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***Palsgraf* Meets Medicine: Physician Beware!—The Unidentified
Nonpatient and the Duty of Care**

Marc D. Ginsberg*

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*“Lurking deep inside the law of tort, permeating and connecting its various components, a vital ingredient defines and gives moral content to the law of negligence, controlling how each element fits together and, ultimately, whether one person is bound to pay another for harm. Foreseeability is the dark matter of tort.”*¹

I. INTRODUCTION

Physicians commonly attend to and treat patients whose medical conditions and medications impair the ability to safely operate a motor vehicle. The circumstances of medical attention and treatment are varied: patients have medical conditions that impair the ability to drive;² physicians “inherit” patients taking medications prescribed by others and the medications impair the ability to drive;³ physicians prescribe or administer medications that impair the ability to drive;⁴ and physicians perform procedures requiring the use of sedation, a side effect of which may impair the ability to drive.⁵

In any of these circumstances, an unfortunate event may occur—the patient operates a motor vehicle despite the impairment (or potential impairment) and causes an accident with another vehicle or pedestrian, resulting in serious injury. The following question arises: Is the physician potentially liable in tort to the accident victim, the unidentified or unidentifiable nonpatient?

This is a complicated problem in many respects. Should a physician, in a non-*Tarasoff*⁶ scenario, suffer liability to a nonpatient, a person unknown to and

1. David G. Owen, *Figuring Foreseeability*, 44 WAKE FOREST L. REV. 1277, 1277 (2009).

2. Francisco Alonso et al., *Perception of the Impact of Certain Health Conditions on Driving Performance*, 2 WORLD J. PUB. HEALTH 1, 1 (2017) (outlining medical conditions which can affect safe operation of motor vehicles).

3. *Id.* at 2.

4. *Id.*; see Thomas Galski et al., *Driving, Medical Illness, and Medications*, in HANDBOOK FOR THE ASSESSMENT OF DRIVING CAPACITY 169 (Maria T. Schultheis et al. eds., 2009) (detailing benefits of medications along with subsequent potential driving impairments); AIDA A. LEROY & M. LEE MORSE, NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP’T OF TRANSP., MULTIPLE MEDICATIONS AND VEHICLE CRASHES: ANALYSIS OF DATABASES 5 (2008) (highlighting age-related factors detrimental to driving ability).

5. See Frances Chung & Nicole Assmann, *Car Accidents After Ambulatory Surgery in Patients Without an Escort*, 106 ANESTHESIA & ANALGESIA 817, 818 (2008) (describing simulated driving tests showing impaired driving following surgery with general anesthesia); see also Hui Yun Vivian Ip & Frances Chung, *Escort Accompanying Discharge After Ambulatory Surgery: A Necessity or a Luxury?*, 22 CURRENT OP. ANAESTHESIOLOGY 748, 753 (2009) (suggesting dangers associated with patient discharge without escort).

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

unidentifiable by the physician?⁷ If so, is it fair to suggest that a physician could owe a tort duty to the nonpatient accident victim when, typically, the physician's duty—to act as a reasonably well-qualified physician would act under the same or similar circumstances (complying with the standard of care)—is owed to a patient?⁸ Extending a physician's duty to an unidentified nonpatient complicates foreseeability, a concept debated in and since *Palsgraf v. Long Island Railroad Co.*⁹ If the physician owes a duty to an unidentified nonpatient, how is the duty discharged by the physician? Unlike a *Tarasoff* scenario, the physician cannot warn the public that a patient has a medical condition or has received medication that impairs the patient's driving ability.¹⁰ If the physician warns the patient about the potential driving impairment and/or actually advises the patient of driving restrictions and enters a corresponding note in the patient's medical chart, the physician has discharged the duty to warn the patient.¹¹ Has the physician similarly discharged a duty to the unidentifiable nonpatient accident victim by doing so?¹² Could the existence of a physician's duty to the unidentifiable nonpatient accident victim result purely from public policy considerations, or are those considerations a component part of the foreseeability analysis?¹³

Is there a medical-ethical foundation for a physician's duty to a nonpatient? Otherwise stated, does a physician's loyalty run solely to the patient, or is the loyalty split between the patient and the general public?¹⁴

Another issue in assessing physician liability to unidentified nonpatient victims of vehicular accidents is that of general versus specific causation in fact.¹⁵ Specifically, despite the fact that certain medical conditions and medications may impair driving ability, vehicular accidents may be caused by factors

7. See *id.* at 350-51 (holding therapist-defendant liable for failure to warn victim of patient's known danger).

8. See BARRY R. FURROW ET AL., *HEALTH LAW* 77 (3d ed. 2015) (detailing standard of care for physicians).

9. *Palsgraf v. Long Island R.R. Co.*, 162 N.E. 99 (N.Y. 1928).

10. Cf. *Tarasoff*, 551 P.2d at 345-46 (requiring duty to warn potential victim if patient poses serious risk of violence to others).

