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Health Care Law: Breaking Down the Boundaries of Malpractice Law

Philip G. Peters Jr.
University of Missouri School of Law, petersp@missouri.edu

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*Philip G. Peters, Jr.**

I. INTRODUCTION

Historically, courts have treated professional malpractice cases as unique. When disputes that would otherwise have been governed by tort rules of general application have arisen in the context of medical treatment, courts have routinely constructed special rules for the resolution of those disputes. Recent evidence suggests that this penchant for special rules may be weakening and that malpractice law may be slowly melting back into the sea of tort doctrine.

The three Missouri health care law cases noted in this issue are the latest evidence that courts today are more willing to resolve medical negligence actions using tort rules of general application than they once were. These three cases also typify the halting, labored nature of common law shifts of this kind.

All three of these cases involved bright-line "no duty" rules that had been specifically fashioned for medical negligence cases. One case involved the duty of "on-call" physicians. Traditionally, on-call specialists have not owed patients a duty to arrive at the hospital quickly unless a prior "physician-patient" relationship existed with the patient.[1] The second case reexamined a similar no-duty rule that excuses pharmacists from a duty to warn their customers of drug risks such as improper dosages and incompatible drugs.[2] The third case considered the viability of the "learned intermediary" doctrine, a no-duty rule that excuses pharmaceutical manufacturers from the duty to warn patients of the risks associated with their prescription drugs.[3] Rules like these erect tidy, bright spheres of obligation in malpractice law that are atypical of modern tort doctrine—a body of law that usually defines obligations with vague, but flexible, concepts such as foreseeability and reasonability.

In two of the three Missouri cases noted here, the Missouri courts backed away from these special duty rules. And in the third, the court was careful to evaluate the continued wisdom of the rule before reaffirming it. Collectively these cases are consistent with other evidence, discussed in Part V below, indicating that courts are increasingly willing to re-examine the special rules formulated for health care torts.

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* Ruth L. Hulston Professor of Law, University of Missouri-Columbia.

1. *See* Millard v. Corrado, 14 S.W.3d 42 (Mo. Ct. App. 1999).
2. *See* Horner v. Spalitto, 1 S.W.3d 519 (Mo. Ct. App. 1999).
3. *See* Doe v. Alpha Therapeutic Corp., 3 S.W.3d 404 (Mo. Ct. App. 1999).

II. "ON-CALL" PHYSICIANS

In Missouri, as in most other states, physicians traditionally have no duty to patients unless a "physician-patient" relationship exists. Across the country, this requirement has had the effect of both immunizing careless advice given in informal consultations[4] and also excusing failures by on-call specialists to arrive promptly at the hospital.[5] Missouri abrogated this latter immunity in *Millard v. Corrado*.[6]

The case involved a surgeon, Dr. Corrado, who had scheduled himself to be on-call even though he knew that he would be over forty miles away at a conference. The plaintiff, Marjorie Millard, was seriously hurt in an automobile accident during the time that Dr. Corrado was away. The plaintiff alleged that the surgeon's unavailability had aggravated her injuries. After she filed her claim, Dr. Corrado requested a summary judgment, alleging the absence of a physician-patient relationship and thus the absence of a legal duty to treat. Because a number of Missouri cases had enunciated this requirement,[7] the trial court granted his motion.

The Missouri Court of Appeals for the Eastern District of Missouri refused to be constrained by this narrow, wooden duty formula. Instead, it applied traditional (and expansive) tort duty analysis to conclude that Dr. Corrado owed an obligation to Ms. Millard. As the concurring opinion of Judge Crahan makes clear, general principles of tort law allow recovery against someone who undertakes to render services and then fails to do so with reasonable care.[8]

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4. *See, e.g.*, McKinney v. Schlatter, 692 N.E.2d 1045 (Ohio Ct. App. 1997).

5. *See, e.g.*, Ortiz v. Shah, 905 S.W.2d 609 (Tex. App. 1995); Fought v. Solce, 821 S.W.2d 218 (Tex. App. 1991). Courts have typically looked for evidence that the on-call *specialist* actually participated in the patient's diagnosis on treatment. *See* Corbet v. McKinney, 980 S.W.2d 166 (Mo. Ct. App. 1998); *Schlatter*, 692 N.E.2d at 1045. Absent such evidence, no physician-patient relationship exists and no duty is owed. By contrast, at least one court has imposed a duty to treat on a *primary care* physician paid to staff the emergency department and on the premises at the time. *See* Hiser v. Randolph, 617 P.2d 774 (Ariz. Ct. App. 1980) (holding doctor's on-call agreement with hospital waived physician's right to insist on physician-patient relationship). In cases involving specialists, however, courts have so far insisted on both a contract obligation to be on-call and participation in treatment of the patient. *See Shah*, 905 S.W.2d at 611.

