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## **DRIVING ON THE CENTER LINE: MISSOURI PHYSICIANS' POTENTIAL LIABILITY TO THIRD PERSONS FOR FAILING TO WARN OF MEDICATION SIDE EFFECTS**

### I. INTRODUCTION

Many people approach administered medications with caution. Due to concerns about the side effects that these medications could have on their ability to perform daily activities, people are hesitant to consume prescribed medications. For many, however, there is no alternative to taking administered medications. Therefore, to minimize the effects that medication may have on a patient's daily routine, physicians need to provide information to their patients about potential side effects. With this information, patients can decide whether to take the medication at a certain time of the day or otherwise ensure that the medication is taken properly. But who should bear the burden of providing individuals with this knowledge? In answering this question, courts are divided and tend to drive on the center line between making physicians liable and placing the burden on patients themselves. The cases in which courts have had to deal with the issue of a physician's liability to the general public typically involve vehicular accidents. Specifically, this area of tort law is confined mostly to situations where a medicated patient operates a vehicle and causes an accident.

Without adequate information, people taking medications may not properly adjust their daily routines. Consider, for example, Attorney Smith, a patient of Doctor Jones. Attorney Smith was recently prescribed a new medication to help ease some joint stiffness. Because Doctor Jones failed to issue additional precautions about the side effects of this new medication, Attorney Smith believed there were no additional risks when taking the medicine. However, because this new medication causes drowsiness in most people, Attorney Smith's productivity level that day suffered. What if Doctor Jones' patient was instead Driver Dan? Again, assume that Doctor Jones failed to issue additional precautions to Driver Dan. Consequently, Driver Dan took the prescribed medication and drove his vehicle. Because Doctor Jones failed to issue a warning, all drivers on the roadway must bear the risk of Driver Dan's drowsiness. If Attorney Smith, now just a fellow driver on the highway with Driver Dan, is hit by Driver Dan's vehicle as a result of Driver Dan's impaired condition, Attorney Smith will want to place the blame on someone. But who should bear the burden, the doctor or the patient? To answer this question, two

basic issues must be considered: (1) in what circumstances does the physician have informational advantages over the patient, so that the doctor should be responsible for issuing warnings about side effects; and (2) if the physician is liable, what warning would be sufficient to discharge the duty owed to third persons to warn of side effects of administered medication? These considerations arise during any discussion of physician liability to third parties.

Missouri is one of the only jurisdictions that has not yet created physician liability to third persons for failing to issue warnings about medication side effects.<sup>1</sup> The standard Missouri adopts will likely rest on a policy of personal responsibility<sup>2</sup> as emphasized in previous Missouri case law. This policy would impose greater liability on individuals when they have an informational advantage over the physician, such as when they consume alcohol before driving a vehicle. In addition, any standard Missouri adopts will likely include an assimilation of the judicial models created by other jurisdictions for this area of law.

Missouri must not sacrifice the professional integrity of physicians by imposing greater burdens upon them. This Comment will argue that Missouri courts should find that physicians<sup>3</sup> may be liable to the general driving public under a simple duty to warn standard, only if patients bring a general negligence claim.<sup>4</sup> To discharge this duty, the physician need only provide a patient with warnings when he administers the medications.<sup>5</sup> Once the physician provides the patient with this information, the physician's duty is discharged. The physician should be under no duty to control the activities of the patient beyond a general warning. In addition, Missouri courts should not attempt to qualify the duty based on the type of medication given.<sup>6</sup> The

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1. See generally Gregory G. Sarno, Annotation, *Liability of Physician, for Injury to or Death of Third Party, Due to Failure to Disclose Driving-Related Impediment*, 43 A.L.R. 4TH 153 (1986) (discussing in detail at least twelve jurisdictions that have rendered significant decisions regarding this issue of physician liability).

2. See *infra* notes 184-208.

3. The group charged with this duty may be expansive enough to include an entire health care provider group, such as a hospital or a medical group, but most likely will be limited to individual physicians since there is an inherent desire to hold responsible the individual able to give orders affecting a person's physical well-being.

4. The Missouri Supreme Court found that duty cases of this type need to be brought within the medical negligence statute of limitations. It also noted that the application to this statute applies whether the claim is that of medical malpractice or general negligence. See *Robinson v. Health Midwest Dev. Group*, 58 S.W.3d 519 (Mo. 2001) (en banc).

5. While it may prove to be administratively cumbersome, physicians may want to consider having patients sign a waiver whether they will be driving or not. However, this may already be general practice for many medical facilities and hospital emergency rooms.

6. For example, a physician who either orders or administers a drug to the patient while in his office would obviously have more control over the conditions under which the drug is given. See Lisa M. Nuttall, *Tort Law – Foreseeability v. Public Policy Considerations in Determining the Duty of Physicians to Non-patients – Lester v. Hall*, 30 N.M. L. REV. 351, 360-61 (2000);

physician should possess the same duty for any medication given within the physician's presence. In addition, physician liability should not replace individual driving duties and responsibilities. Missouri courts should not impose a duty in situations where other impairing factors, such as alcohol, may be involved. Only when a patient takes the medication within the physician's immediate presence should the physician have a potential duty to the general public.<sup>7</sup> Any other result would compromise the professional integrity of the medical profession.

This Comment provides a practical judicial model for Missouri courts to follow. Part II discusses the effect that the landmark duty to warn case of *Tarasoff v. Regents of University of California*<sup>8</sup> had on potential physician liability to third parties and the issues *Tarasoff* left open. Part III analyzes the judicial models of Texas, Washington and New Mexico to show how Missouri could structure its own standard. Part IV examines the traditional duties imposed upon Missouri physicians, extensions of these traditional duties and issues left unanswered by Missouri case law regarding liability to third persons. Part V discusses Missouri's public policy, which favors allocating liability to third parties between the physician who fails to warn of medication side effects and the individual patient who inflicted the harm. Finally, in Part VI this Comment concludes that based on Missouri's case law and public policy, individual responsibility should mitigate physician liability to third persons.

## II. THE DUTY TO WARN—TARASOFF V. REGENTS OF UNIVERSITY OF CALIFORNIA

Any discussion of a duty to warn should begin by considering the first case to impose this duty, *Tarasoff v. Regents of University of California*.<sup>9</sup> While *Tarasoff* focused on the duty that psychotherapists owe to third parties, it has become a seminal case regarding a doctor's duties to third parties generally.<sup>10</sup>

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Lester v. Hall, 970 P.2d 590, 592-93 (N.M. 1998). However, a physician who prescribes an antibiotic to his patient, but does not discuss the potential side effects with the patient, may have less control over the way that the patient takes the medication and when it is taken. See Nuttall, *supra*, at 360-61; Wilschinsky v. Medina, 775 P.2d 713 (N.M. 1989).

7. This is not to say that physicians would not otherwise be liable to their patients for failure to warn of medication side effects, but this would need to be brought as a medical malpractice claim, not general negligence. See generally Linda A. Sharp, *Malpractice: Physician's Liability for Injury or Death Resulting from Side Effects of Drugs Intentionally Administered to or Prescribed for Patient*, 47 A.L.R. 5TH 533 (1997).

8. *Tarasoff v. Regents of Univ. of California*, 551 P.2d 334 (Cal. 1976).

9. *Id.*

10. See Michael L. Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 LAW & PSYCHOL. REV. 29, 33-35 (1992) (classifying one of *Tarasoff's* broadest extensions to be the consideration of a duty owed by a physician to a third party for failure to warn the patient of medication side effects); Fillmore Buckner & Marvin

In *Tarasoff*, the court paved the way for cases regarding physician liability to third parties when failing to warn of medication side effects. The following famous language from *Tarasoff* provides a foundation for the doctor's duty to the general public: "[t]he protective privilege ends where the public peril begins."<sup>11</sup>

Suprisingly, the facts of *Tarasoff* contributed to the development of a complex web of general duty cases. In *Tarasoff*, Patient Prosenjit Poddar admitted to his psychologist that he intended to kill Tatiana, a fellow classmate and love interest, upon her return from a summer trip to Brazil.<sup>12</sup> Campus police took no action to warn either Tatiana or her parents after the police were notified by Poddar's psychologist of Poddar's intentions, even though the psychologist suggested detaining Poddar.<sup>13</sup> After examining Poddar, however, the psychologists decided that Poddar's mental condition did not warrant confinement of him at the time and released him.<sup>14</sup> After she returned, Poddar went to Tatiana's home and shot her with a pellet gun, pursued her into the back yard, and stabbed her to death with a kitchen knife.<sup>15</sup> It is clear from *Tarasoff* that if the doctor had warned Tatiana of the potential dangers, she may have escaped death.

*Tarasoff* broke new ground by holding that a psychologist's professional duty to his patients included a duty to warn third persons of a known danger. The concept of duty assumes that in situations of a particular type, the actor that causes damage should be held liable for the actions taken or not taken.<sup>16</sup> The court described duty as "not sacrosanct in itself, but only an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection."<sup>17</sup> The common law concept of duty imposed an obligation upon the psychologists to warn Tatiana of Poddar's

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Firestone, "Where the Public Peril Begins" 25 Years After *Tarasoff*, 21 J. LEGAL MED. 187, 202-03 (2000).

11. See *Tarasoff*, 551 P.2d at 347; Perlin, *supra* note 10, at 33.

12. See *Tarasoff*, 551 P.2d at 339-40.

13. See *id.* at 340; Buckner & Firestone, *supra* note 10, at 194-95 (suggesting that the parents were possibly not aware of details of the threats against Tatiana and the attempts to confine Poddar until the psychiatrist testified at court).

14. See *Tarasoff*, 551 P.2d at 340-41; Buckner & Firestone, *supra* note 9, at 193.

15. Buckner & Firestone, *supra* note 9, at 194.

16. For example, when a special relationship exists between two parties, liability for nonfeasance is a remedy for the injured party. See Allison L. Almason, *Personal Liability Implications of the Duty to Warn are Hard Pills to Swallow: From Tarasoff to Hutchinson v. Patel and Beyond*, 13 J. CONTEMP. HEALTH L. & POL'Y 471, 474 (1997).

17. *Tarasoff*, 551 P.2d at 342.

intentions to harm her.<sup>18</sup> After *Tarasoff*, many courts expanded its holding to cover a health care professional's duty to protect the general public.<sup>19</sup>

*Tarasoff* staked out the general boundaries of the nature of duty, specifically a doctor's duty to a third person.<sup>20</sup> It explicitly instructed that for a duty to be imposed, a special relationship must exist between the physician and either the foreseeable victim or the person likely to inflict the harm.<sup>21</sup> Without a special relationship, physicians cannot be burdened with a duty to control the party in question.<sup>22</sup> Before *Tarasoff*, foreseeability was not considered the most important factor used when determining whether a duty is owed.<sup>23</sup> The court in *Tarasoff* held that the foreseeability of Tatiana's injuries required the doctor to warn her of potential risks.<sup>24</sup> Thus, the harm caused to a third person needs to be foreseeable to the physician at the time the side effect warning should have been given for a duty to third persons to exist.

Physicians can only be expected to meet a reasonable professional standard. *Tarasoff* provided that the physician is not required to act perfectly when preventing harm to the potential victim, because such a standard may not be feasible for any professional.<sup>25</sup> Rather, the standard should be "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar

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18. See *id.* at 343 (imposing this duty only upon the psychologists, and not the police officers who were to confine Poddar since they did not have a special relationship with Poddar that could be extended to Tatiana).

19. See Buckner & Firestone, *supra* note 10, at 202-03 (explaining that the effect of the *Tarasoff* decision has influenced decisions in medical fields outside of psychiatry in two specific areas: (1) driving related dangers and (2) transmission of infectious diseases). See also Perlin, *supra* note 10, at 29-30 (stating that while the *Tarasoff* legend had grown to "mythic proportions", no other judicial decision has received this level of recognition).

