fails to perform as advertised, it is a breach of express warranty. For example, in *Crocker v. Winthrop Laboratories,*[69] the patient, Mr. Crocker, was admitted to the hospital for a hernia operation. His physician prescribed both Demerol and Talwin for pain. After discharge from the hospital, Crocker developed an addiction to Talwin and was able to obtain prescriptions from several physicians to support a habit he developed. He was eventually admitted to the hospital for detoxification. After six days, Crocker walked out of the hospital and went home. He became agitated and abusive, threatening his wife, and she eventually called a physician at his request. The physician arrived and gave Crocker an injection of Demerol. Crocker then retired to bed and subsequently died. Action was brought against the drug company for the suffering and subsequent wrongful death that occurred as the proximate result of the decedent's addiction to Talwin.

The district court rendered a judgment for the plaintiff and the court of appeals reversed. On further appeal, the Texas Supreme Court held that when a drug company positively and specifically represents its product to be free and safe from all dangers of addiction and when the treating physician relies on such representation, the drug company is liable when the representation proves to be false and injury results.

Implied Warranty

An *implied warranty* is a guarantee of a product's quality that is not expressed in a purchase contract. An implied warranty assumes that the item sold can perform the function for which it is designed. Implied warranties are in effect when the law implies that one exists by operation of law as a matter of public policy for the protection of the public. *Jacob E. Decker & Sons v. Capps*[70] is a case involving the question of the liability of a manufacturer of food products to the consumer for damages sustained by ingestion of contaminated sausage. One member of a family died and others became seriously ill as a result of eating contaminated food. The jury found that the sausage had been contaminated before being packaged by the defendant and that it was unfit for human consumption. The Texas Supreme Court decided that the defendant was liable for the injuries sustained by the consumers of the contaminated food under an implied warranty. Liability in such a case is based neither on negligence nor on a breach of the usual implied contractual warranty. It is based on the broad principle of the public policy to protect human health and life.

The patient in *Perlmutter v. Beth David Hospital*[71] contracted serum hepatitis from a blood transfusion. She relied on an implied sales warranty as the basis of her suit. The court denied recovery, pointing out that even though a separate charge of $60 was made for the blood, the charge was incidental to the primary contract with the hospital for services. Because there was no claim of negligence, the court determined that blood provided by the hospital was a service, rather than a sale, and, therefore, barred recovery by the patient. The rationale of this case did not extend to relieve commercial blood banks from liability on the basis of strict liability warranty theories. Action could have been instituted against the hospital if it had been shown that the hospital was negligent in handling the blood.

Strict Liability

Strict liability refers to responsibility without fault and makes possible an award of damages without any proof of manufacturer negligence. The plaintiff needs only to show that he or she suffered injury while using the manufacturer's product in the prescribed way.

The following elements must be present for a plaintiff to proceed with a case on the basis of strict liability:

- The product must have been manufactured by the defendant.
- The product must have been defective at the time it left the hands of the manufacturer or seller. The defect in the product normally consists of a manufacturing defect, a design defect in the product, or an absence or inadequacy of warnings for the use of the product.
- The plaintiff must have been injured by the specific product.
- The defective product must have been the proximate cause of injury to the plaintiff.

In *Green v. Smith & Nephew AHP, Inc.,*[72] Green began her employment at St. Joseph's Hospital in Milwaukee, where she worked as a radiology technologist. Hospital rules

required Green to wear protective gloves while attending patients. To comply with these rules, Green wore powdered latex gloves manufactured by Smith & Nephew AHP (S&N). Initially, Green used one or two pairs of gloves per shift. However, upon her promotion to the CT department, this use began increasing. Green's job required her to change up to approximately 40 pairs of gloves per shift. Green began suffering various health problems. Her hands became red, cracked, and sore and began peeling. In response to this condition, she applied hand lotion, changed the soap she used and the type of hand towels she used, and tried various other remedies. Green was eventually diagnosed with a latex allergy. Her symptoms grew increasingly severe, eventually culminating in an acute shortness of breath, coughing, tightening of the throat, and hospitalization on more than one occasion.

Green claimed that S&N should be held strictly liable for her injuries. She argued that although S&N could have significantly reduced the protein levels in and discontinued powdering of its gloves by adjusting its production process, S&N nonetheless utilized a production process that maintained these defects in the gloves. These defects, Green alleged, created the unreasonable danger that S&N's gloves would cause consumers to develop latex allergy and suffer allergy-related conditions. The primary cause of latex allergy is latex gloves and, for this reason, latex allergy disproportionately affects members of the health care profession. According to Green's medical experts, the vast majority of people with latex allergy—up to 90 percent—are health care workers. And although latex allergy is not common among the general population, Green's medical experts testified that it affects between 5 and 17 percent of all health care workers in the United States.