6. 14 S.W.3d 42 (Mo. Ct. App. 1999). *See* Jane Drummond, Note, *Could Somebody Call a Doctor? On-Call Physicians and the Duty to Treat*, 64 MO. L. REV. 1055 (2000).

7. *See Corbet*, 980 S.W.2d at 166.

8. *Millard*, 14 S.W.2d at 53-54 (citing RESTATEMENT (SECOND) OF TORTS § 324A (1965)). Courts have no difficulty finding an undertaking when a defendant performs some overt act. *See* JOSEPH H. KING, JR., THE LAW OF MEDICAL MALPRACTICE 17 (2d ed. 1986). However, they have struggled with cases in which the defendant has merely promised to perform in the future. Some courts leave those cases to contract law. *See* DAN B. DOBBS, THE LAW OF TORTS 864-65 (2000). However, the contract doctrine of

Remarkably, however, no court had previously applied this reasoning to the duties of "on-call" physicians. This failure demonstrates how the traditional sequestration of medical malpractice doctrine from the rest of tort law has made it difficult for both courts and attorneys to recognize when well-established general principles of tort law provide useful tools for analyzing a malpractice action.[9]

III. PHARMACISTS' DUTIES

In tort law, pharmacists have traditionally been viewed as assistants to physicians, obliged only to fill prescriptions correctly. They have had no duty to protect their patients from other dangers, such as taking incompatible drugs, even if a reasonable pharmacist would have realized the danger. This special rule for pharmacists was an exception to the general tort obligation to exercise reasonable care under the circumstances.[10] It was premised on the assumption that the imposition of more extensive duties would lead pharmacists to interfere with the physician-patient relationship.[11]

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promissory estoppel provides a tort-like remedy for such cases. *See* RESTATEMENT (SECOND) OF CONTRACTS § 90 (1979). Moreover, courts "seize upon almost any act beyond a mere promise." KING, *supra*, at 20. Signing up for call should meet this test. Furthermore, the requirement of an overt act seems to be eroding in tort law. *See* DOBBS, *supra*, at 865-66.

9. Sadly, however, the court felt that it had to engage in some slight of hand in order to reach its eminently reasonable result. The court divided the plaintiff's negligence claim into two counts, one for ordinary negligence and one for medical malpractice. Only the general negligence claim was governed by general tort duty analysis. On the malpractice claim, formalism substituted for analysis. Under previous holdings of the Missouri Supreme Court, the claim for medical negligence could not succeed without proof that a physician-patient relationship had existed. Millard v. Corrado, 14 S.W.2d 42, 49 (Mo. Ct. App. 1999); *Corbet*, 980 S.W.2d at 169. Therefore, the court felt obliged to look for proof of a physician-patient relationship to preserve the malpractice claim. There was some evidence that Dr. Corrado had discussed the plaintiff's conduct over the phone and had made some treatment recommendations. *Millard*, 14 S.W.2d at 50-52. Whether that would be sufficient to create a physician-patient relationship is unclear under Missouri law. *See Corbet*, 980 S.W.2d at 169 (holding that a relationship can arise out of physical examination, billing the patient, or a contractual obligation to treat the patient combines with participation in diagnosis or treatment). Reliance on this test elevates form over substance. Concurring Judge Cravens correctly points out that this episode of "treatment," while doctrinally important under *Corbet*, is logically irrelevant. The plaintiff did not claim that Corrado's telephone orders were negligent, but that he had breached a duty by not being available sooner and in person! Under *Corbet*, at least as interpreted in *Millard*, the physician's belated response created retroactive duties to Ms. Millard.

10. *See* Horner v. Spalitto, 1. S.W.3d 519, 522 (Mo. Ct. App. 1999).

11. *See Horner*, 1 S.W.3d at 523-24; McKee v. Am. Home Prods., Corp., 782 P.2d 1045, 1055-56 (Wash. 1989).

That was the law in Missouri until *Horner v. Spalitto*.[12] *Horner* involved a pharmacist who had filled a prescription for a strong hypnotic drug at three times the normal dosage. The patient died a few days later of an apparent drug overdose. When his family filed suit for wrongful death, the trial court dismissed the action on the ground that the pharmacist's only duty was to fill the prescription accurately, which the Horner family conceded he had fulfilled.