11. See *Hardee v. Bio-Med. Applications of S.C., Inc.*, 636 S.E.2d 629, 631-32 (S.C. 2006) (providing duty to warn when patient's capacities affected by treatment).

12. See *id.* at 632 (recognizing duty to motorists discharged by warning patient); *Davis v. S. Nassau Cmty. Hosp.*, 46 N.E.3d 614, 624 (N.Y. 2015) (concluding duty discharged by warning patients of dangers of medication impairment).

13. See *Jarmie v. Troncale*, 50 A.3d 802, 814 (Conn. 2012) (discussing public policy implications of issue); *McKenzie v. Haw. Permanente Med. Grp., Inc.*, 47 P.3d 1209, 1216 (Haw. 2002) (noting policy arguments against imposing liability).

14. See AM. COLL. OF EMERGENCY PHYSICIANS, *CODE OF ETHICS FOR EMERGENCY PHYSICIANS* 3 (2017) (articulating physicians' duty to patients, society, and public health); AM. MED. ASS'N, *CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION* 1-2 (2017) (noting physicians primarily responsible to patients but also to society).

15. See Vern R. Walker, *Restoring the Individual Plaintiff to Tort Law by Rejecting "Junk Logic" About Specific Causation*, 56 ALA. L. REV. 381, 383 (2004) (distinguishing between general and specific causation).

unrelated to a medical condition or medication.¹⁶ Certainly, this is a problem of proof, not duty, but it does complicate the discussion of physician liability.

Additionally, it may be helpful to look to the third-party beneficiary rule of contract law to base physician liability to unidentified nonpatient victims of vehicular accidents caused by patients.¹⁷ This may be a reasonable consideration because tort law principles may not provide a viable explanation for imposing tort liability upon physicians in these circumstances; unless of course, it is preferable to rely on the foreseeability analysis to address the inquiry.

Physician liability to unidentifiable nonpatient victims of vehicular accidents caused by patients is a controversial topic. Legal and medical issues abound, with perhaps, not unexpectedly, varied approaches by courts. This Article seeks to address these issues and survey the jurisprudence of the states, focusing primarily on courts of last resort.

II. BACKGROUND

A. Motor Vehicle Accidents

Motor vehicle accidents and collisions are ubiquitous worldwide¹⁸ and in the United States.¹⁹ The U.S. Government reported that “37,461 people [were] killed in crashes on U.S. roadways during 2016.”²⁰ The causes of these unfortunate events have been studied in both younger and older drivers.²¹ It has been determined that “collisions of older drivers more often involve driver error” resulting from “age-related decline in visual, cognitive, and mobility functioning in older age” as well as from “[m]edical conditions, such as heart disease and stroke,” and “psychoactive medications.”²² These psychoactive medications “induce[] a

16. See Jonathan J. Rolison et al., *What Are the Factors That Contribute to Road Accidents? An Assessment of Law Enforcement Views, Ordinary Drivers' Opinions, and Road Accident Records*, 115 ACCIDENT ANALYSIS & PREVENTION 11, 12 (2018) (listing other causes of vehicular accidents).

17. See Jean Fleming Powers, *Expanded Liability and the Intent Requirement in Third Party Beneficiary Contracts*, 1993 UTAH L. REV. 67, 78-79 (1993) (discussing ways third-party claims can arise in tort and contract law). Professor Powers notes that some situations giving rise to third-party claims may stem from a tort principle, but the duty for such a claim resides in third-party beneficiary rules of contract law. See *id.* at 79.

18. See Rolison et al., *supra* note 16, at 11 (noting vehicle collisions worldwide cause millions of deaths and injuries annually).

19. See NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP'T OF TRANSP., 2016 FATAL MOTOR VEHICLE CRASHES: OVERVIEW 1 (2017) (reporting thousands of U.S. deaths from vehicle collisions and 5.6% increase in 2016).

20. *Id.*

21. See generally Rolison et al., *supra* note 16 (exploring study of vehicular accident causes). The study also notes how some collision factors, such as skill level and risk taking, are more often implicated in young driver collisions than with older drivers. See *id.* at 11.

22. See *id.* at 12 (explaining collisions for older drivers frequently caused by age-related declines and medical conditions). Psychoactive drugs are those “prescribed to treat psychiatric disorders” and include “antidepressants, antipsychotics, anxiolytics, stimulants, and drugs . . . used to treat bipolar disorder.” Joanna Moncrieff et al., *The Psychoactive Effects of Psychiatric Medication: The Elephant in the Room*, 45 J. PSYCHOACTIVE DRUGS 409, 409 (2013).

distinctive altered mental and physical state” which may include sedation.²³ The National Highway Traffic Safety Administration (NHTSA) has reported “that both the kinds and number of medication exposures, and the characteristics of diseases/disorder present . . . may predict an increase in risk for [motor vehicle collisions] among older adults.”²⁴

Motor vehicle accidents, not surprisingly, have been associated with “sleepiness at the wheel.”²⁵ A recent study concluded that “[t]he positive association between sleepiness at the wheel and motor vehicle accidents . . . strongly suggests that sleepiness at the wheel should appear in the future version of medical fitness to drive guidelines.”²⁶

The pervasiveness of motor vehicle accidents is undeniable. This Article next focuses on various medical conditions and medications (including sedation) that may impair driving ability.