20. See Peter F. Lake, *Revisiting Tarasoff*, 58 ALB. L. REV. 97, 114 (1994) (stating that *Tarasoff's* statement of the nature of duty incorporates "three critical points: (1) an analysis of liability in tort begins with the question of 'duty'; (2) 'duty,' in itself, is neither sacrosanct nor immutable and is merely a conclusion as to whether liability should attach under specified conditions; and (3) the determination of when a duty is owed depends on policy considerations").

21. See *Tarasoff v. Regents of Univ. of California*, 551 P.2d 334, 343 (Cal. 1976); Charles E. Cantu & Margaret H. Jones Hopson, *Bitter Medicine: A Critical Look at the Mental Health Care Provider's Duty to Warn in Texas*, 31 ST. MARY'S L.J. 359, 372 (2000) (stating that while jurisdictions vary in their application of the *Tarasoff* doctrine, all include that a special relationship exists between patient and physician).

22. Prior to *Tarasoff*, common law stated that a person does not owe an affirmative duty to protect a certain person from danger or harm. See Almason, *supra* note 16, at 474 (stating that under the *Tarasoff* decision, if a special relationship exists, then the actor has a duty to control the third person).

23. See Cantu & Hopson, *supra* note 21, at 368 (stating that in *Tarasoff II*, the court identified foreseeability of harm to be the greatest factor creating a duty to warn).

24. See *Tarasoff*, 551 P.2d at 343-44.

25. See *id.* at 345.

circumstances.”<sup>26</sup> The reasonableness of the action is based upon the traditional negligence standard that exists for the circumstances in question.<sup>27</sup> Even though professional standards may prohibit disclosing confidential physician-patient information, the court advised that this concern should not be given great weight.<sup>28</sup> After weighing the costs and benefits, any harm caused to the plaintiff resulting from the patient’s actions negates the consequences of the therapist’s breach of confidentiality.<sup>29</sup> Thus, *Tarasoff* provides a sound basis for public policy analysis.

After *Tarasoff*, there are numerous open issues relating to warnings of medication side effects. *Tarasoff* suggested that its decision should not be limited to situations where the physician had a special relationship to *both* the patient and the victim.<sup>30</sup> A doctor must warn his patient of the potential dangers associated with his condition or medications that may cause him to be dangerous to others.<sup>31</sup> While applying *Tarasoff*’s holding to driving related impairments may be dubious, the court in dicta does provide for this possibility.<sup>32</sup> Additionally, *Tarasoff* did not directly provide whether the general public placed at risk by driving related impairments would be a foreseeable victim. Therefore, the question is—how far the court expected the concept of duty to stretch, considering the importance of foreseeability?

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26. See Cantu & Hopson, *supra* note 21, at 368.

27. See *Tarasoff v. Regents of Univ. of California*, 551 P.2d 334, 345 (Cal. 1976). Imposing a duty to warn third persons is independent from a physician’s duty to diagnose, which is strictly applicable to his patients. See Almason, *supra* note 16, at 487-88. Several states, including Louisiana, have held that duty to warn cases do not fall under the state medical malpractice statute. See *id.* at 488. This distinction has caused commentators to then call into question the actual existence of this physician duty if it rests outside of the physician’s professional standards. *Id.* at 496.

28. See *Tarasoff*, 551 P.2d at 346-47. While there may always be some confidentiality presumed between physicians and patients, dealing with mental health care patients may entail more personal involvement. Thus, general health care providers may not be subjected to such a risk as addressed in *Tarasoff*. See Perlin, *supra* note 10, at 35-36.

29. See *Tarasoff*, 551 P.2d at 346-47.

30. See *id.* at 344.

31. See *id.* at 343-44 (stating that such dangers included driving dangers); see also Perlin, *supra* note 10, at 34 (considering the application of *Tarasoff* to driving impairment cases to be an example of the broadest extension of this decision).

32. See *Tarasoff*, 551 P.2d at 343-44 (citing *Kaiser v. Suburban Transp. Sys.*, 398 P.2d 14 (Wash. 1965)); Almason, *supra* note 16, at 475 (reiterating that the *Tarasoff* court stated a duty to warn situation is analogous to cases where the physician fails to warn others of a patient’s communicable disease, implying the potential effects of the *Tarasoff* decision on duty to warn third person cases).

### III. JURISDICTIONAL DEVELOPMENTS OUTSIDE MISSOURI

When deciding cases of first impression, the Supreme Court of Missouri will inevitably look to other jurisdictions for guidance.<sup>33</sup> Several jurisdictions have created common law variations of a duty to warn directed towards physicians.<sup>34</sup> Courts in Texas, Washington and New Mexico<sup>35</sup> have all rendered decisions that provide a good backdrop for analyzing a physician's duty to warn the general public. The Texas model creates a broad general duty owed by physicians to foreseeable third persons when the physician has informational advantages over the patient, but *rejects* any duty to control the patient. The Washington model provides a moderate standard, which imposes physician liability for injuries inflicted on foreseeable third parties, but also limits this liability in cases of intervening driver negligence. Finally, the New Mexico model focuses on the public need for good available health care and *limits* a physician's duty owed to third parties to situations where the physician *personally controlled* the administration of medication in his office.

#### A. *Texas: The Gooden v. Tips Legacy*

In Texas, the likelihood of physicians possessing a broad general duty to foreseeable third persons, including the driving public, when the physician fails to warn his patient of medication side effects is high. In *Gooden v. Tips*, the court held that a physician owes a duty to the general driving public when failing to properly warn a patient of medication side effects.<sup>36</sup> In *Gooden*, Doctor Tips had treated his patient for almost twenty years prior to the accident in question, which clearly demonstrated a patient-physician relationship.<sup>37</sup> Doctor Tips therefore knew the medical history of the patient, including her propensity to abuse drugs and to not take medication in the manner intended. Nevertheless, he neglected to warn his patient not to drive or operate machinery while under the influence of the drug Quaalude.<sup>38</sup> Consequently,

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33. See Kevin L. Kelley, *Negligence – Third Party Liability – Physician Owed Duty of Care to Third Party When His Negligence in Failing to Warn Patient Not to Drive Contributes to Third Party's Injury*, 15 ST. MARY'S L.J. 493, 499-500 (1984) (stating that the decision in *Gooden* relied on three cases from other jurisdictions to decide its decision of first impression); Buckner & Firestone, *supra* note 10, at 203 (stating that *Kaiser* was followed in other jurisdictions both before and after the decision of *Tarasoff*).

34. For a discussion of some of the variances taken by state courts, see generally Cantu & Hopson, *supra* note 21, at 372-79.

35. Judicial decisions in these three jurisdictions offer a good discussion of precedential cases, which Missouri courts may choose to follow.

36. *Gooden v. Tips*, 651 S.W.2d 364 (Tex. App. 1983) (deciding an issue of first impression in Texas, necessitating an evaluation of other jurisdictions having already decided this issue).

37. See *id.* at 365; Cantu & Hopson, *supra* note 21, at 381.

38. *Gooden*, 651 S.W.2d at 365; see also Kelley, *supra* note 33, at 494-96 (stating that courts rendering decisions in this area of law need to discuss the doctrine of privity between the



everyone in the driving realm of the patient was at risk of the patient's impaired condition caused by the medication. *Gooden* held that any of those drivers were foreseeable victims.<sup>39</sup>

*Gooden* framed the issue as a two-part inquiry. First, the court considered whether a physician who prescribes a medication and knows or should have known of the medication's side effect has a duty to the public to warn the patient not to drive.<sup>40</sup> Second, the court contemplated whether the physician has a duty under the circumstances to reduce the likelihood of injury to a third person that the patient may come in contact with.<sup>41</sup> After consulting the law of other jurisdictions, *Gooden* found a duty to warn when that person "was in the general field of danger which should reasonably have been foreseen by the doctor when he administered the drug."<sup>42</sup> Thus, a physician could owe a duty to the general driving public. After *Gooden*, a court could find a general duty without considering whether the doctor had an informational advantage over the patient. This standard makes a physician's duty to third persons very broad.

Despite its breadth, *Gooden* did reject one important aspect of *Tarasoff's* reasoning.<sup>43</sup> The physician's duty did not include the duty to *control the conduct* of the patient.<sup>44</sup> Therefore, under *Gooden*, a physician need only tell the patient not to drive in order to discharge the duty to warn.<sup>45</sup> Following *Gooden*, other decisions have found a similarly specific, yet limited duty.<sup>46</sup> Thus, the Texas model provides that while the physician does have a general duty, giving a simple warning may easily discharge the duty.

Since *Gooden*, the physician's duty to warn in Texas has been further limited. In two specific instances, courts have not imposed third person liability upon physicians when the physician does not have an informational advantage over the patient. For example, in *Flynn v. Houston Emergicare, Inc.*, the court held that physicians treating patients known to have taken mind-altering drugs, such as cocaine, did not owe a duty to warn the general driving

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doctor and the third party, so that the decision would be applicable to future situations, which is something that the court in *Gooden* failed to do).

39. *Gooden*, 651 S.W.2d at 369-70.

40. *Id.* at 366.

41. *See id.*

42. *See Kelley, supra* note 33, at 501.

43. *Gooden*, 651 S.W.2d at 370.

44. *Id.*; Cantu & Hopson, *supra* note 21, at 381-82. Physicians do not "take charge" of their patients in such a way as to control the patient's driving propensities.

45. *See Gooden*, 651 S.W.2d at 370 (deciding only that the warning needs to be given, but leaving open the determination as to what point in the treating process it needs to be given).

46. *See Helms v. Gonzalez*, 885 S.W.2d 535 (Tex. App. 1994) (recognizing that the physician had to warn the patient to discharge the duty, and in doing so was not liable to a third party injured in an accident with the drowsy patient); *see also* Cantu & Hopson, *supra* note 21, at 392-99 (noting the limitations placed on the *Gooden* decision).

public.<sup>47</sup> The court reasoned that the physician had not caused the impairment that contributed to the patient's collision with the third person.<sup>48</sup> Additionally, in *Praesel v. Johnson*, the court held that when the patient's knowledge of his condition is equal to that of the physician, the physician does not owe a duty to the public to warn the patient not to drive.<sup>49</sup> To impose a duty on physicians who have no informational advantage over patients would outweigh the damages incurred by injured third persons.<sup>50</sup>

While Texas has generally adhered to the *Gooden* standard, some decisions place this decision in question. Courts may only impose this duty in limited circumstances. Since *Tarasoff* first created a psychologist's duty to warn third persons,<sup>51</sup> cases creating a duty to warn the general public stem from similar professional liability situations. Unlike the *Tarasoff* court, however, the Supreme Court of Texas has refused to impose a duty upon mental health care providers.<sup>52</sup> While many of these cases discuss *Gooden*, they recognize its limits and then distinguish it from the issue being decided.<sup>53</sup> Legislative models have been proposed to resolve this discrepancy in Texas,<sup>54</sup> but there seems to be a common law tradition going against this proposed legislation.

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47. See *Flynn v. Houston Emergicare, Inc.*, 869 S.W.2d 403 (Tex. App. 1993) (relying on language in *Gooden* stating that to owe a duty to the general public, the physician needs to have gone so far in the relationship with the patient that he has begun to adversely affect the interests of the patient).

48. See *id.* at 406. The dissent noted concern about holding a physician liable for not warning a patient of medication side effects, but not holding the physician liable when he knows of the dangers of driving under the influence of cocaine. See *id.* at 406-08.

49. See *Praesel v. Johnson*, 967 S.W.2d 391 (Tex. 1998) (considering a patient that was known to have epileptic seizures for many years before the accident to have a condition obvious to the patient).

50. See *id.* at 398 (reasoning that while there is a benefit to warning an epileptic patient to not drive, there is no assurance that this patient will adhere to this warning, given the patient's propensity for having seizures, making the benefit not comparable to the responsibility placed upon the physician).

51. See *Tarasoff v. Regents of Univ. of California*, 551 P.2d 334 (Cal. 1976).

52. See *Cantu & Hopson*, *supra* note 21, at 382-83; see also Noreen M. Grant, *Psychiatrists Have No Duty to Warn Third Parties of Patients' Threats: Tarasoff is Kicked out of Texas . . . Finally!*, 7 TEX. WESLEYAN L. REV. 157, 158 (2001) (congratulating the court for denying to apply the *Tarasoff* doctrine to psychiatrists in Texas as held in *Thapar v. Zezulka*, 994 S.W.2d 635, 636 (Tex. 1999)).