The Missouri Court of Appeals for the Western District of Missouri reversed, holding that pharmacists have a duty to exercise reasonable care under the circumstances.[13] The court based this holding on its belief that pharmacists have the skills to notice errors, that pharmacists are in the best position to alert physicians to possible errors, and that making pharmacists legally accountable will increase the overall quality of health care.[14] In addition, the court concluded that any antagonism generated by pharmacist-physician interaction would be outweighed by the public benefit.[15] As a consequence, the court abandoned the old duty rule that would have immunized the pharmacist's conduct and applied the general tort obligation of reasonable care under the circumstances.[16] Although this position is still the minority view, it appears to be the modern trend.[17]

IV. THE LEARNED INTERMEDIARY DOCTRINE

The last of the three health law cases noted in this issue does not fit into this larger pattern of judicial reabsorption. In *Doe v. Alpha Therapeutic Corp.*,[18] the plaintiffs alleged that the supplier of a blood clotting factor had failed to warn them about the risk of contracting AIDS. Using the "learned intermediary"

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12. *See* Kampe v. Howard Stark Prof'l Pharmacy, Inc., 841 S.W.2d 223, 227 (Mo. Ct. App. 1992).

13. The court clearly indicated that it was not passing judgment on the conduct of the pharmacist. It specifically noted that he had consulted with someone in the prescribing physician's office, but the court did not know the contents of that conversation. *See Horner*, 1 S.W.3d at 524.

14. *See id.* at 523-24.

15. *See id.* at 523 n.5. Scholars have also suggested that pharmacists are often in a better position than any one physician to reduce medication-based risks, as patients often have many physicians but only one pharmacist. *See* David B. Brushwood, *The Professional Capabilities and Legal Responsibilities of Pharmacists: Should "Can" Imply "Ought"?*, 44 DRAKE L. REV. 439, 441-42 (1996).

16. *See* Horner v. Spalitto, 1. S.W.3d 519, 522 (Mo. Ct. App. 1999) ("Anthony Spalitto's duty was to exercise the care and prudence that a reasonably careful and prudent pharmacist would exercise in the same or similar circumstances."). Interestingly, pharmacists seem to embrace their new obligations. *See* Michele L. Hornish, Note, *Just What the Doctor Ordered—Or Was It?: Missouri Pharmacists Duty of Care in the 21st Century*, 64 MO. L. REV. 1075 (2000).

17. *See* Hornish, *supra* note 16, at 1081 & n.36, 1084-85 & n.66.

18. 3 S.W.3d 404 (Mo. Ct. App. 1999).

doctrine, the Missouri Court of Appeals for the Eastern District of Missouri held that the suppliers needed only to inform the plaintiff's physician of this risk and did not have to inform the patients directly.[19]

This case warns us not to assume that all of the special duty rules in health care law will be abandoned. Although the courts are examining each of these rules for its continued vitality, they retain those that they still consider to be appropriate. In *Alpha Therapeutic*, the court wrote an extended analysis of the policy reasons supporting the learned intermediary exception and concluded that they still are persuasive.

V. COMMENTS

Malpractice law has been a distinct branch of tort law for many decades. Its separation from mainstream tort law began late in the nineteenth century with the adoption of a special custom-based standard of care. Thereafter, the courts fashioned an elaborate architecture of other rules tailored specially for health care torts. Some, like the respectable minority rule and the honest error in judgment rule, further explained the malpractice standard of care. Others, like the informed consent doctrine, imposed unique duties on physicians. By the late twentieth century, malpractice law had become a special field of tort law with its own rules and its own special problems.

After the "malpractice crises" of the 1970's and 1980's, many experts felt that medical negligence needed an even more unique set of rules. At that time, the American Law Institute and prominent legal scholars articulated the case for no-fault, exclusive hospital liability.[20] Although this idea had considerable merit, it never generated significant support in state legislatures.

Ironically, the courts appear to be moving in the opposite direction. Not only have they not concluded that a unique no-fault regime is necessary, but they have begun to revisit the rules that have long differentiated traditional malpractice law from ordinary negligence law.[21] Although some of the unique

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19. It further found that these physicians were already aware of the risk and, therefore, that any failure by the supplier to inform them was not proximate cause of the plaintiffs' injuries. *Id.* at 421. *See* Bradford B. Lear, Note, *The Learned Intermediary Doctrine in the Age of Direct to Consumer Advertising*, 64 MO. L. REV. 1101 (2000).