B. Medical Conditions that Impair Driving Ability

Not unexpectedly, many medical conditions known to and treated by physicians may impair driving ability. This is well appreciated, particularly when considering the skill set required to drive, explained as follows:

Driving is a complex task that requires possessing sufficient cognitive, visual and motor skills. The driver must have adequate motor strength, speed and coordination. Perhaps more importantly, higher cognitive skills including concentration, attention, adequate visual perceptual skills, insight and memory need to be present. Higher cortical functions required for driving include strategic and risk taking behavioral skills, including the ability to process multiple simultaneous environmental cues in order to make rapid, accurate and safe decisions. The task of driving requires the ability to receive sensory information, process the information, and to make proper, timely judgements and responses.²⁷

In 2005, the NHTSA published a review of forty years of literature “on the effects of medical conditions on driving performance.”²⁸ Here, the NHTSA identified nine categories of medical conditions which could adversely affect driving: visual conditions/diseases, cardiovascular disease, cerebrovascular disease, diseases of the nervous system, respiratory diseases, metabolic diseases, renal

23. See Moncrieff et al., *supra* note 22, at 410 (discussing psychoactive effects of psychiatric medications).

24. LEROY & MORSE, *supra* note 4, at viii.

25. See Stéphanie Bioulac et al., *Risk of Motor Vehicle Accidents Related to Sleepiness at the Wheel: A Systematic Review and Meta-Analysis*, 40 SLEEP, no. 10, Oct. 2017, at 1. Sleepiness at the wheel is “defined as difficulty in remaining awake interfering with driving skills.” *Id.*

26. *Id.* at 4 (observing twofold increase in motor vehicle accidents due to sleepiness).

27. See Steven H. Yale et al., *Neurologic Conditions: Assessing Medical Fitness to Drive*, 1 CLINICAL MED. & RSCH. 177, 178 (2003). *But see* Alonso et al., *supra* note 2, at 1-2 (stating drivers underestimate impact of conditions and not always aware of related driving risks).

28. See BONNIE M. DOBBS, NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP’T OF TRANSP., MEDICAL CONDITIONS AND DRIVING: A REVIEW OF THE LITERATURE (1960-2000), at 1 (2005) (reviewing historical literature relating to each condition and including preliminary fitness-to-drive guidelines for physicians).

disease, dementia, and psychiatric diseases.²⁹ The NHTSA and American Association of Motor Vehicle Administrators have also produced *Driver Fitness Medical Guidelines* relating to these and other conditions.³⁰

Medical literature is replete with reports on various medical conditions which cause impaired driving, including vision impairment,³¹ psychiatric conditions,³² substance abuse,³³ epilepsy,³⁴ diabetes mellitus,³⁵ and dementia,³⁶ as well as other neurologic conditions.³⁷ When one considers the various medical conditions that may impair driving ability, as well as the likely prevalence of these conditions in motor vehicle drivers, the potential liability of physicians to unidentified nonpatient victims should not be underestimated if a legal duty to the victims is recognized. Of course, this will be explored later in this Article.

C. Medications that Impair Driving Ability

An impressive array of medications may impair driving ability. “[M]any medications used to treat disorders and diseases can adversely interfere with physiological functioning, particularly [central nervous system] functioning, or exacerbate the effects of medical conditions on driving in indeterminable ways.”³⁸ Perhaps the more obvious culprits are psychiatric medications. “Drugs prescribed to treat psychiatric disorders, including . . . antidepressants, antipsychotics, anxiolytics, stimulants, and drugs . . . used to treat bipolar disorder, also modify normal mental processes and behavior . . .”³⁹ Other medications may affect driving ability, such as antihistamines, “commonly prescribed to alleviate

29. See *id.* at 3 (listing “red flag” conditions for functional driving impairment).

30. See generally NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP’T. OF TRANSP. & AM. ASS’N OF MOTOR VEHICLE ADM’RS, *DRIVER FITNESS MEDICAL GUIDELINES* (2009) (providing guidance to assist licensing agencies in evaluating individual’s fitness for driving).

31. See Cynthia Owsley & Gerald McGwin, *Vision Impairment and Driving*, 43 SURV. OPHTHALMOLOGY 535, 535 (1999) (discussing implications of vision impairment on driving ability); Jeffrey T. Berger et al., *Reporting by Physicians of Impaired Drivers and Potentially Impaired Drivers*, 15 J. GEN. INTERNAL MED. 667, 668 (2000) (emphasizing importance of physicians educating patients on conditions impairing driving, for example conditions affecting vision).