Although a manufacturer is not under a duty to manufacture a product that is absolutely free from all possible harm to every individual, it is the duty of the manufacturer not to place upon the market a defective product that is unreasonably dangerous to the ordinary consumer.

The jury returned a verdict in favor of Green, finding that S&N's gloves were defective and unreasonably dangerous and that they caused Green's injuries. The jury awarded Green $1 million in damages. The court of appeals affirmed the circuit court judgment. S&N then petitioned the supreme court of Wisconsin to review the court of appeals decision.

The Wisconsin Supreme Court affirmed the decision of the court of appeals. Strict products liability imposes liability without regard to negligence and its attendant factors of duty of care and foreseeability. Regardless of whether a manufacturer could foresee the potential risks of harm inherent in its defective and unreasonably dangerous product, strict products liability holds the manufacturer responsible for injuries caused by that product. When a manufacturer places a defective and unreasonably dangerous product into the stream of commerce, the manufacturer, not the injured consumer, should bear the costs of the risks posed by the product.

Negligent blood handling held a blood bank strictly liable in *Weber v. Charity Hospital of Louisiana at New Orleans,*[73] when a hospital patient developed hepatitis from a transfusion of defective blood during surgery. Evidence established that the blood bank collected, processed, and sold the blood to the hospital. Although the hospital administered the blood, absent any negligence in its handling or administration, it was not liable for the patient's injury. Many states have enacted statutes to exempt blood from the product category and thus remove blood products from the theory of strict liability.

Res Ipsa Loquitur

Liability also may be based on the concept of *res ipsa loquitur* (the thing speaks for itself) by showing all of the following:

- The product did not perform in the way intended.
- The product was not tampered with by the buyer or third party.
- The defect existed at the time it left the defendant manufacturer.

For example, a manufacturer mislabeled a box of Duragesic patches, a strong prescription medication for moderate-to-severe chronic pain, marking the box as containing 25 mcg patches. In actuality, the box contained 100 mcg patches. The patient placed a patch on her back to provide relief of severe back pain. Instead of receiving the 25 mcg dosage recommended by her physician, she received 100 mcg, four times the recommended dosage. The patient went into a coma and eventually died.

Products Liability Defenses

Defenses against recovery in a products liability case include:

- *Assumption of a risk* (e.g., voluntary exposure to such risks as radiation treatments and chemotherapy treatments)
- Intervening cause (e.g., an intravenous solution contaminated by the negligence of the product user, rather than that of the manufacturer)
- Contributory negligence (e.g., use of a product in a way that it was not intended to be used)
- Comparative fault (e.g., injury is the result of the concurrent negligence of both the manufacturer and the plaintiff)
- Disclaimers (e.g., manufacturers' inserts and warnings regarding usage and contraindications of their products)

Disclaimers and waivers of liability for products are often invalidated by courts as against public policy. Warranties are limited so that manufacturers and retailers are held responsible for personal injuries caused by the use of the product.

Successful products liability cases tend to have a negative impact on the development of new drugs. In addition, manufacturers tend to remove older technologies from the marketplace to decrease their exposure to liability and potential financial risks. On the positive side, the slipshod manufacture of products is discouraged. This is increasingly evident in the sale of food products where consumers are demanding full disclosure of the contents of packaged products.

The Court's Decision

The Ohio Court of Appeals held that the delay in providing the plaintiff treatment fell below the medically acceptable standard of care. The court was appalled that the physician had characterized his evaluation as a medical examination or had implied that what he described as a "cursory breast examination" should be considered a medically sufficient breast examination. It seemed incredible to the court that a physician would deliberately choose not to take the additional few minutes or seconds to thoroughly palpitate the sides of the breasts, which is a standard minimally intrusive cancer detection technique. His admission that he merely "pressed" on the plaintiff's breasts, coupled with the additional admission that such acts would not necessarily disclose lumps in the breasts, constituted poor medical care.

It was probable that an earlier procedure would have safely and reliably conserved a large part of the plaintiff's right breast. Through inexcusable delays, the plaintiff lost this option and, instead, was medically required to have the entire breast removed. The court concluded that the defendant's negligence was the sole and

CHAPTER REVIEW

1. A *tort* is a civil wrong, not including breach of contract, that is committed against a person or property for which a court provides a remedy in the form of an action for damages. Three categories of torts are negligent torts, intentional torts, and torts where strict liability is assessed regardless of fault.
2. *Negligence* is a tort—a civil or personal wrong. It is the unintentional commission or omission of an act that a reasonably prudent person would or would not do under the same or similar circumstances.
3. *Negligence* has three basic forms:
   - *Malfeasance:* the execution of an unlawful or improper act
   - *Misfeasance:* the improper performance of an act that results in injury to another
   - *Nonfeasance:* a failure to act when there is a duty to do so
4. There are two degrees of negligence:
   - *Ordinary negligence* is the failure to do what a reasonably prudent person would do or doing what a reasonably prudent person would not do under the circumstances of the act or omission in question.