20. *See* REPORTERS' STUDY, THE AMERICAN LAW INSTITUTE, 2 ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY 487-516 (1991) (outlining rationale for no-fault medical malpractice compensation system); PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE 145-42 (1993) (same).

21. This movement away from malpractice law's special set of rules arguably began when courts abandoned the "locality rule" that had tied the standard of care to the physician's locality. *See, e.g.*, Hall v. Hilbun, 466 So. 2d 865, 871 (Miss. 1985) (requiring physicians to follow a national, rather than a local, standard of care); BARRY R. FURROW ET AL., HEALTH LAW § 6-2, at 360 (1995) (discussing the standard of care).

malpractice rules, like the informed consent doctrine, are likely to survive this reexamination, many others probably will not.

Across the country, state courts are quietly retreating from the custom-based standard of care that fundamentally differentiated malpractice actions from other negligence actions.[22] The "honest error in judgment" rule is also losing favor.[23] Now, in Missouri at least, the bright-line "no duty" rules are also showing signs of weakness. Increasingly, the courts are deciding medical negligence cases using tort rules of general applicability.

This merging of malpractice law into general negligence law is consistent with the halting twentieth century movement of tort law away from an array of special duties and immunities and toward a general obligation of reasonable care.[24] The courts have, for example, partially or totally abrogated the charitable and family immunities.[25] Courts and legislatures have also modified many other special duty rules, like those governing rescue,[26] landowner obligations,[27] and recovery for emotional distress.[28] Medical malpractice law appears to be undergoing the same transition.

No one can say whether this trend will continue or how extensive its impact will be. At present, all we have are tantalizing clues. But if it does continue, medical malpractice cases may one day be ruled by essentially the same rules that govern other accidental injuries. The special malpractice rules that survive this process will be ones that remain persuasive in an era less willing to protect physician prerogatives and less willing to assume that health care is unique.[29]

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22. *See* Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 185 (2000).

23. *See, e.g.*, Ouellette v. Subak, 391 N.W.2d 810, 813-16 (Minn. 1986) (concluding "honest error in judgment" instruction is inappropriate); McCourt v. Abernathy, 457 S.E.2d 603, 606 (S.C. 1995) (noting "error in judgment" instruction may confuse jury).

24. *See* Gary T. Schwartz, *The Vitality of Negligence and the Ethics of Strict Liability*, 15 GA. L. REV. 963, 963-77 (1981) (discussing growth of negligence principle and abrogation of special classifications and immunities).

25. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS §§ 131-35, at 1032-73 (5th ed. 1984) (surveying immunities).

26. *See, e.g.*, Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 339-48 (Cal. 1976) (finding that psychiatrist has duty to warn potential victims of dangerous patient); Madden v. C & K Barbecue Carryout, Inc., 758 S.W.2d 59, 63 (Mo. 1988) (finding that business owner has duty to protect customers from foreseeable crimes of third parties).

27. *See, e.g.*, Rowland v. Christian, 443 P.2d 561 (Cal. 1968) (discarding common-law classifications of trespasser, licensee, and invitee).

28. *See, e.g.*, Dillon v. Legg, 441 P.2d 912, 921 (Cal. 1968) (allowing emotional distress recovery to mother who witnessed child's death, but was not in danger herself); Bass v. Nooney Co., 646 S.W.2d 765, 768-73 (Mo. 1983) (abandoning impact rule in emotional distress cases).

29. Tort law is not the only field of law in which courts have abandoned rules that once treated the medical profession as unique. Antitrust law is the most obvious of

This simplification of malpractice doctrine may be temporary, however. The ascendancy of managed care (and whatever succeeds it) may produce a new wave of malpractice-specific tort rules.[30] If so, the movement toward merger and reabsorption will reverse itself. However, the pruning that twentieth century malpractice law is now experiencing guarantees that the body of malpractice law that ultimately emerges will look very different from the one that preceded it. In that event, future lawyers will speak not of the disappearance of malpractice law, but of its metamorphosis.

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several examples where courts have stripped the profession of previously afforded privileges. *See* Peters, *supra* note 22, at 199-201.

30. One intriguing candidate is an expanded rule of vicarious liability for managed care entities. *See* Clark C. Havighurst, *Making Health Plans Accountable for the Quality of Care*, 31 GA. L. REV. 587 (1997).