32. See Sanghee Moon et al., *Comparison of Unsafe Driving Across Medical Conditions*, 92 MAYO CLINIC PROC. 1341, 1341, 1348 (2017) (comparing unsafe driving in patients with medical conditions and psychiatric disorders).

33. See *id.* (noting increase in collisions when substance abuse involved).

34. See William C. Chen et al., *Epilepsy and Driving: Potential Impact of Transient Impaired Consciousness*, 30 EPILEPSY & BEHAV. 50, 51 (2014) (describing epilepsy symptoms impairing driving).

35. See Phiroze Hansotia & Steven K. Broste, *The Effect of Epilepsy or Diabetes Mellitus on the Risk of Automobile Accidents*, 324 NEW ENG. J. MED. 22, 22, 25 (1991) (concluding drivers with diabetes mellitus have slightly increased risk of traffic accidents).

36. See Brian R. Ott et al., *Clinician Assessment of the Driving Competence of Patients with Dementia*, 53 J. AM. GERIATRICS SOC. 829, 832 (2005) (studying effect of dementia on driving capability and physician assessment).

37. See Yale et al., *supra* note 27, at 177 (examining effect of neurological disorders on complex task of driving).

38. Galski et al., *supra* note 4, at 169.

39. Moncrieff et al., *supra* note 22, at 409.

allergy symptoms,⁴⁰ anticonvulsants,⁴¹ anti-Parkinsonians,⁴² narcotic analgesics,⁴³ cardiovascular medications,⁴⁴ and intravenous sedating agents used in ambulatory surgery and procedures.⁴⁵

This wide array of medications suggests that virtually any physician may prescribe or administer these medications, or treat a patient who is taking one or more of them as prescribed by another physician.⁴⁶ The potential risk that a patient may cause a vehicular collision as a result of medication-induced impaired driving is not insubstantial. Therefore, if courts recognize a physician's duty of care to the unidentifiable public, many physicians may be at risk of liability. Should the law recognize such a duty?

III. ESTABLISHING A PHYSICIAN'S DUTY TO AN UNIDENTIFIABLE NONPATIENT VICTIM

A. Foreseeability

Characterizing foreseeability as “the dark matter of tort” is apt.⁴⁷ Of course, since *Palsgraf*, foreseeability has been the subject of extensive study and comment.⁴⁸ For purposes of this Article, it is important to address how foreseeability relates to a physician's duty of care. Is it a component or element of a physician's duty of care? If not, is foreseeability a function or component of proximate causation? This concern is complicated by the fact that at trial physician conduct is

40. See Galski et al., *supra* note 4, at 171-72 (explaining effect of antihistamines on driving).

41. See *id.* at 172 (stating varying results in studies on effects of anticonvulsant medications on driving).

42. See *id.* at 174-75 (highlighting studies showing increased impairment of driving ability with use of dopamine agonist medications).

43. See *id.* at 175-76 (noting inconsistent findings on effects of opioid use on driving ability).

44. See Galski et al., *supra* note 4, at 177 (listing driving-related side effects of commonly used cardiovascular medications).

45. See Chung & Assmann, *supra* note 5, at 819 (asserting caregiver's responsibility to prohibit patients driving home after anesthesia or sedation); Jeong Han Lee, *Anesthesia for Ambulatory Surgery*, 70 KOREAN J. ANESTHESIOLOGY 398, 399 (2017) (cautioning patients should not drive for at least twenty-four hours after anesthesia); see also Akira Horiuchi et al., *Safety and Driving Ability Following Low-Dose Propofol Sedation*, 78 DIGESTION 190, 192, 194 (2008) (evaluating impact of low-dose propofol sedation on driving ability).

46. See D. Scott Jones, *Medication Management for Medical Practices and Physicians*, 12 J. HEALTH CARE COMPLIANCE 19, 20-21, 24 (2010) (asserting impossibility of physicians maintaining current knowledge of all medications prescribed).

47. Owen, *supra* note 1, at 1277.

48. See generally, e.g., *id.*; Benjamin C. Zipursky, *Foreseeability in Breach, Duty, and Proximate Cause*, 44 WAKE FOREST L. REV. 1247 (2009) (examining foreseeability through Restatement of Torts); W. Jonathan Cardi, *The Hidden Legacy of Palsgraf: Modern Duty Law in Microcosm*, 91 B.U. L. REV. 1873 (2011) (exploring *Palsgraf*'s impact on negligence cause of action across United States); Fleming James, Jr., *Scope of Duty in Negligence Cases*, 47 NW. U. L. REV. 778 (1953) (elucidating extent of duty to others); Banks McDowell, *Foreseeability in Contract and Tort: The Problems of Responsibility and Remoteness*, 36 CASE W. RESV. L. REV. 286 (1985) (comparing contract and tort understanding of foreseeability); Leon Green, *Foreseeability in Negligence Law*, 61 COLUM. L. REV. 1401 (1961) (analyzing negligence formulas); Fowler Vincent Harper, *The Foreseeability Factor in the Law of Torts*, 7 NOTRE DAME LAW. 468 (1932) (evaluating use of foreseeability in tort law).

measured by “the standard of care,” which may be defined as “that degree of knowledge, skill, and care which a reasonably well-qualified physician in the same or similar community would bring to a similar case under similar circumstances” or “the ‘required degree of care, skill and diligence’ under the circumstances” or “what the ‘reasonable practitioner’ would do in like circumstances.”⁴⁹ The standard of care definition, which characterizes a physician’s duty, does not refer to foreseeability. Therefore, the relationship between foreseeability in tort and a physician’s duty of care is subject to question.