- Gross negligence is the intentional or wanton omission of care that should be provided or the performance of an improper act.

5. To recover damages caused by negligence, the following elements must be present:
   - *Duty to care:* exists when there is a legal obligation of care, performance, or observance imposed on one party to guard the rights of others
   - Breach of duty: failure to meet a prevailing standard of care
   - Injury: without proof of harm or injury, a defendant cannot be found liable for negligence
   - Causation: the defendant's negligence must be a substantial factor in having caused an injury
6. *Foreseeability* is the reasonable anticipation that harm or injury will result from an act or a failure to act. The test for foreseeability is whether one should have reasonably anticipated that the event in question or a similar event would occur.
7. For liability to be established based on failure to follow a specified standard of care outlined by statute, three elements must be present:
   - The defendant must have been within the specified class of persons outlined in the statute.
   - The plaintiff must have been injured in a way that the statute was designed to prevent.
   - The plaintiff must show that the injury would not have occurred had the statute not been violated.
8. Intentional wrongdoing involves a willful act that violates another person's interests. Not only must the action be intentional, but also the perpetrator must realize that the action will result in harm.
9. *Assault* is the infringement on the mental security or tranquility of another person; *battery* is the violation of another person's physical integrity. No actual physical harm need have occurred for an individual to be guilty of assault.
10. *False imprisonment* is the unlawful restraint of an individual's personal liberty or the unlawful restraint or confinement of an individual. For a false imprisonment charge to warrant recovery, the plaintiff must be aware of the confinement and have no reasonable means of escape.
11. *Defamation of character* is a false oral or written communication to someone other than the individual defamed that subjects that individual's reputation to scorn and ridicule in the eyes of a substantial number of respectable people in the community. Two aspects of defamation of character are *libel,* which results from the written word, and *slander,* which results from the spoken word.
12. *Fraud* is a willful and intentional misrepresentation that could cause harm or loss to an individual or property. To prove fraud, the following three facts must be shown:
    - An untrue statement known to be untrue by the party making it and made with the intent to deceive
    - A justifiable reliance by the victim on the truth of that statement
    - Damages as a result of that reliance
13. *Invasion of privacy* is a wrong that interferes with the right of an individual to personal privacy.
14. The intentional or reckless infliction of *mental distress* is conduct so outrageous that it goes beyond the bounds tolerated by a decent society. Mental distress can include mental suffering from painful emotions such as grief, public humiliation, despair, shame, and wounded pride.
15. *Strict liability* refers to liability without fault and makes possible an award of damages without any proof of manufacturer negligence. The plaintiff needs only to show that he or she suffered injury while using the manufacturer's product in the prescribed way.
16. *Products liability* is the liability of a manufacturer, seller, or supplier of chattels to a buyer or other third party for injuries sustained because of a defect in a product. An injured party may proceed with a lawsuit against a seller, manufacturer, or supplier on three legal theories: (1) negligence, (2) breach of warranty (express or implied), and (3) strict liability.
17. Products liability defenses include *assumption of a risk; intervening cause; contributory negligence; comparative fault;* and *disclaimers.*

REVIEW QUESTIONS

1. Describe the objectives of tort law.
2. Discuss the distinctions among negligent torts, intentional torts, and strict liability.
3. What forms of negligence are described in this chapter?
4. How does one distinguish between negligence and malpractice?
5. What elements must be proven in order to be successful in a negligence suit? Illustrate your answer with a case (the facts of the case can be hypothetical).
6. Can a "duty to care" be established by statute or contract? Discuss your answer.
7. Describe the categories of intentional torts.
8. How does slander differ from libel? Give an example of each.
9. What is products liability? Describe what legal theories an injured party may use in proceeding with a lawsuit against a seller, manufacturer, or supplier of goods.
10. Describe the defenses often used in a products liability case.