53. See Ann Whitley Henneman, *Texas Supreme Court Limits Duty of Medical Professionals to Third Parties*, 32 HOUS. LAW. 15 (1994); see, e.g., *Bird v. W.C.W.*, 868 S.W.2d 767 (Tex. 1994) (noting the great social utility in encouraging mental health professionals to assist in examination and in diagnosis of sexually abusive patients would be eroded if a duty to warn third parties was imposed upon such professionals); *Thapar*, 994 S.W.2d at 635 (considering Texas legislation, stating mental health providers are not obligated to report potential dangers, as an indicator of the current public policy regarding such a liability to third parties).

54. See *Cantu & Hopson*, *supra* note 21, at 402-06.

Of the three models discussed, the Texas model provides the broadest standard for physician liability to third parties. The physician's duty to warn, as articulated in *Gooden*, made physicians potentially liable to foreseeable third parties injured by the actions of misinformed patients without considering the physician's informational advantages. More recently, however, the Texas standard has been modified in specific circumstances to prevent physicians from being liable when they do not have a definite informational advantage over the patient. Moreover, when the physician does have a duty to warn, the duty is discharged with a simple warning since the duty does not include controlling the patient.

*B. Washington: The Driver Intervening Negligence Defense*

Washington imposes a duty on physicians to foreseeable third persons, but allows courts to limit this liability for situations where drivers are themselves negligent. In 1965, the Supreme Court of Washington decided a case similar to *Gooden*. In *Kaiser v. Suburban Transportation System*,<sup>55</sup> the defendant was a bus driver whose lapse of consciousness caused the bus to run off of the road and crash into a telephone pole.<sup>56</sup> The driver's physician had prescribed the drug Pyribenzamine for him and he took the first pill on the morning of the accident. The court held that the physician's liability to the plaintiff, a bus passenger, for failing to warn the driver of the medication side effects was a question for the jury.<sup>57</sup>

The Washington standard, which is narrower than that of Texas, includes three issues not addressed by Texas courts. First, unlike Texas, *Kaiser* held that a physician could be liable for damages if he fails to possess the skill and knowledge usually possessed by an average member of the profession of the locality where the physician practices.<sup>58</sup> This standard has since been overturned in favor of a standard of care "in the same or similar communities."<sup>59</sup> Second, *Kaiser* introduced the possibility of mitigating the

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55. *Kaiser v. Suburban Transp. Sys.*, 398 P.2d 14 (Wash. 1965). Note that the decision in *Kaiser* was rendered several years before that of *Tarasoff*.

56. *See id.* at 15; *see also* Robert P. Giacalone, *Kirk v. Michael Reese Hosp. & Medical Center: The Treatment of a Third Party Plaintiff in a Medical Context*, 38 DEPAUL L. REV. 749, 760-61 (1989).

57. *Kaiser*, 398 P.2d at 15; *see also* Sarno, *supra* note 1, at 13 (characterizing this duty as that of failure to warn the patient rather than a duty to the general driving public, since the physician entered the suit on cross-claim by driver).

58. *Kaiser*, 398 P.2d at 16.

59. *See Pederson v. Dumouchel*, 431 P.2d 973, 977 (Wash. 1967) (en banc) (holding the correct standard of care to be that of all similar localities). *See also* Fay Anne Freedman, *The Psychiatrist's Dilemma: Protect the Public or Safeguard Individual Liberty?*, 11 U. PUGET SOUND L. REV. 255, 272-74 (1988) (stating that another difference between *Kaiser* and *Pederson* is that *Pederson* advocates a more generalized duty for physicians to protect third persons in

physician's negligence based on a driver's intervening negligence.<sup>60</sup> Even though this was not the case in *Kaiser*, this case made the application of an intervening negligence standard available to courts.<sup>61</sup> Third, instead of imposing a duty to protect the general driving public, *Kaiser* provided a limited physician liability for failing to warn patients of potential driving impairments caused by medications.<sup>62</sup> Under the Washington standard, the physician must have a clear informational advantage over the patient in order to be charged with liability to a third party. This standard, thus, favors individual responsibility over physician liability.

Washington caselaw provides a fairly straightforward standard for determining when a physician's duty to warn patients of medication side effects is discharged. As suggested in *Kaiser*, if the physician has affirmatively warned the patient of possible side effects of the administered medication, then the physician's duty to warn has been discharged.<sup>63</sup> If the patient then proceeds to drive the car, despite the physician's warning, the patient/driver's duty becomes the sole issue. However, this standard leaves undetermined the extent to which a patient's individual duty lessens the physician's liability to discharge this duty to any third persons injured as a result.

Washington's reluctance to impose a broad, general duty upon physicians is also evident in its failure to impose upon a health care institution a duty to care for members of the public not involved in the traditional physician-patient relationship.<sup>64</sup> In *Pedroza v. Bryant*,<sup>65</sup> the Washington Supreme Court held

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situations beyond simply failing to warn of medication side effects when the physician has superior knowledge of the patient's medical condition).

60. *Kaiser*, 398 P.2d 14, 17 (calling this situation that of the "drugged driver", not the "sleeping driver").

61. The physician argued that since the driver did not pull over after experiencing grogginess, dry mouth and lips, his failure to warn the patient could not be the proximate cause of the accident. *See Kaiser v. Suburban Transp. Sys.*, 398 P.2d 14, 18-19 (Wash. 1965).

62. While the dissent advocated imposing strict liability on drivers for injuries caused when falling asleep, there would still be a question for the jury regarding whether the physician exercised reasonable medical care in warning the patient of side effects. *See id.* at 19-23. New York courts have held that medical providers may owe a duty of care to a patient and such persons that "he knew or reasonably should have known were relying on him." *See Purdy v. Pub. Adm'r of County of Westchester*, 526 N.E.2d 4, 8 (N.Y. 1988) (calling *Kaiser* into question and holding that physicians do not undertake a duty of care to the community at large). Additionally, the split in jurisdictions regarding a duty extended to the general public may cause courts to be leery of implementing the decision of *Kaiser* if not presented with a fact pattern specifically suggesting such a duty. *See Lester v. Hall*, 970 P.2d 590 (N.M. 1998).

63. *See Kaiser*, 398 P.2d at 19.

64. Arguably, the *Kaiser* decision left open the question of the physician's duty to the public. Thus, subsequent case law has tried to determine the correspondence between the *Kaiser* line of reasoning and the potential duty to the public in such circumstances.

65. *Pedroza v. Bryant*, 677 P.2d 166 (Wash. 1984) (en banc).

hospitals and medical facilities subject to the doctrine of corporate negligence.<sup>66</sup> The *Pedroza* decision<sup>67</sup> limited a hospital's duty to patients to the time period during which such patients are within the care of the hospital.<sup>68</sup> The court was reluctant to extend the hospital's duty to the general public coming in contact with the physician, because members of the general public were not foreseeable victims.<sup>69</sup> A limited application of this duty suggests additional financial concerns for holding health care providers liable to the public at large.

The Washington model, like Texas's, provides a moderate standard whereby physicians are liable only to foreseeable third person victims. The standard of care for physicians is clear: that of a similar physician in the community. More importantly, Washington limits a physician's liability based on intervening driver negligence. Finally, Washington gives physicians a relatively clear standard for discharging the duty to warn patients. Physicians simply must provide the patient with an affirmative warning. While this standard leaves room for further development and clarification, it presents a straightforward and balanced approach worthy of examination by Missouri courts.

### C. *New Mexico: Presenting a View From the Other Side of the Line.*

New Mexico provides a standard of limited physician liability to the driving public. In an attempt to maintain the availability of quality health care, New Mexico refrains from imposing liability on physicians except in situations where the physician personally administered medication to a patient. New Mexico is, therefore, one of many jurisdictions reluctant to find such a duty.<sup>70</sup> In *Lester v. Hall*,<sup>71</sup> a physician prescribed lithium for a patient five days before

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66. *See id.* at 168-70 (stating that the doctrine of corporate negligence has been used by courts to require that hospitals exercise a reasonable degree of care to ensure physicians hired are competent to assume such a position).

67. In *Pedroza*, the hospital that was a co-defendant of the treating physician had limited the physician's ability to treat certain types of pregnancies. *See id.* at 167-68. However, this physician treated the plaintiff's wife in his personal office for pregnancy complications that he would not be allowed to treat if he had seen her at the hospital. *See id.* As a result, her condition necessitated treatment at the hospital, which was unable to stabilize the condition, resulting in the woman's death. *Id.* at 168.

68. *See id.* at 172 (holding that plaintiff could not recover from the hospital because the wife was not subject to hospital-patient relationship at the time of alleged negligent treatment).

69. *See id.*

70. As in Missouri, this duty issue was only recently raised before New Mexico courts. *See Wilschinsky v. Medina*, 775 P.2d 713 (N.M. 1989).

71. *Lester v. Hall*, 970 P.2d 590 (N.M. 1998). The court considered the facts of *Lester* in light of the court's previous ruling in *Wilschinsky*. *Wilschinsky*, 775 P.2d at 720 (holding that physicians owe a duty to the public who might be potentially injured by a patient if the "doctor administered powerful drugs in his office").

the patient was involved in a collision.<sup>72</sup> A factual dispute existed as to whether the physician had warned the patient of the potential side effects of the lithium prescription.<sup>73</sup> Noting that it was following a substantial number of other jurisdictions, the court declined to extend a physician duty to non-patients when dealing with prescription situations.<sup>74</sup>

Statutorily provided health care coverage in New Mexico seriously influenced the limitations placed on physician liability to third parties. In 1978, the New Mexico legislature limited health care liability by enacting the Medical Malpractice Act,<sup>75</sup> which made professional liability insurance available to health care providers.<sup>76</sup> This public policy has prevailed in New Mexico and significantly influenced the court when deciding *Lester*. In declining to extend a general physician duty, *Lester* stated that, “[t]he Legislature has clearly demonstrated a concern for the health of the citizens of New Mexico as it is affected by the availability of practicing physicians and assured by the availability of malpractice insurance.”<sup>77</sup> Even though it had the authority to create a general duty, the court stated, in light of the Medical Malpractice Act, “this authority must be exercised sparingly, especially when the Legislature has spoken in a manner inconsistent with the expansion of tort liability for health care providers.”<sup>78</sup> After recognizing a definite split in authorities regarding a duty to the general driving public,<sup>79</sup> *Lester* held that New Mexico’s public policy precluded extending a physician’s liability to include a duty to the general public.<sup>80</sup>

*Lester* established that physicians in New Mexico are liable to third parties only when they have a clear informational advantage over the patient. This limitation was a change to the general duty to warn the public that existed under *Wilschinsky v. Medina*.<sup>81</sup> In *Lester*, one key element to finding

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72. See *Lester*, 970 P.2d at 591.

73. *Id.*

74. See Nuttall, *supra* note 6, at 360 (noting the considerations in *Lester* were contradictory to those in *Wilschinsky*, where the court found more compelling decisions from jurisdictions holding a duty to third parties).

75. N.M. STAT. ANN. § 41-5-2 (Michie 1978).

76. See *Lester*, 970 P.2d at 593 (reiterating the deference given to legislatures to codify public policy concerns). In further attempting to limit potential liability for physicians, a shorter three-year statute of limitations is imposed for medical malpractice rather than for general negligence claims. See Nuttall, *supra* note 6, at 359.

77. *Lester*, 970 P.2d at 593.

78. *Id.* at 593-94.

79. See *id.* at 596-97 (Wash. 1985) (en banc) (finding the *Praesel v. Johnson*, 967 S.W.2d 391 (Tex. 1998), decision to be more favorable to the present situation than that of *Gooden*, thus calling into question the *Gooden* decision, which imposed a duty to the general driving public).

80. *Lester*, 970 P.2d at 595.