Foreseeability may focus on plaintiff-foreseeability or harm-foreseeability.⁵⁰ In the typical physician-patient treatment relationship, “there is no need to independently determine whether the patient falls within the class of people who could foreseeably be injured, because the existence of the physician’s duty to that patient is already clear.”⁵¹ Similarly, on the assumption that medical negligence causes an injury that is clearly linked to the treatment, harm foreseeability would not become an issue.

Neither of those circumstances are of concern here. Instead, the concern is whether a physician may owe a duty of care to a patient which inures to the benefit of an unidentifiable nonpatient, or whether a physician may owe a duty (of some kind) directly to an unidentifiable nonpatient. Yet, both victim foreseeability and harm foreseeability may play a role.

There are various foreseeable situations which do or may arise in the context of the physician-patient relationship:

- A physician treats a patient who has a medical condition which may impair driving ability.
- A physician prescribes medication for a patient, the effects of which may impair driving ability.
- A physician administers medication to a patient, the effects of which may impair driving ability.
- A physician performs an outpatient procedure requiring sedation, the effects of which may impair driving ability.
- In any of the above scenarios, the patient operates a motor vehicle, causes an accident and injures a previously unidentifiable nonpatient victim.

Furthermore, the above scenarios require the assumption that the physician has not warned the patient about the risks of driving and/or has not advised the

49. Compare *Purtill v. Hess*, 489 N.E.2d 867, 872 (Ill. 1986) (outlining Illinois’s definition of standard of care plaintiff must prove for negligence action), with *FURROW ET AL.*, *supra* note 8, at 76 (quoting *Bardessono v. Michaels*, 478 P.2d 480, 484 (Cal. 1970)) (stating basic principles of malpractice liability and usual definition of malpractice), and *MARCIA M. BOUMIL & PAUL A. HATTIS, MEDICAL LIABILITY IN A NUTSHELL* 43 (4th ed. 2017) (defining standard of conduct required to meet due care obligation).

50. See *Cardi*, *supra* note 48, at 1885 (outlining modern-day applications of foreseeability theories).

51. *Cromer v. Child.’s Hosp. Med. Ctr.*, 29 N.E.3d 921, 929 (Ohio 2015).

patient to avoid driving entirely or for a specified period of time. Whether foreseeability is an element of duty or an element of proximate causation, is the harm or victim foreseeable?

Certainly, the first four scenarios mentioned above are foreseeable. Medical conditions, medications, and sedation are well known to impact one's ability to operate a motor vehicle. Serious motor vehicle accidents are prevalent and predictable.⁵² They may be caused by or despite a medical condition, medication, or sedation.⁵³ That a specific patient, in the absence of a warning, will nevertheless drive, cause an accident and injure an unknown, unidentifiable nonpatient is possible. Is foreseeability implicated to the extent that the patient's physician may be liable in tort to the unidentifiable nonpatient victim? If so, is liability premised upon a duty of care owed by the physician to the patient, or some other tort duty owed to the victim?

Professor David Owen has noted that "the recurring categories of cases where careless conduct does not always give rise to liability for resulting harm, where negligence claims may be barred or limited, are those involving harm to third parties that may result from the negligence of certain types of actors, such as . . . professionals."⁵⁴ The claims addressed in this Article fall within this category. Owen has also commented that, even in cases in which harm is foreseeable, certain "defendants in such situations should be categorically exempt from the normal reach of the law of negligence" as a result "of fairness, justice, and social policy."⁵⁵ Are physicians this type of defendant? Should they be immune from liability due to principle or policy?

B. Medical Ethics

Should medical ethics inform the existence of a physician's duty to a patient or others? Scholarship and codes of medical ethics suggest this is so.⁵⁶ Many years ago, Professor DeWitt, speaking of medical ethics, stated:

Unquestionably, the patient must be given primary and ultimate consideration.
But the physician's duty does not necessarily end with the patient; the health of

52. See NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., *supra* note 19, at 1 (describing recent increases in motor vehicle crash fatalities); see also LEROY & MORSE, *supra* note 4, at viii (explaining kinds and number of medications drivers take may predict risk for motor vehicle collisions).

53. See LEROY & MORSE, *supra* note 4, at 45 (concluding vehicle crashes may occur due to underlying conditions or medications treating them).

54. David G. Owen, *The Five Elements of Negligence*, 35 HOFSTRA L. REV. 1671, 1675 (2007).

55. *Id.* at 1676.