NOTES

1. *Tomcik v. Ohio Dep't of Rehabilitation & Correction,* 598 N.E.2d 900 (Ohio Ct. App. 1991).
2. *Id.* at 904.
3. www.wrongdiagnosis.com/malpractice/malpractice.htm.
4. 11 A.2d 132 (N.Y. App. Div. 1960).
5. 498 So. 2d 713 (La. Ct. App. 1986).
6. 787 S.W.2d 494 (Tex. Ct. App. 1990).
7. *Id.* at 496.
8. 57A AM JUR. 2D *Torts* § 148 (1989).
9. 343 N.E.3d 589 (Ill. 1976).
10. No. 2004-00863 (N.Y. App. Div. 2004).
11. 175 N.W.2d 588, 596 (Iowa 1970).
12. 349 A.2d 245 (Md. 1975).
13. *Greene v. Bowen,* 639 F. Supp. 544, 561 (E.D. Cal. 1986).
14. 706 P.2d 1383 (Nev. 1985). 19. 355 S.E.2d 104 (Ga. Ct. App. 1987).
15. 355 S.E.2d 104 (Ga. Ct. App. 1987).
16. 57A AM JUR. 2D *Torts* § 26 (1989).
17. 498 So. 2d 713 (La. Ct. App. 1986).
18. 128 So. 2d 485 (Ala. 1961).
19. 483 So. 2d 634 (La. Ct. App. 1985).
20. 57A AM. JUR. 2D *Torts* § 78 (1989).
21. 384 S.E.2d 92 (Va. 1989).
22. *Id.*
23. 498 So. 2d 713 (La. Ct. App. 1986).
24. *Dic v. Brooklyn Hospital Center,* No. 2003-01976 (N.Y. App. Div. 2004).
25. 691 A.2d 1147 (D.C. App. 1997).
26. 57A AM. JUR. 2D *Torts* § 80 (1989).
27. 33. 654 A.2d 771 (Conn. App. 1995).
28. *Id.* at 777.
29. *Clark v. Wagoner,* 452 S.W.2d 437, 440 (Tex. 1970).
30. 57A AM. JUR. 2D *Torts* § 134 (1989).
31. 296 S.E.2d 216 (Ga. Ct. App. 1982).
32. 142 N.E.2d 337 (Mass. 1957).
33. 116 Cal. Rptr. 733 (Cal. Ct. App. 1974).
34. 504 So. 2d 22 (Ala. 1986).
35. 457 A.2d 431 (N.J. 1983).
36. 865 S.W.2d 833 (Mo. Ct. App. 1993).
37. 841 F.2d 851 (8th Cir. 1988).
38. 358 S.E.2d 865 (Ga. Ct. App. 1987).
39. Garrard, *Evaluation of Neuroleptic Drug Use by Nursing Home Elderly under Proposed Medicare and Medicaid Regulations,* 265(4) JAMA 463 (1991).
40. 461 S.W.2d 195 (Tex. Ct. App. 1970).
41. 562 N.Y.2d 127 (N.Y. App. Div. 1990).
42. *Id.* at 129.
43. 856 S.W.2d 437 (Tex. Ct. App. 1993).
44. *Id.* at 447.
45. *Id.*
46. *Keller v. Miami Herald Publishing Company,* 778 F.2d 711 (11th Cir. 1985).
47. *Id.* at 713.
48. 285 N.W.2d 891 (Wis. Ct. App. 1979).
49. *Id.* at 893.
50. *Id.* at 894.
51. *Associates and Aldrich Co. v. Times Mirror Co.,* 440 F.2d 133, 136 (9th Cir. 1971).
52. 317 S.E.2d 652 (Ga. Ct. App. 1984).
53. 143 S.E. 489 (Ga. Ct. App. 1965).
54. *Id.*
55. *Miller-Douglas v. Keller,* 579 So. 2d 491 (La. Ct. App. 1991).
56. 150 N.E.2d 202 (Ill. App. Ct. 1958).
57. 739 S.W.2d 680 (Ark. 1987).
58. 936 P.2d 784 (Kans. App. 1997).
59. 589 So. 2d 1202 (La. Ct. App. 1991).
60. *Id.* at 1204.
61. 527 S.W.2d 133 (Tenn. Ct. App. 1975).
62. 336 S.E.2d 329 (Ga. App. 1985).
63. *Id.*
64. 638 S.W.2d 660 (Ark. 1982).
65. 700 F. Supp. 151 (S.D.N.Y. 1988).
66. 403 F.2d 580 (D.C. Cir. 1968).
67. *Id.*
68. 974 F.2d 598 (5th Cir. 1992).
69. 514 S.W.2d 429 (Tex. 1974).
70. 164 S.W.2d 828 (Tex. 1942).
71. 123 N.E.2d 793 (N.Y. 1955).
72. 629 N.W.2d 727 (2001).
73. 487 So. 2d 148 (La. Ct. App. 1986).