81. See *id.* at 595 (stating that the decision in *Wilschinsky* is a narrow exception to the general rule that physicians do now owe a duty to the non-patient public).

physician liability was whether the medication was administered in the presence of a physician or was prescribed to the patient and taken on his own.<sup>82</sup> Therefore, the amount of control that a physician has over the administration of the medication will affect his liability.<sup>83</sup> When giving a patient medication while in his office, a physician is obligated to guard against any foreseeable danger the patient could create after leaving the office and driving his car.<sup>84</sup> This duty could be discharged, however, by warning the patient of the medication's potential impairments.<sup>85</sup> In New Mexico, the dividing line for imposing a duty to the general driving public depends on how the patient receives medication. This standard is much narrower than the standard of either Texas or Washington.

One issue left unresolved by New Mexico may cause concern for physicians practicing within the state.<sup>86</sup> While the purpose of the Medical Malpractice Act is to limit physician liability, doctors are not given much leeway in deciding whether to treat an in-office patient with a shot of medication that is not a narcotic.<sup>87</sup> While such uncertainty is likely to cause unrest within the medical and professional communities,<sup>88</sup> it does place a greater burden on individual patients to be responsible, rather than automatically imposing the duty on physicians.

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82. See *id.* at 592-93 (differentiating between the prescription situation presented in *Lester* and the administration of a narcotic shot in *Wilschinsky*).

83. Compare *Wilschinsky*, 775 P.2d at 715 (stating that a difference existed between the doctor having control over situations arising within his offices and under the administration of powerful narcotics and having control physically over the patient), with *Gooden v. Tips*, 651 S.W.2d 364 (Tex. App. 1983). See also *Weitz v. Lovelace Health Sys., Inc.*, 214 F.3d 1175, 1181-82 (10th Cir. 2000) (holding, as an extension of the *Wilschinsky* ruling, that New Mexico will continue to find that outpatient relationships with physicians do not present situations where physicians have a duty to control patients, due to the lack of opportunity for physicians to monitor patients in that type of setting).

84. See *Wilschinsky*, 775 P.2d at 717 (concluding that reasonableness includes a duty to warn the general driving public when the patient is given a driving impairing medication); see also *Hoover's Dairy, Inc. v. Mid-America Dairymen, Inc.*, 700 S.W.2d 426 (Mo. 1985) (en banc) (implementing a similar public policy factor analysis to impose a duty on manufacturers of a milking machine who failed to warn consumers of electric volt surges).

85. See *Wilschinsky*, 775 P.2d at 718 (stating that options for safeguarding patients include explaining to the patient that he would need to stay under observation until able to drive and withholding an injection until another means of transportation arrives). The court's consideration here, while expressly limiting the duty being imposed to a set of individuals potentially affected by the patient while driving, seems to imply that the physician should assume some control over the behavior of the patient. Cf. *Gooden*, 651 S.W.2d at 370 (stating expressly that a physician does not need to assert control over the patient).

86. See Nuttall, *supra* note 6, at 361.

87. See *id.* at 360-61.

88. See *id.*

New Mexico courts have limited a physician's duty to warn to situations where the physician has an informational advantage over the patient. This occurs when a physician personally administered medication to a patient in his office. In this situation, simply warning the patient before he leaves the office would discharge the physician's duty. Applying this limited standard furthers New Mexico's policy of providing quality uniform health care to individuals as mandated by the Medical Malpractice Act. The New Mexico standard advocates finding physicians not liable when prescribing medications to be taken outside the office and control of the physician.

#### IV. MISSOURI'S DUTY TO WARN

Missouri has traditionally imposed duties upon physicians.<sup>89</sup> Missouri caselaw, however, does not establish a clear standard for physician liability to the general public for failure to warn of medication side effects. By contemplating and implementing standards from other jurisdictions, such as the three models discussed previously, Missouri can clarify this ambiguity. Missouri's precedent, though ambiguous, does indicate that physicians in Missouri have always owed a duty to patients. Making physicians liable to injured third parties for failing to warn patients of side effects could be a natural extension of this original duty. However, a historical consideration of a physician's duty in Missouri challenges this natural extension argument, because Missouri physicians have not held an absolute duty to the general public. Even though the concept of duty in Missouri has evolved considerably over the past several decades, it remains a potentially expansive doctrine.<sup>90</sup>

##### A. *Expanding the Traditional Physician Duty to Patients*

Missouri physicians possess a traditional duty to patients. For such a duty to extend to a specific patient, the parties must have a legal relationship.<sup>91</sup> This physician-patient relationship is necessary for the pursuit of a medical malpractice claim.<sup>92</sup> As Missouri law defines it, the physician-patient relationship is a "consensual relationship where the patient or someone acting on the patient's behalf knowingly employs a physician who consents to treat

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89. For a general discussion of the legal evolution of the application of duty in Missouri, see David. C. Kneiriem, *Exploding the Firecracker: Duty in Missouri*, 53 J. MO. B. 9 (1997).

90. See *id.* at 9 (discussing the difficulty Missouri courts may face when confronted with new types of duty cases, including duty to warn cases).

91. See *Hoover's Dairy, Inc. v. Mid-America Dairyman, Inc.*, 700 S.W.2d 426, 432 (Mo. 1985) (en banc); *Millard v. Corrado*, 14 S.W.3d 42, 46-47 (Mo. Ct. App. 1999).

92. See *Richardson v. Rohrbaugh*, 857 S.W.2d 415, 417-18 (Mo. Ct. App. 1993) (determining that there was no physician-patient relationship present between the mother of a newborn baby and the neurologist who failed to diagnose a genetic medical condition that warranted bringing a medical malpractice claim); *Millard*, 14 S.W.3d at 49.



the patient.”<sup>93</sup> In this relationship, a physician has an informational advantage over the patient that enables him to make an educated decision regarding the patient’s medical treatment. Missouri caselaw states that in most situations a physician-patient relationship begins when the physician personally examines the patient.<sup>94</sup> These decisions indicate that this relationship is contractual in nature.<sup>95</sup> Thus, when a physician acts within his capacity to treat a patient, he establishes a physician-patient relationship. The existence of a physician-patient relationship is necessary to extend a physician’s duty from his patient to third parties at risk of being injured by the patient.<sup>96</sup>

Missouri has previously found only that psychotherapists owe a duty to a foreseeable victim if a “special relationship” exists with the patient. Generally, a physician is not required to control the conduct of a person even if he may cause foreseeable harm.<sup>97</sup> Nevertheless, Missouri courts, following *Tarasoff*, have recognized that a duty to control may arise when a “special relationship” exists between the parties.<sup>98</sup> As in *Tarasoff*, however, Missouri courts have

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93. *Millard*, 14 S.W.3d at 49.

94. *See id.* at 50 (noting that other jurisdictions have recognized a physician-patient relationship to exist without any personal contact, “where the consultant physician does not physically examine or bill the patient . . . [but where] . . . the physician is contractually obligated to provide assistance in the patient’s diagnosis or treatment and does so”) (quoting *Corbet v. McKinney*, 980 S.W.2d 166, 169 (Mo. Ct. App. 1998)).

95. *See id.* at 171 (holding that being contacted by emergency room physician to provide advice for outpatient, but never speaking to or examining patient did not create a physician-patient relationship that would impose a liability).

96. A plaintiff pursuing a third party claim against a physician may have another potential defendant if courts find that hospitals also hold a potentially expansive duty to patients. The hospital itself may also be liable to patients if it does not meet a certain standard of care. According to Missouri law, a hospital owes a duty of reasonable care to all of its patients, which is separate from the duty of the physician. *See Poluski v. Richardson Transp.*, 877 S.W.2d 709, 713 (Mo. Ct. App. 1994) (stating that if the conduct is administrative, ministerial or routine in caring for the patient, the standard is that of ordinary care owed to the patient); *Stacy v. Truman Medical Ctr.*, 836 S.W.2d 911, 922 (Mo. 1992) (en banc). If this duty arises, then there is a possibility that the hospital could also owe a duty to warn the general public, if the physician in a similar situation would be held liable for breach of this duty. After finding the hospital to have an informational advantage over the patient, Missouri case law has held that the duty of reasonable care exists until the patient is either officially discharged, meaning signing the discharge paperwork, or until the patient physically leaves the premises. *See Poluski*, 877 S.W.2d at 713-14.

97. *But see Kuhn v. Budget Rent-A-Car*, 876 S.W.2d 668, 674 (Mo. Ct. App. 1994) (holding that rental car company had a duty to a third person to control the intoxicated off-duty employee from driving one of its owned vehicles, which struck the third person’s vehicle and killed the driver).

98. *See Bradley v. Ray*, 904 S.W.2d 302, 311 (Mo. Ct. App. 1995); Timothy E. Gammon & John K. Hulston, *The Duty of Mental Health Care Providers to Restrain Their Patients or Warn Third Parties*, 60 MO. L. REV. 749, 766 (1995) (stating that a recognized exception to the rule

found this special relationship to exist primarily only between psychotherapists and their patients.<sup>99</sup> In such a relationship, the therapist has a duty to warn an identifiable third party victim.<sup>100</sup> Recent decisions have therefore limited a physician's duty to warn to potential victims, rather than extending a duty to warn to all third persons.<sup>101</sup> Outside of this special relationship,<sup>102</sup> a physician may owe a duty to third persons depending on the special circumstances of the case and the dangerous conditions facing the third party.<sup>103</sup> Consequently, outside of a psychotherapist-patient relationship, special circumstances must be present to impose upon a physician a duty to warn. However, even under special circumstances, there is no duty to control.

*B. Discharging the Physician Duty Owed to Patients and Preventing Potential Expansion*

Once established, the physician's duty to a patient continues until the physician-patient relationship ends.<sup>104</sup> After the relationship has ended, the physician no longer has an informational advantage over the patient, and the duty to the patient has been discharged. As a result, the physician should no longer owe a duty to the public with whom the patient comes in contact.<sup>105</sup> The Supreme Court of Missouri recently established a four-factor test in *Weiss*

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that a person has no duty to control the actions of another is the creation of a "special relationship". See also RESTATEMENT (SECOND) TORTS §§ 315 (1963-64).

99. See *Bradley*, 904 S.W.2d at 311 (noting that other situations imposing a "special relationship" between the parties include dealings of innkeeper-guest relationships, common carrier-passenger relationships, school-student relationships, and potentially employee-employer relationships) (quoting *R.C. v. Southwestern Bell Tel. Co.*, 759 S.W.2d 617, 620-21 (Mo. Ct. App. 1988)).

100. See *id.* at 306-07 (following the *Tarasoff* line of reasoning).

101. See *id.* at 312 n.7; Gammon & Hulston, *supra* note 99, at 767 (stating that generally courts in Missouri "have been loathe to impose liability for a defendant's failure to control a third party's actions").

102. This Comment will argue that the existence of this special relationship indicates that the potentially liable party has had an opportunity to know or should have known the mental status of the individual due to the nature of the relationship or the treatment environment under which the relationship operates.

103. See *Kuhn*, 876 S.W.2d at 673; *Bradley*, 904 S.W.2d at 311-12. The creation of this duty is a version of the foreseeability of harm argument that imposes upon the defendant a duty to warn.

104. See *Millard*, 14 S.W.3d at 52.

105. This consideration should be contingent upon the type of treatment needed by the patient. For example, if the patient is in need of long term or chronic care, then these factors would not be reasonably applicable to the discussion of the relationship ending upon meeting one of the factors propounded by *Weiss*. This results from the original purpose of the discussion of the duty to warn, which is that the physician has some relationship with his patient. If there was no relationship in which the physician was capable of either prescribing medication or administering such, then the duty to warn would not even be an issue.

*v. Rojanasathit* (hereinafter the “*Weiss* test”) to be used when determining the end of a physician-patient relationship.<sup>106</sup> The factors of the *Weiss* test include: “(1) the mutual consent of the parties, (2) the physician’s withdrawal after reasonable notice, (3) the dismissal of the physician by the patient, or (4) the cessation of the necessity that gave rise to the relationship.”<sup>107</sup> If a physician meets any of these factors, he no longer has a duty to the patient. The physician may still be liable for not discharging his duty to warn while in the relationship—otherwise he would not have any potential duty beyond the termination of the relationship.