56. See Clinton DeWitt, *Medical Ethics and the Law: The Conflict Between Dual Allegiances*, 5 W. RSRV. L. REV. 5, 8 (1953) (comparing physician's ethical duty of secrecy to patients and moral duty of disclosure to community); AM. MED. ASS'N, *supra* note 14, at 1 (recognizing physician's responsibility to patients first, then to society, other health professionals, and themselves); Lois Snyder Sulmasy & Thomas A. Bledsoe, *American College of Physicians Ethics Manual*, 170 ANNALS INTERNAL MED. S1, S1 (Supp. 2019) (noting role of physician in society and with colleagues); AM. COLL. OF EMERGENCY PHYSICIANS, *supra* note 14, at 3 (describing principles of ethics for physicians relating to patients, colleagues, and themselves).

the community may also have to be considered. Accordingly, it is now generally recognized that in particular circumstances the physician occupies a two-fold relation toward the subject-matter of his employment. The rights and interests of the patient and those of the State, as guardian of the health and safety of its citizens, may have to be balanced, one against the other. Two widely disparate duties stem from these dual allegiances: (a) an ethical duty to the patient, (b) a legal or, sometimes, a moral duty to the public or to particular members thereof.⁵⁷

Codes of medical ethics echo the physician's duties to the patient and the public. The preamble to the American Medical Association (AMA) Principles of Medical Ethics states that "[t]he medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society."⁵⁸

The AMA Principles of Medical Ethics also address the physicians of impaired drivers, noting that physicians "have unique opportunities to assess . . . [a] patients' ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety."⁵⁹ Physicians are, similarly, advised to "[t]actfully but candidly discuss driving risks with the patient" and "[h]elp the patient . . . formulate a plan to reduce risks."⁶⁰

The American College of Physicians (ACP) Ethics Manual advised that "[t]he physician's primary commitment must always be to the patient's welfare and best interests" and that "[p]hysicians must fulfill the profession's collective responsibility to advocate for the health, human rights, and well-being of the public."⁶¹ The Code of Ethics of the American College of Emergency Physicians (ACEP) notes that "[t]he emergency physician owes duties not only to his or her patients, but also to the society in which the physician and patients dwell," and that "[e]mergency patients have first-hand knowledge of the grave harms caused by . . . motor vehicles."⁶²

The ethical principles enunciated by the AMA, ACP, and ACEP suggest that physicians owe primary duties to their patients but are also responsible to society. This Article now focuses on the jurisprudence of the states in an effort to discern how courts analyze and resolve the issue of whether a physician, through a duty to the patient or society, may be answerable in tort to unidentifiable nonpatients who are injured by patients causing vehicular accidents.

57. DeWitt, *supra* note 56, at 6.

58. AM. MED. ASS'N, *supra* note 14, at 1.

59. *Id.* at 126.

60. *Id.*

61. Sulmasy & Bledsoe, *supra* note 56, at S3, S19.

62. AM. COLL. OF EMERGENCY PHYSICIANS, *supra* note 14, at 11, 14.

IV. A SURVEY OF JURISPRUDENCE OF THE STATES

A. No Duty Owed to Unidentifiable Nonpatient Victims

1. Connecticut

In *Jarmie v. Troncale*,⁶³ the Supreme Court of Connecticut identified the following appellate issue: “[W]hether a physician who fails to advise an unaware patient of the potential driving risks associated with her underlying medical condition breaches a duty to the victim of the patient’s unsafe driving because of the failure to advise.”⁶⁴ The patient was under the care of a gastroenterologist who “diagnosed and treated [the patient] for various liver and kidney ailments, including hepatic encephalopathy.”⁶⁵ This condition “is a frequent complication of chronic liver disease, which is characterized by cognitive and motoric dysfunction and indicates a poor prognosis.”⁶⁶ Her gastroenterologist did not warn the patient of the possible driving impairment associated with her condition; after leaving the medical office, the patient subsequently blacked out and struck the plaintiff while driving.⁶⁷ This precipitated a lawsuit filed by the injured nonpatient accident victim against the treating gastroenterologist and his employer.⁶⁸ The trial court dismissed the claims, finding that the defendants “owed no duty to the plaintiff to warn [the patient] of the driving risks associated with her medical condition.”⁶⁹

The Supreme Court of Connecticut embarked on a lengthy, detailed analysis and resolution of the issue posed at the outset of its published opinion.⁷⁰ It addressed “duty” under Connecticut law, noting “our threshold inquiry has always been whether the specific harm alleged by the plaintiff was foreseeable to the defendant.”⁷¹ Yet, the court noted that foreseeable harm was insufficient to create a tort duty, stating “[t]he final step in the duty inquiry . . . is to make a determination of the fundamental policy of the law, as to whether the defendant’s responsibility should extend to such results.”⁷²

Despite this statement, the court did undertake a foreseeability analysis, but instead focused on the victim, concluding that the plaintiff was not a foreseeable

63. 50 A.3d 802 (Conn. 2012).