Missouri courts have applied this four-factor test to situations involving emergency treatment. For example, Missouri courts have held that upon completion of an emergency surgery, the physician-patient relationship ended pursuant to the fourth factor of the “*Weiss* test.”<sup>108</sup> The physician only had a duty to warn the patient of a medication side effect prior to the termination of the relationship, while he had an informational advantage over the patient. If any of the *Weiss* factors are met, then the relationship has arguably ended and the duty should not be extended to third parties.

### C. *Reliance on Principles of Public Policy*

Because Missouri has a public policy favoring a common law duty to warn, it is likely that it will move towards finding physicians liable to third persons for failing to warn patients of medication side effects. Courts often consider public policy when making decisions. Missouri has adopted a six-factor public policy analysis to be used in finding a duty to warn.<sup>109</sup> The public policy factors include: (1) the social consensus that the interest is worthy of protection; (2) the foreseeability of harm and the degree of certainty that the protected person suffered injury; (3) moral blame attached to the conduct by society; (4) the extent to which the conduct could prevent future harm; (5) the potential cost and the ability to spread the risk of loss; and (6) the economic burden placed on the actor and the community that may be

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106. See *Weiss v. Rojanasathit*, 975 S.W.2d 113, 119-20 (Mo. 1998) (en banc).

107. *Id.* at 199-20; see also *Millard*, 14 S.W.3d at 522. The application of these factors in *Weiss* was specifically adapted to discuss the running of the statute of limitations and the continuing care exception for medical malpractice cases, but it was also used to address the issue of treatment in an emergency room in *Millard*.

108. See *Millard*, 14 S.W.3d at 52-53 (remanding and holding that if the trial court found a physician-patient relationship to exist that the relationship had ended three hours after patient’s arrival at emergency room, when she received emergency surgery).

109. See *id.* at 47 (holding that Missouri courts are guided by the factors presented by *Hoover’s Dairy* to find a duty when no special relationship exists between the parties); *Bradley*, 904 S.W.2d at 310; *Hoover’s Dairy*, 700 S.W.2d at 432 (stating that these factors are the basis for sound public policy).

affected.<sup>110</sup> All of these factors are considered together as a collective social policy of the Missouri legislature.<sup>111</sup> If imposing a duty is supported under these factors then neither actual nor constructive knowledge will be necessary.<sup>112</sup> Missouri courts will likely use these factors to make future decisions regarding physician liability to third parties for failure to warn of medication side effects. Driving-related accidents may affect any member of the general public.

Since legislatures are usually in the best position to evaluate and implement public policy, the Missouri legislature's stance regarding a physician's liability to third parties will help determine the state's policy. The Missouri legislature has drafted and passed several statutes specifically addressing a professional's duty to warn others.<sup>113</sup> For example, the Child Abuse Reporting Act<sup>114</sup> requires a psychologist to report to the proper authorities when he believes that a child has been or will be subjected to abuse.<sup>115</sup> In *Bradley v. Ray*,<sup>116</sup> the court stated that physicians who are told of such abuse by their patients or who have reason to know that a child will be abused should report such violence.<sup>117</sup> In these situations, physicians have an informational advantage not over the patient, but over the patient's potential victim. Therefore, reporting the potential abuse is the only way a physician can discharge his duty.

A psychologist's duty to report situations of child abuse is unique based on the "special relationship" that exists between the patient and the physician. The policy underlying this duty is relevant, though, in discussing a physician's duty to third parties not within the physician's immediate control.<sup>118</sup> In

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110. *See Hoover's Dairy*, 700 S.W.2d at 432.

111. *See Millard*, 14 S.W.3d at 47 (stating that the legislature is a political body that for the most part bases its decision on public sentiment inherent in these public policy factors and holding that the statute regarding "on call" emergency physicians represented the social consensus).

112. *See Hoover's Dairy*, 700 S.W.2d at 432.

113. *See Bradley*, 904 S.W.2d at 305-06. Missouri has specifically created a duty of the physician to warn third persons of the HIV status of their patients. *See* MO. REV. STAT. § 191.653(3) (2000 & Supp. 2001) (stating that physicians are under a duty to report to the Department of Health any patients that are infected with HIV); MO. REV. STAT. § 191.656(2) (2000 & Supp. 2001) (stating that physicians are not liable for disclosing confidential information to warn spouses or care givers of the patient's HIV status).

114. MO. REV. STAT. § 210.115(1) (2000 & Supp. 2001). This Act states: "When any . . . psychologist, . . . has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observe a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately report or cause a report to be made to the division . . ."

115. *See id.*

116. *Bradley v. Ray*, 904 S.W.2d 302 (Mo. Ct. App. 1995).

117. *See id.* at 310.

118. *See Gammon & Hulston, supra* note 99, at 765.

*Bradley*, the court severely limited the potential duty owed by the physician. In light of the statute,<sup>119</sup> the court did not create any additional common law duties.<sup>120</sup> Rather, the court recognized an injured party's right to bring an action "only for failure to warn of specific risks of future harm to readily identifiable victims."<sup>121</sup> The specific acts or omissions of the physician must foreseeably cause either harm or injury to a third party that the patient encounters.<sup>122</sup> Thus, a psychologist's duty to warn only exists when the victim is foreseeable.

Because the *Bradley* court did not impose upon treating physicians the same duty owed by psychologists, the decision left several questions unanswered. *Bradley* restricted the psychologist's duty to a duty to warn, *not to control*.<sup>123</sup> Thus far, Missouri has adopted and enforced a duty to warn on psychologists only, as in *Bradley*, but has left open the question of a physician's duty to third parties. Missouri, however, has demonstrated some interest in creating such a common law duty upon other physicians. The holding of *Bradley* provides a good example of how public policy influences judicial decisions in Missouri. Yet, without a statute to rely upon, courts must independently decide Missouri's public policy.

#### D. Two Important Exceptions to Traditional Duties in Missouri

Missouri courts have crafted two exceptions to the traditional duties imposed on physicians. They have limited the physician's duty to his patient when danger is open and obvious to the patient. In these cases, the physician would not owe a duty to the public. In addition, they have limited the physician's duty to the general public when imposing such a duty would violate the personal freedom of the patient. In both situations, the informational advantage of the physician is considered equal to or less than the patient's. Missouri courts have considerable room for interpretation and application of traditional duties, which may present a dilemma for the courts when ruling on the physician's duty to warn.

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119. Consider the difference between circumstances presented in *Bradley*, where a statute already existed, with the situation typically presented in duty to warn cases, where the duty has typically been developed by common law and then later imposed in the form of statutory law.

120. *See Bradley*, 904 S.W.2d at 311.

121. *See id.*

122. *See id.* (quoting *Madden v. C & K Barbecue Carryout, Inc.*, 758 S.W.2d 59, 62 (Mo. 1988) (en banc)).

123. *See Bradley*, 904 S.W.2d at 312 (stating that a psychologist now has a duty under the common law of Missouri to warn the intended victim, which includes notifying proper officials, but not to control the patient's actions). *See also* Gammon & Hulston, *supra* note 99, at 765 (drawing attention to the open questions that *Bradley* left for future Missouri cases, including under what circumstances physicians will be adjudged to have discharged their duty).

### 1. Open and Obvious Dangers

A physician that *does not* have an informational advantage over a patient may not owe a duty to the patient. For example, warning a patient may not be required when the danger is open and obvious or commonly known to the patient, even though a physician-patient relationship exists. Consequently, when presented with a case factually similar to both *Gooden* and *Kaiser*, Missouri courts did not find that the physician owed a duty to a third party.<sup>124</sup> In *Young v. Wadsworth*, the plaintiff claimed that the physician failed to warn his patient not to drive when taking Xanax.<sup>125</sup> The patient experienced a blackout spell while driving, causing the driver to crash into the vehicle of the plaintiff, killing the driver.<sup>126</sup> The court addressed only the issue of proximate cause necessary to find a duty owed by the driver for the injuries incurred.<sup>127</sup> The court found that the physician was under no duty to warn because the driver suffered blackouts before the medication was prescribed and because there was no evidence that the patient had taken any medication before the accident.<sup>128</sup> For this reason, the physician in *Young* did not have an informational advantage over the patient nor a duty to warn patient.

*Young* reveals Missouri's judicial hesitation to assert two important standards, each of which could impose a duty on physicians to third parties for failing to warn patients of medication side effects. First, *Young* provides that regardless of the doctor's traditional duty, a physician has no duty to warn of dangers that are open and obvious to the patient.<sup>129</sup> Second, the court in *Young* refused to extend a duty to third persons for failing to warn the patient not to drive.<sup>130</sup> While *Young* does not indicate when physicians would be liable to

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124. See *Young v. Wadsworth*, 916 S.W.2d 877 (Mo. Ct. App. 1996).

125. *Id.* at 878.

126. See *id.*

127. See *id.*

128. See *id.* at 879 (acknowledging but declining to extend the decisions of *Gooden* and *Kaiser* to the present situation, stating that none of the factual scenarios in those cases were present).

129. This proposition comes from a line of Missouri products liability cases. See *Richardson v. Holland*, 741 S.W.2d 751, 754 (Mo. Ct. App. 1987); *Grady v. Am. Optical Corp.*, 702 S.W.2d 911, 915 (Mo. Ct. App. 1985).

130. In *Young*, the court distinguished this situation from three types of situations where other courts had held a physician liable to a third party under a failure to warn theory; where the doctor actually created the conditions and then failed to warn the patient, where the doctor knew that the patient had an unknown physical condition that could result in the cause of an accident and failed to warn him, and where the doctor advised the patient to continue to drive. See *Young*, 916 S.W.2d at 879. While these situations do not seem to be all that contradictory or distinguishable from the situation presented in *Young*, the court implied that to be held liable, a physician must possess a higher level of knowledge about a patient's condition than the patient does. See *id.* at 878-79. Arguably, the court was simply hesitant to apply such a standard upon physicians in Missouri.

third parties, physician liability to third parties should not exist unless the physician has a clear informational advantage over his patient.

## 2. Denial of Extension of Duty in Favor of Personal Freedom

Missouri courts have limited the doctor's duty to warn if doing so violates a patient's personal freedoms. The decision in *Bradley* was unique because the court declined to extend a duty to warn in cases both prior to and contemporaneous with it.<sup>131</sup> Adopting *Tarasoff's* reasoning, Missouri courts previously distinguished between warning an identifiable victim and warning the general public.<sup>132</sup> The courts differentiated the facts of these cases from *Tarasoff*, which enabled them to avoid accepting the doctrine at that point.

While Missouri's public policy supports the sanctity of a patient's individual freedom, it may support extending a physicians' duty to the general public. After the court applies the *Hoover's Dairy* public policy factors, the social consensus may seem to favor imposing a duty. However, imposing a duty on the physician may also work contrary to Missouri's public policy, which favors personal liberty.<sup>133</sup> In *Sherrill v. Wilson*, the Missouri Supreme Court held that imposing a duty would be inappropriate in light of the public interest.<sup>134</sup> In *Sherrill*, the court addressed whether treating physicians owed a duty to the general public when deciding which involuntary patients should be released on pass.<sup>135</sup> The court held that patients must be kept in the least restrictive means possible if found to qualify for involuntary confinement.<sup>136</sup> Physicians should be given deference in making decisions about their patients'

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131. See *Bradley*, 904 S.W.2d at 309-10 (noting that previous decisions had declined to address the issue of whether Missouri would follow the reasoning imposed by the *Tarasoff* legacy, but that the present case allowed the court to decide such an issue).

132. See *Matt v. Burrell, Inc.*, 892 S.W.2d 796 (Mo. Ct. App. 1995); *Sherrill v. Wilson*, 653 S.W.2d 661 (Mo. 1983) (en banc).

133. See *Sherrill*, 653 S.W.2d at 664. Recently, the Missouri Court of Appeals for the Eastern District rendered a decision regarding physician liability for driving-related impairments that reinforced the holdings of both *Matt* and *Sherrill*. See *Virgin v. Hopewell Center*, No. ED 78857, 2001 WL 1155854, at \*2 (Mo. Ct. App. Oct. 2, 2001). The court specifically stated that where a patient is not committed to a facility, Missouri law would not allow for the court to find that the physician had a duty to warn motorists and to take precautionary steps to reduce any risk that a patient may pose to these motorists. See *id.* Even though the driver in *Virgin* was a psychiatric patient, this decision seems to show the hesitancy of Missouri courts to hold physicians liable for driving-related accidents, because the potential victims are unforeseeable. See *id.* Additionally, the court in *Virgin* noted the status of *Robinson*, and while following the same case law considered by the court in *Robinson*, found instead that no duty existed under the current status of Missouri law. See *id.* at \*3.

134. See *Sherrill*, 653 S.W.2d at 664; Gammon & Hulston, *supra* note 99, at 756-57.

135. See *Sherrill*, 653 S.W.2d at 664 (stating that involuntary patients may be confined in mental hospitals if they are judicially determined to be a threat to themselves or to the public).

136. See *id.*

best interests.<sup>137</sup> However, imposing a greater burden on the physician, such as a duty to the general public, could pressure physicians to provide restrictive treatment to their patients, even if their best judgment would dictate otherwise.<sup>138</sup> If imposed with additional liability, physicians may seek to protect their own interests rather than provide the best treatment for their patients. For example, in *Sherrill*, the Missouri Supreme Court found that public policy actually advocated not holding patients against their own will.<sup>139</sup> Thus, Missouri courts have been reluctant to extend a duty to the general public regarding the release of involuntary patients, indicating Missouri's public policy in favor of individual freedom. But, if held liable to the general public, physicians may not be willing to release such patients for fear of being held personally liable for their patients' actions.

Missouri courts have issued similar decisions regarding treatment of voluntary patients, in either an emergency room or outpatient setting. Courts note distinctions in duties owed to patients depending on their treatment status. In *Matt v. Burrell*, the court stated "a duty with respect to the acts of a voluntary outpatient is less than that owed with respect to a voluntary inpatient, and the heaviest duty is imposed with respect to a person who has been involuntarily committed."<sup>140</sup> In *Matt*, a patient presented herself to the community psychiatric rehabilitation center, where she had been a patient for several years. The patient stated her intent to leave the facility and kill herself by wrecking her car.<sup>141</sup> Even though the physicians did not stop the patient from leaving, they were not liable to the third party hit and killed by the patient.<sup>142</sup> This decision followed *Sherrill's* failure to extend a physician's duty to the general public. Again, Missouri's public policy acted as a restraint against requiring a physician to control a patient by preventing her from leaving. Certain acts are beyond traditional duties owed by physicians.

Both *Sherrill* and *Matt* urged physicians to respect their patients' personal freedom. However, both cases failed to address several important issues

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137. *See id.* (stating that physicians may have thought that releasing the patient for a period of time was beneficial to his treatment).

138. *See id.*

139. *See id.* at 669 (recognizing that this decision is not meant to overturn any previous decisions which held physicians or public officers liable under a failure to warn theory if the victim was an identifiable individual rather than the general public). Instead of relying on the *Tarasoff* legacy, as the decision in *Bradley* did, the *Sherrill* court relied upon the reasoning of *Thompson v. County of Alameda*, which is considered the counterpart of *Tarasoff*. *See Thompson v. County of Alameda*, 614 P.2d 728 (Cal. 1980).

140. *Matt v. Burrell, Inc.*, 892 S.W.2d 796, 801 (Mo. Ct. App. 1995).

141. *Id.* at 798.

142. *See id.* at 797-98. Note the difference in the degree of the relationship in this situation, where the physicians had an ongoing relationship with the patient prior to her presentation at the clinic on the day of the accident, and in an emergency room situation, where it is very likely that the physician had not treated the patient prior to the time when treatment began.



regarding a standard for physician liability to third parties. First, these cases do not establish the required informational advantage a physician must have over the patient to impose a duty to third parties. Furthermore, while these two cases advocated not holding patients against their will, they did not discuss a similar policy when medication was involved. Lastly, since physicians do not owe a public duty to keep patients from leaving, there is no standard addressing how a physician's duty could be discharged. Nevertheless, since both *Sherrill* and *Matt* did not obligate physicians to control their patients' behavior, issuing a simple warning would most likely discharge any duty found. Addressing these issues is important when deciding whether a physician is liable to third parties.

E. *Application of Missouri's Evolving Duty to Warn in Robinson v. Health Midwest Development Group*

In *Robinson v. Health Midwest Development Group*,<sup>143</sup> the Missouri Supreme Court had an opportunity to adjudicate an issue other jurisdictions have grappled with for decades. *Robinson* presents the only written<sup>144</sup> analysis of the duty to warn for Missouri, even though the court failed to create an identifiable standard. In advocating the position Missouri courts should take, *Robinson* may serve as a predictor of where this area of Missouri law is headed. The court of appeals decision, which was dismissed by the supreme court, provides the only interpretation of Missouri's public policy regarding physician liability to third parties. Even though it was dismissed, this decision is important because setting a third person liability standard for physicians will reshape individual duties for Missouri citizens who are ultimately the patients. Since the same issues will almost certainly come before Missouri courts again, the *Robinson* decisions frame the approach Missouri courts will likely take in the future.

Despite its unique facts, *Robinson* provides a good starting point for discussing physician liability to third persons. In *Robinson*, Driver Schmidt arrived at the Lafayette Regional Health Center emergency room during the afternoon of November 17, 1993, seeking medication to help calm her nerves.<sup>145</sup> A physician examined Schmidt and ordered Compazine, a non-narcotic drug used to treat nausea, to be given intravenously to her.<sup>146</sup> Allegedly, neither the physician nor the staff nurse warned Schmidt of

143. See *Robinson v. Health Midwest Dev. Group*, 58 S.W.3d 519 (Mo. 2001) (en banc).

144. See *id.* (dismissing the issues decided by the court of appeals and affirming the trial court's summary judgment ruling in favor of the defendants).

145. See *id.* at 521.

146. See *id.*

potential side effects of this medication, which included drowsiness, dizziness and lowered blood pressure.<sup>147</sup>

Thirty-five minutes after receiving this medication through injection, Schmidt left the emergency room and attempted to drive her vehicle.<sup>148</sup> Because of her abrupt and unknown departure, the staff did not properly discharge her from the emergency room. Approximately ten minutes after leaving the emergency room, Schmidt lost control of her vehicle, crossed the centerline and collided with Plaintiff Robinson's vehicle.<sup>149</sup> The Missouri Highway Patrol Report noted that Robinson's attempt to stop her vehicle and avoid the collision resulted in twenty-one feet of braking tire marks.<sup>150</sup> Plaintiff Robinson suffered injuries as a result of the collision and initiated a lawsuit against Health Midwest Development Group.

While the cause of the accident was not stated, certain factors make Schmidt's physical condition at the time of the accident questionable. Officers found an empty beer container in Schmidt's vehicle upon investigating the accident scene.<sup>151</sup> Moreover, Schmidt admitted to consuming alcohol prior to the accident.<sup>152</sup>

*Robinson* went to trial in July of 1999, but the jury was unable to reach a decision.<sup>153</sup> Before *Robinson* was reset for a new trial, Defendant Health Midwest Development Group filed a motion for summary judgment.<sup>154</sup> The trial court entered summary judgment in favor of the defendant on February 15, 2000, holding that it did not owe a duty to Robinson as a member of the public. The plaintiff appealed the trial court's decision and requested that summary judgment be overturned. The court of appeals granted the plaintiff's request and remanded this case to the trial court with the instruction that the

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147. *See id.* (stating that these side effects were generally known in the medical community to be associated with Compazine). Respondent's brief noted that Schmidt told the nurse that someone was with her at the emergency room that would be able to drive her home. *See* Respondent's Brief at 4, *Robinson v. Health Midwest Dev. Group*, 58 S.W.3d 519 (Mo. 2001) (No. 83645), available at <http://www.osca.state.mo.us/sup/index.nsf>. The court's decision does not mention or address this fact.

148. *See Robinson*, 2001 WL 212776, at \*1.

149. *See id.* at \*1-2.

150. *See Robinson v. Health Midwest Dev. Group*, 2001 WL 212776, at \*2 (Mo. Ct. App. March 5, 2001).

151. *See id.*; Respondent's Brief at 5, *Robinson*, (No. 83645), available at <http://www.osca.state.mo.us/sup/index.nsf>.

152. *See Robinson*, 2001 WL 212776, at \*2.

153. *See id.*; Respondent's Brief at 5, *Robinson*, (No. 83645), available at <http://www.osca.state.mo.us/sup/index.nsf>. Consider the implications for a trial case when reasonable people in the position of the jurors cannot come to a logical conclusion given a set of facts. This seems indicative of the split decisions that jurisdictions have rendered when presented with a similar fact pattern.

154. *See Robinson*, 2001 WL 212776, at \*2.

physician could be liable to the general public when failing to warn a patient of the side effects of an administered medication.<sup>155</sup> The cause was ordered transferred to the Missouri Supreme Court at the request of the defendant on June 26, 2001.

The Missouri Supreme Court handed down its decision in *Robinson* on October 23, 2001.<sup>156</sup> The decision adds little to the current analysis of a physician's duty to third parties regarding warning of medication side effects. The court decided under which statute, for purposes of the statute of limitations, a case such as *Robinson* would fall, but it declined to rule on the substantive issue presented in *Robinson*. One of many possible reasons for this could be that this case was time-barred.

The one important clarification that *Robinson* provided was that the statute of limitations in Missouri for claims against health care providers is two years,<sup>157</sup> rather than the five-year statute of limitations allowed for general negligence claims.<sup>158</sup> Thus, regardless of whether Robinson's claim was brought against the physicians or against the hospital, the court believed that such claims needed to be filed within two years. The court used this statute in *Robinson* because the statute listed particular defendants who fall under this two-year umbrella.<sup>159</sup> This interpretation must stand given the clear and

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155. *See id.* at \*18. The court of appeals limited prior Missouri case law to a specific application of the facts. For example, the court of appeals discounted the broader principle stated in *Sherrill*, that in the interest of personal liberties and in deference to the decisions of treating physicians, a general duty owed by physicians should not be imposed for releasing an involuntary patient. *See supra* notes 131-37; *Robinson v. Health Midwest Dev. Group*, 2001 WL 212776, at \*7-8 (Mo. Ct. App. March 5, 2001). Instead, the court stated the belief that the decision in *Sherrill* should only be limited to medical decisions rendered by the standard regarding whether the patient should be released. *See id.* The court of appeals similarly limited the decision of *Young* to provide a statement of whether the side effects of the medication administered should have been open and obvious to the patient. *See id.* at \* 8; *supra* notes 122-27. However, the open and obvious danger in the situation of *Robinson* may not have been the medication's side effect, but the disputed circumstantial facts of the intoxication of the patient upon entering the emergency room. *See Robinson*, 2001 WL 212776, at \*8. Such a standard would hinder the general principle advocated by Missouri that courts should be hesitant to impose upon physicians a duty to warn the general public.

156. *Robinson v. Health Midwest Development Group*, 58 S.W.3d 519 (Mo. 2001) (en banc).

157. MO. REV. STAT. § 516.105 (West 2000) (stating that any claim regarding the care, custody or treatment of a patient falls within the provisions of this statute). This statute provides that "all actions against physicians, hospitals . . . pharmacists . . . and any other entity providing health care services and all employees . . . acting in the course and scope of their employment, for damages for malpractice, negligence . . . shall be brought within two years from the date of occurrence." *See id.* Robinson's claim was filed slightly more than three years after the time of the incident. *See Robinson*, 58 S.W.3d at 521.

158. MO. REV. STAT. § 516.120 (West 2000) (applying to general negligence claims against those defendants that do not fall into the aforementioned statute).

159. *See Robinson*, 58 S.W.3d at 522.

unambiguous language of the statute.<sup>160</sup> After *Robinson*, the one guarantee provided to both physicians and potential plaintiffs is that the claim needs to be filed within two years of the incident.