64. *Id.* at 804.

65. *Id.*

66. Gerald Kircheis et al., *Hepatic Encephalopathy and Fitness to Drive*, 137 GASTROENTEROLOGY 1706, 1706 (2009); see Christian Wein et al., *Minimal Hepatic Encephalopathy Impairs Fitness to Drive*, 39 HEPATOLOGY 739, 739 (2004) (describing medical symptoms and complications caused by hepatic encephalopathy).

67. See *Jarmie*, 50 A.3d at 804 (summarizing events leading to lawsuit).

68. See *id.* (noting defendants include licensed gastroenterologist and his employer).

69. *Jarmie v. Troncale*, 50 A.3d 802, 804 (Conn. 2012).

70. See *id.* at 807 (highlighting legal questions).

71. *Id.* at 809.

72. *Id.* at 810.

victim of medical negligence, as the plaintiff was not identifiable.⁷³ The pre-accident unidentifiability of the victim outweighed the possible foreseeability of the event—a motor vehicle accident caused by the defendant’s patient due to a medical condition known to the defendant, about which the patient was not warned.⁷⁴

In addressing the public policy considerations in connection with “determining the extent of a legal duty as a matter of public policy,” the court identified the following four factors for consideration: “(1) the normal expectations of the participants in the activity under review; (2) the public policy of encouraging participation in the activity, while weighing the safety of the participants; (3) the avoidance of increased litigation; and (4) the decisions of other jurisdictions.”⁷⁵

In reviewing these factors, the court noted that at common law, a physician owes a duty of care to the patient and not to nonpatients.⁷⁶ The court undertook its analysis and emphatically concluded that a physician, under the circumstances of this case, involving the attention to and treatment of an underlying medical condition, did not owe a duty to an unidentifiable, nonpatient victim.⁷⁷

The court’s public policy analysis can be summarized as follows. First, it held that a duty to the plaintiff would threaten or weaken the physician-patient relationship by compromising the physician’s duty of loyalty to the patient by diverting the physician’s attention to potential third-party liability.⁷⁸ Next, the extension of the physician’s duty to nonpatient third parties would harm physician-patient confidentiality as lawsuits filed by nonpatients would result in the disclosure of otherwise confidential patient medical records.⁷⁹ Additionally, the extension of the physician’s duty to nonpatients could compromise the physician’s duty of loyalty by influencing the physician to warn about a driving impairment when the patient has not yet complained of an impairment. “[A] physician’s desire to avoid potential lawsuits may result in far more restrictive advice than necessary for the patient’s well-being,” advice which the patient may disregard.⁸⁰ The court identified “the most egregious interference with the physician-patient relationship” as the “lawsuits brought against health care providers for breach of the duty that the plaintiff urges in this case.”⁸¹

Perhaps the most interesting aspect of the majority opinion, which refused the invitation to extend a physician’s duty to unidentifiable victims, is its limitation to cases involving “a latent driving impairment caused by the patient’s

73. See *Jarmie*, 50 A.3d at 813 (neglecting to focus on foreseeability and focusing on plaintiff’s unidentifiability).

74. See *id.* (explaining impossibility of knowing victims before motor vehicle accidents).

75. *Jarmie v. Troncale*, 50 A.3d 802, 816 (Conn. 2012) (citations omitted).

76. *Id.* at 817.

77. See *id.* at 828 (holding no duty to nonpatients).

78. See *id.* at 818-19.

79. *Jarmie*, 50 A.3d at 819.

80. *Id.* at 821.

81. *Jarmie v. Troncale*, 50 A.3d 802, 822 (Conn. 2012).

underlying medical condition, not by prescribed medication or treatment”⁸² Frankly, this is a distinction without a difference. It is understandable that a court may prefer to opine only on the facts before it, however, the Supreme Court of Connecticut could have easily concluded that a physician’s duty to warn a patient of a potential driving impairment incidental to an underlying medical condition, medication, or treatment is the same in each of those circumstances. The court was clearly interested in protecting the medical profession as a matter of public policy. The court could have offered complete protection if it had included all of the circumstances encountered by physicians which require warning patients of potential driving impairments.⁸³

The lengthy majority opinion was followed by a lengthy dissent. At its core, the dissent urged that the injury to the nonpatient victim was foreseeable: “An out of control car, by its very nature, carries a high degree of risk of injury, not only to those in the car, but also to other users of the roadways, including pedestrians, such as the plaintiff.”⁸⁴ Additionally, the dissent noted that the physician’s duty to the nonpatient victim would be discharged by fulfilling the duty to the patient, which should include warning the patient about the potential driving impairment and placing a confirmatory note in the patient’s chart.⁸⁵ Essentially, the dissenting opinion, after considering the same facts as the majority, simply opted for the opposite result.