Missouri courts will have to further clarify many issues *Robinson* did not provide clear answers about. No definitive answer was provided for whether Missouri would find a duty to warn in medical malpractice or general negligence suits.<sup>161</sup> Based on the statute's wording, however, practitioners do know that a two-year statute of limitations applies to both medical malpractice and negligence claims.<sup>162</sup> The court of appeals found Missouri's public policy to support imposing physician liability to third persons with driving related accidents. While *Robinson* was perhaps just not the right case to force the court to decide this issue, the court of appeals decisions may be followed in the future.

#### VI. MISSOURI'S PUBLIC POLICY DILEMMA: ADDITIONAL DUTIES OR INDIVIDUAL RESPONSIBILITIES

Missouri's public policy, which favors imposing liability and additional duties upon physicians, will influence the adoption of a third party liability standard for failing to warn of medication side effects. Three general policies have developed in Missouri that explain the controversy between imposing additional duties upon physicians and holding individuals responsible for their own actions: the learned intermediary doctrine, the informed consent doctrine and the stigma attached to driving while intoxicated. Intertwined with these three issues are two considerations also addressed by the other jurisdictions discussed. When the physician has an informational advantage over the patient, placing the duty to warn on the physician may be justified. Still, the patient's knowledge about his personal physical conditions may cause him to be responsible despite the physician's failure to warn. If the physician does owe a duty, the court must determine what warning would discharge the duty.

Even though Missouri imposes traditional duties on physicians, the concept of duty in Missouri is constantly changing as new situations arise for adjudication. Missouri courts may be driving in the direction of imposing greater rather than lesser duties upon Missouri physicians, especially regarding the administration of medications.<sup>163</sup> Missouri has a strong interest in

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160. *See id.*

161. The importance of this distinction regards the relationship that would be needed to bring a claim against a physician. If regarded as a medical malpractice claim, plaintiff drivers do not fall into a physician-patient relationship. However, if allowed to fall under a general negligence heading, public policy factors may possibly allow for the duty to be extended to the general public.

162. *See Robinson*, 58 S.W.3d at 522.

163. As noted before, the only decision rendered in Missouri regarding physician liability to third parties was given in *Robinson*. In rendering its decision, the court of appeals seemed to be

protecting drivers on its roadways. However, the judiciary should not be so quick to re-allocate the responsibility of safe driving from the individual to the physician. Based on Missouri's case law and applicable public policy issues, Missouri courts should adopt a simple duty to warn standard that requires them to warn patients.

A. *The Learned Intermediary Doctrine and Burden Shifting*

The learned intermediary doctrine, adopted by Missouri, requires physicians to maintain an informational advantage over patients regarding knowledge about medications. This doctrine essentially provides a defense to drug companies or manufacturers when charged with negligent manufacturing of their products.<sup>164</sup> Numerous public policy considerations form the basis of the learned intermediary doctrine.<sup>165</sup> In applying this doctrine, the physician acts as a learned intermediary between the drug manufacturer and the consumer, who is ultimately the physician's patient.<sup>166</sup> The physician's warning about the potential side effects of certain medications has the same effect as if the manufacturer were personally warning the patient, which shifts the burden to the physician.<sup>167</sup> The primary rationale behind this doctrine is that the physician is in a better position than the manufacturer to reach the patient.<sup>168</sup> Additionally, the potential side effects are often so complicated that patients may actually understand the dangers better if the physician is the one explaining them.<sup>169</sup> Thus, Missouri courts determined the physician to be in the best position to warn of the potential medication side effects.

The physician may be liable for not warning the patient even if the drug manufacturer failed to warn the physician.<sup>170</sup> Thus, the physician's duty to

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most closely following the reasoning applied by the courts in Texas, which applies a very broad duty to warn standard. *See supra* notes 35-52.

164. Bradford B. Lear, *The Learned Intermediary Doctrine in the Age of Direct Consumer Advertising*, 65 MO. L. REV. 1101, 1104 (2000). Missouri applied the doctrine of learned intermediary for one of the first times in a 1967 Missouri Supreme Court decision. *See Krug v. Sterling Drug, Inc.*, 416 S.W.2d 143, 151-52 (Mo. 1967) (stating that when a physician is properly warned of potential side effects there is a greater possibility that the patient will not be subject to injuries as a result).

165. *See Lear, supra* note 168, at 1104-05.

166. *See Doe v. Alpha Therapeutic Corp.*, 3 S.W.3d 404, 419 (Mo. Ct. App. 1999).

167. *See id.*

168. *See Lear, supra* note 168, at 1115. Missouri caselaw states that the reasoning behind this doctrine is that "a patient may obtain the product only through a qualified professional who presumably will explain the dangers of the product to the patient." *See Menschik v. Mid-America Pipeline Co.*, 812 S.W.2d 861, 864 (Mo. Ct. App. 1991).

169. *See Lear, supra* note 168, at 1115.

170. *See Callahan v. Cardinal Glennon Hosp.*, 863 S.W.2d 852, 862 (Mo. 1993) (resolving the issue left unanswered by the court in *Sterling Drug* regarding a physician's liability when the pharmaceutical company failed to warn the physician and holding that as long as the physician

warn the patient goes beyond simply informing the patient about the side effects.<sup>171</sup> A physician has a professional duty to keep abreast of all current medical developments.<sup>172</sup> The physician could therefore be liable if he knew or reasonably should have known of current medical developments regarding the medication, but did not tell the patient.<sup>173</sup> Because Missouri wants to impose a greater burden upon physicians, courts do not want to create an exception to this doctrine for direct-to-consumer advertising.<sup>174</sup> This exception would mitigate the physician's duty and place the burden back on the manufacturers who are doing the direct advertising.<sup>175</sup> By not recognizing this exception,<sup>176</sup> Missouri continues to impose a heightened duty on physicians, suggesting that it may rule in favor of extending a duty to the general public if the physician does not issue a warning and the patient harms someone as a result.

#### *B. Informed Consent Doctrine—A Fully Informed Patient*

The informed consent doctrine compliments Missouri's learned intermediary doctrine by advocating that patients be aware of all of the potential dangers of a treatment before the procedure is performed. Thus, the standard used to determine if the patient did not have informed consent before undertaking the procedure is "whether a reasonable person in plaintiff's position would have consented to the procedure had the proper disclosure been made."<sup>177</sup> When bringing an action for lack of informed consent, the injured patient has the burden of proving that a fully informed reasonable person would not have consented to the procedure.<sup>178</sup> By disclosing all information to

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already knew or had information regarding potential future injuries to the patient, then a failure to warn the physician could not have been the proximate cause of the injuries); *Doe*, 3 S.W.3d at 420.

171. See *Doe v. Alpha Therapeutic Corp.*, 3 S.W.3d 404, 420 (Mo. Ct. App. 1999).

172. See *id.*

173. See *id.* (holding that the physician kept informed of the potential transmission of AIDS through blood and blood products and spoke with other physicians, but failed to give the patients the warnings and continued to use the potentially infected products, should have done so and took the liability off of the manufacturer).

174. See *Lear*, *supra* note 166, at 1116.

175. See *id.* (arguing that Missouri should allow for this exception because by participating in direct-to-consumer advertising, the manufacturers are negating the principles for which the learned intermediary doctrine is imposed and assuming that patients will be able to understand the side effects on their own).

176. See *id.* (discussing concern about continuing to impose this duty on physicians when the expansive growth of medical technology precludes physicians from reasonably being able to educate themselves fully about all of the side effects of different medications).

177. See *Wilkerson v. Mid-America Cardiology*, 908 S.W.2d 691, 696-97 (Mo. Ct. App. 1995) (quoting *Aiken v. Clary*, 396 S.W.2d 668, 676 (Mo. 1965); *Wuerz v. Huffaker*, 42 S.W.3d 652, 657 (Mo. Ct. App. 2001)).

178. See *Wilkerson*, 908 S.W.2d at 697.

the patients, individuals can make complete decisions regarding their personal health.

A physician is not required to present to the patient a detailed description of each and every option available.<sup>179</sup> The physician need only disclose those options which a “reasonable medical practitioner would [provide] under the same or similar circumstances” to the patient.<sup>180</sup> What a reasonable doctor would disclose is based on the circumstances and facts of each case. Importantly, Missouri courts have stated, “a reasonable doctor would not necessarily disclose every possible alternative, nor would that doctor necessarily disclose all details about the risks associated with each alternative.”<sup>181</sup> Thus, while physicians are required to provide patients with sufficient information to make an informed decision, physicians are allowed some leeway in using their best judgment to decide.

If physicians and patients are to be placed on an equal informational footing regarding treatment, physicians must make sure that patients are informed. Missouri has explicitly notified physicians that nothing less than complete professional integrity in their treatment of patients is expected. Missouri courts’ deference to a physician’s decision regarding medical treatment further demonstrates their faith in the medical profession. Missouri courts also assume that individuals with sufficient information can make their own informed decisions.<sup>182</sup> So, physicians are only required to disclose all potentially threatening information to their patients, because patients can then make their own informed decisions. Missouri presumes that individuals have the capability to do so.

### C. *The Patient’s Individual Responsibility as a Driver—Lessening the Physician’s Burden*

Missouri caselaw asserts that public policy favors imposing a duty upon professionals rather than on the individuals who actually inflict the injuries.<sup>183</sup> However, to hold individuals responsible for their actions, including injuries

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179. *See id.* at 697.

180. *See id.* at 698; *Eichelberger v. Barnes Hosp.*, 655 S.W.2d 699, 705 (Mo. Ct. App. 1983).

181. *See Wilkerson*, 908 S.W.2d at 698.

182. The Washington standard has addressed this issue pertaining to giving warnings of medication side effects. In *Presleigh v. Lewis*, the court held that drivers, when undertaking to operate a vehicle, assume a duty to drive the vehicle in a reasonable manner so that they will not physically injure another person or do damage to such person’s property. 534 P.2d 606 (Wash. Ct. App. 1975). Upon being warned of the potential side effects of the medication, the driver has the option of either gambling with the chance of driving or taking precautions and not operating his vehicle under the intoxicating effects. *See id.* at 607-08.

183. In ascribing to the public policy analysis attributed to the Missouri Supreme Court’s decision in *Hoover’s Dairy*, the facts of *Robinson* were applied to impose a duty to warn on physicians. *See Robinson v. Health Midwest Dev. Group*, No. 58290, 2001 WL 212776, at \*9 (Mo. Ct. App. March 5, 2001).

inflicted by their own negligence, Missouri must take account of situations where the patients have a clear informational advantage over the physician. The patient should maintain individual responsibility for his actions when the patient's knowledge puts the physician at an informational disadvantage. In such situations, the physician should still be under a duty to warn the patient of any medication side effects, but will not be liable to third parties injured as a result of the patient's own negligence.

Missouri's public policy stigmatizes any driver who gets behind the wheel of a car while intoxicated. Missouri seeks to eliminate from the roadways all drivers that are either intoxicated or under the influence of drugs, recognizing that such drivers may cause injuries to others.<sup>184</sup> Therefore, it should use both criminal and civil law to do everything within its power to prevent drivers that have such impairments from operating vehicles.<sup>185</sup> Physicians may be in the most ideal position to assist the state in fulfilling this interest.<sup>186</sup> This assumes, of course, that only when the physician is at an informational advantage over the patient should he be held liable to third persons. Because consuming alcohol is out of the control and knowledge of the physician, he is almost always at a disadvantage even after discharging his duty to warn the patient of any medication side effects.

Proximate cause must be proven when bringing a negligence claim against a physician for failure to warn a patient of medication side effects. The injured plaintiff needs to show that the breach of the physician's duty to the patient was the proximate cause of the injuries sustained.<sup>187</sup> Thus, the plaintiff would need to show that the defendant physician knew or should have known that an injury would have resulted due to the omission.<sup>188</sup> A potential defense to this proximate cause standard should be the patient's intervening negligence, such as alcohol impairment.<sup>189</sup> While Missouri has discounted this defense, other

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184. *See id.* at \*11 (relying on Missouri criminal statutes that make it a crime to drive under such situations). *Compare* *Virgin v. Hopewell Center*, No. 78857, 2001 WL 1155854, at \*2 (Mo. Ct. App. Oct. 2, 2001) (rendering court of appeals decision concurrently with *Robinson*).

185. *See Robinson*, 2001 WL 212776, at \*11. Missouri has recently lowered the blood alcohol content level needed to determine legal liability for driving while intoxicated to eight-hundredths of one percent. *See* MO. REV. STAT. § 577.012 (West 2000 & Supp. 2001).

186. *See Robinson*, 2001 WL 212776, at \*11.

187. *See id.* at \*5. The standard used by the court in *Robinson* was "whether, after the occurrences, the injury appears to be the reasonable and probable consequence of the act or omission of the defendant." *See id.*

188. *See id.* at \*16.

189. To serve as an intervening cause, the act needs to be "independent of the original actor's negligence and severs the connection between the original actor's conduct and the plaintiff's injury as a matter of law." *See Robinson v. Health Midwest Dev. Group*, No. 58290, 2001 WL 212776, at \*17 (Mo. Ct. App. March 5, 2001).



jurisdictions include this defense in their physician duty to warn standard.<sup>190</sup> Missouri should not allow physicians to be responsible by extending a duty to the general public when intervening circumstances caused the patient's physical condition.<sup>191</sup> If the patient consumed either alcohol or non-prescription drugs, the physician should not be held liable to the general public. The moral blame attached to the individual's behavior should negate the physician's potential duty.

Missouri courts recently deflected some of this responsibility away from individuals. In *Robinson*, the court of appeals compared holding physicians liable for failing to warn patients of medication side effects with the liability imposed upon bartenders under the dramshop liability statute in Missouri.<sup>192</sup> Missouri imposes a statutory duty for tavern keepers who provide a knowingly intoxicated individual with additional alcohol.<sup>193</sup> Thus, the court argued that both physicians and bartenders should have parallel duties to the general public. If a "mere bartender" is liable to the general public then a trained and skilled physician should have a parallel duty to his patients.<sup>194</sup> Certainly both professions can help prevent intoxicated drivers or drivers under the influence of medication from entering the roadways.<sup>195</sup> By drawing this comparison, Missouri can impose on physicians a liability to third parties if the physician fails to discharge his duty to warn. Still, this comparison fails to consider the patient's intervening negligence. While the bartender's liability will terminate at the end of the night if the patron makes it safely home, many other factors are involved in the physician-patient relationship. Most situations encountered

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190. See *id.* at \*16. Cf. *Kaiser v. Suburban Transp. Sys.*, 398 P.2d 14, 18-19 (Wash. 1965) (making the defense of the driver's intervening negligence a possible avenue for physicians).

191. Missouri has previously refused to impose a duty to warn on physicians when the potential danger would be open and obvious to the patient. See *Young v. Wadsworth*, 916 S.W.2d 877 (Mo. Ct. App. 1996). Even the broadest duty to warn standard imposed by Texas will not extend the duty to the general public when the patient is under the influence of another substance, since the informational costs on the physicians are then higher. See *Flynn v. Houston Emergicare, Inc.*, 869 S.W.2d 403 (Tex. Ct. App. 1994).

192. See *Robinson*, 2001 WL 212776, at \*13. The Missouri statute prohibiting dramshop liability from being declared the proximate cause of injuries caused by intoxicated patrons caused great controversy. See MO. REV. STAT. § 537.053 (West 2000). However, this statute was recently declared unconstitutional. See *State ex rel. Dos Hombres-Independence, Inc. v. Nixon*, 48 S.W.3d 76 (Mo. Ct. App. 2001). In New Mexico, the plaintiff made the argument in *Lester* that physicians should carry a duty to the public similar to that of a tavern-keeper, which the court found to have no application to the situation presented. See *Lester*, 970 P.2d at 595 (stating that since the legislature had enacted a statute that makes it illegal for bartenders to sell alcohol to obviously intoxicated patrons, if bartenders act contrary to this statute, then they should rightfully be held liable to any third persons who are injured as a result of the patron's intoxication).

193. See *Robinson*, 2001 WL 212776, at \*13.

194. See *id.*

195. See *Robinson v. Health Midwest Dev. Group*, No. 58290, 2001 WL 212776, at \*13 (Mo. Ct. App. March 5, 2001).

will involve medication taken outside the control of the physician. The physician, unlike the bartender, will not always have an informational advantage over the patron, and he should not always be held liable to third parties.

Washington provides a good example of a policy that allows personal responsibility to mitigate professional liability. Washington's policy of deterring driving while intoxicated also emphasizes judicial support for personal responsibility. In *Hartley v. State*, the Washington Supreme Court relied on *Kaiser* and *Peterson* in holding county and State officials not liable to the public for failing to revoke an intoxicated person's driver's license.<sup>196</sup> *Hartley* did not involve a physician's neglect to give a warning to the patient who then injured a third person, but the duty applied in this case could have had a similar consequence.<sup>197</sup> In *Hartley*, the plaintiffs' decedent was killed when an intoxicated driver crossed the centerline into the decedent's lane.<sup>198</sup> The Washington State Department of Licensing had recently reinstated the individual's drivers license following a one-year revocation for other driving while intoxicated offenses.<sup>199</sup> The court emphasized that, as in *Kaiser*, liability was imposed based on the defendant's relationship to the third party that caused the injury.<sup>200</sup> Importantly, the cause in fact of the accident was the intoxication of the driver, not the reinstatement of the license.<sup>201</sup> Washington case law advocates imposing responsibility and liability on individuals who choose to drive while intoxicated instead of another entity.<sup>202</sup> Such decisions reinforce the inherent personal responsibility that members of the public, especially the driving public, have when getting behind the wheel of a car. Imposing a similar duty of individual responsibility upon drivers is needed to deal with the intoxicating effects of prescribed medications.

Missouri should apply a policy similar to Washington's when finding a physician liable to the general driving public. Additional financial costs from

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196. See *Hartley v. State*, 698 P.2d 77 (Wash. 1985) (en banc).

197. All of these situations involve consideration of the duty of the original actor, whether that be the doctor, car owner or state official, to the plaintiff, based on injuries inflicted on the plaintiff from driving impairments of a third party.

198. See *Hartley*, 698 P.2d at 79.

199. See *id.* at 79.

200. See *id.* at 86; see also *Pratt v. Thomas*, 491 P.2d 1285, 1286 (Wash. 1972) (en banc) (holding that an accident occurring with stolen car, and high speed police chase to recover the vehicle, did not allow plaintiff to recover from defendant car owners due to lack of a "natural and continuous sequence of events which flowed" from leaving the parked car).

201. See *Hartley*, 698 P.2d at 86 (arguing that to impose such a duty would be against public policy because public and state officials would then be open to many such situations of liability in the future).

202. See *Hartley v. State*, 698 P.2d 77, 86 (Wash. 1985) (en banc) (stating that the state's failure to continue to revoke the driver's license to drive was "too remote and insubstantial to impose liability" for the drunk driving of the third party driver).

imposing a physician duty to the general public should favor patient responsibility over physician liability. Missouri has and must consider any economic burdens on physicians and its ability to spread the risk of liability beyond the physician-patient relationship.<sup>203</sup> One additional burden that must be considered is the cost of additional liability insurance for physicians.<sup>204</sup> Missouri courts, however, have dismissed this policy consideration, stating that the duty owed to the patient would also satisfy the physician's duty owed to the general public.<sup>205</sup> Courts make the argument that the physician would not be burdened with any more responsibility than already imposed upon him as part of his profession. This analysis does address discharging the duty owed to both the patient and the public. However, this fails to acknowledge the financial burden imposed on physicians.<sup>206</sup> Patients will absorb at least some of the burden if physicians can plead an intervening negligence defense. Physicians would, however, still possess a duty to warn the patient, but with no additional financial risk. The intervening negligence defense would not only reinforce Missouri's public interest in individual driver responsibility, it would also create a level informational playing field between physicians, patients and third parties. Therefore, Missouri should establish this defense.

*D. Discharging the Duty to Warn—Not Yet Discussed in Missouri Case Law*

Even if Missouri allows for an intervening negligence defense, Missouri's current public policy seems to favor expanding physician liability to third persons. Given this trend, it is important for Missouri to set a standard that

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203. Missouri courts must also address the issue of additional costs associated with placing a duty to warn third persons on physicians. As suggested earlier, there are grounds for concern when claims against physicians for failure to warn of medication side effects are removed from the legal category of medical malpractice and placed into general negligence. *See* Almason, *supra* note 16, at 490 (expressing concern for the integrity of the professional medical community as a result of this increased burden). Physicians can no longer be covered by medical malpractice insurance given this situation. *See id.* As a result, a potential gap in insurance coverage will result, imposing greater financial responsibilities upon physicians. *See id.* Missouri may be able to effectively curb this increased burden on physicians by limiting the application of the duty to warn in Missouri.

204. *See id.*

205. *See id.* (implying that the court was enforcing not only the duty to warn the patient but also to protect the general public).

206. While not discussed in the decision of *Robinson*, other jurisdictions have considered the state's interest in ensuring complete and adequate medical treatment for patients. When weighing the burden imposed upon physicians against this desire for good medical care, some jurisdictions have concluded that the risk that physicians would protect their own medical integrity rather than making sure patients receive the best medical care was too high and would be against the public policy of that jurisdiction. *See Lester v. Hall*, 970 P.2d 590 (N.M. 1998).

defines when the physician's duty to warn is discharged.<sup>207</sup> To be safe, Missouri should require physicians to warn patients at the time that the medication is given. Other jurisdictions that have addressed this requirement have stated that it is at this point that the necessity to warn is discharged.<sup>208</sup> Missouri should consider adopting New Mexico's standard which imposes a duty on the physician proportionate to the amount of control that the physician has over the administration of the medication.<sup>209</sup> Thus, in emergency room situations, for example, a duty to warn the patient would be imposed only where the physician personally administered a drug to the patient while in the emergency room. If the patient receives medication either orally in the form of a pill or through an injection, the physician should be under a heightened duty to the general public because the physician was in control of the administration. The physician would still have a duty to warn the patient of the side effects if the medication was to be taken outside of the physician's presence, but the possibility of conditions beyond his control interfering would mitigate the physician's liability to the general driving public.

## VI. CONCLUSION

A physician's liability to third persons in Missouri should be premised on a desire to ensure that Missouri drivers remain individually responsible for their own negligence. All Missouri courts should advocate a policy of personal responsibility when dealing with issues related to the general driving public. Missouri courts will likely rely heavily on the holdings of other jurisdictions that have considered this issue of duty. The jurisdictions that provide a good variety of considerations to choose from include Texas, Washington and New Mexico.

The trend of recent Missouri case law has been to impose greater burdens and duties upon physicians. However, Missouri has not imposed on a physician a duty to the general public. Nevertheless, the State's courts seem to be headed in that direction. As such, the Missouri judiciary should adopt a standard that holds physicians liable under a general duty to warn standard that may be mitigated by a driver's intervening negligence.

The potential effects on the professional community of finding that physicians owe a duty to the general driving public may be quite extreme. For this reason, Missouri needs to adopt a strict standard of duty to make sure that physicians are explicitly aware of their potential liabilities. We must not forget

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207. This issue was not discussed by the court of appeals in the *Robinson* decision. See generally *Robinson v. Health Midwest Dev. Group*, No. 58290, 2001 WL 212776 (Mo. Ct. App. March 5, 2001).

208. This is a slightly more stringent standard than that imposed by the states of Texas and Washington, but follows the same general principles.

209. See *supra* notes 78-79.

that cases in which a duty will be imposed will involve fact-specific circumstances. Thus, in certain situations, such as that presented in *Robinson*, the facts will be too sensitive to enable courts to impose a greater burden upon all physicians. Nevertheless, Missouri courts should find a general duty to the driving public. If Missouri courts choose to do so, interested parties, such as physicians, medical staff and even attorneys, will likely push for a bright-line test in the form of legislation. Without legislation in place, judicial administration costs for determining these cases of duty may be too great. Unless Missouri adopts a stringent standard, the public peril of *Tarasoff* will continue.

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