2. Illinois

In *Kirk v. Michael Reese Hospital & Medical Center*,⁸⁶ the Supreme Court of Illinois refused to recognize a physician’s duty of care to a passenger in a psychiatric patient’s automobile, injured in an accident likely caused by the patient-driver’s impairment.⁸⁷ The relevant facts are straightforward. The patient had been hospitalized for psychiatric treatment, during which he was prescribed psychiatric medications.⁸⁸ Following his discharge, he consumed alcohol, drove an automobile in which the plaintiff was a passenger, and ultimately “left the roadway and struck a tree.”⁸⁹ The passenger (plaintiff) was injured.⁹⁰

Procedurally, the plaintiff sued the physicians, the hospital, and a pharmaceutical manufacturer on various theories, including failure to warn the patient “that

82. See *id.* at 823 (emphasis omitted) (expressing no opinion on duties arising from treatment-based impairments).

83. See *id.* at 828-41 (Eveleigh, J., dissenting) (limiting discussion of physician duty to case facts).

84. *Id.* at 830.

85. *Jarmie*, 50 A.3d. at 831-33 (noting similar state decisions to impose duty on physician for failure to warn).

86. 513 N.E.2d 387 (Ill. 1987).

87. See *id.* at 390-91, 398 (holding physician duty exists towards “identifiable potential victim” not general public).

88. *Id.* at 390 (noting types of psychiatric drugs prescribed to plaintiff during hospital treatment).

89. *Id.* at 390-91 (describing events leading up to car crash).

90. *Kirk*, 513 N.E.2d at 391.

the prescribed drugs administered would diminish his physical and mental abilities.”⁹¹ These claims were dismissed.⁹² On appeal, the dismissals were reversed on the duty to warn issue, “which duty, the court stated, was implicitly extended to cover members of the public who may be injured as a proximate cause of the failure to adequately warn.”⁹³

The Illinois Supreme Court focused on the plaintiff’s claim that a duty to warn “is owed . . . [to] the public generally.”⁹⁴ More specifically, the court noted the “plaintiff is arguing that a third party with no patient/hospital or patient/physician relationship be allowed to bring a cause of action based on the alleged negligent treatment of another.”⁹⁵ The court’s analysis turned to foreseeability as a component of duty, specifically referring to “the foreseeability of injury from the defendant’s conduct to the plaintiff” or, reasonable foreseeability of the harm.⁹⁶ Without a detailed foreseeability analysis, the court then noted other factors to be considered in the determination of a duty: “the likelihood of injury, the magnitude of the burden of guarding against it and the consequences of placing that burden upon the defendant.”⁹⁷

Ultimately, the court concluded that there was no legal duty “running from the doctors to those in the general public who may reasonably be expected to come in contact with the patient on the day he is released” and therefore, the defendant-physicians did not owe a duty to the passenger-plaintiff.⁹⁸ The lack of a physician-patient relationship between the defendant-physicians and the plaintiff, and the lack of other special relationship between the plaintiff and the patient yields the lack of a viable claim against the physicians.⁹⁹ The court, therefore, refused to recognize a “physician’s duty of care to an indeterminate class of potential plaintiffs.”¹⁰⁰

3. North Dakota

Recently, in *Cichos v. Dakota Eye Institute, P.C.*,¹⁰¹ the Supreme Court of North Dakota rejected a request to recognize a physician’s duty to a nonpatient

91. *See id.* (detailing plaintiff’s third amended complaint).

92. *See Kirk v. Michael Reese Hosp. & Med. Ctr.*, 513 N.E.2d 387, 391 (Ill. 1987) (noting trial court granted motions of hospital, two doctors, and two drug companies).

93. *Id.* (describing appellate court’s reasoning for reversing and remanding dismissal counts).

94. *See id.* at 392 (emphasizing other jurisdictions recognized duty of manufacturers of prescription drugs to warn public).

95. *Id.* at 395 (summarizing plaintiff’s duty to warn argument).

96. *See Kirk*, 513 N.E.2d at 396 (labeling reasonable foreseeability of harm key factor in determining whether duty exists).

97. *See id.* (explaining foreseeability merely one factor in determining existence of duty).

98. *See Kirk v. Michael Reese Hosp. & Med. Ctr.*, 513 N.E.2d 387, 397 (Ill. 1987) (setting forth court’s reasoning for declining to find duty to warn).

99. *See id.* at 399 (concluding no valid medical malpractice claim where no direct or special relationships present).

100. *Id.*

101. 933 N.W.2d 452 (N.D. 2019).

third party.¹⁰² Here, the patient-plaintiff suffered a vision impairment and drove into a horse-drawn trailer.¹⁰³ Four of the trailer's passengers were injured, and one passenger was killed.¹⁰⁴ This accident followed two medical examinations, the first of which resulted in the patient receiving instructions not to drive, while the second resulted in a determination of improved vision and ability to drive "with some restrictions."¹⁰⁵

The court noted this case did not involve the administration of medication to the patient, and, therefore, the administration of medication cases from other jurisdictions were not particularly persuasive.¹⁰⁶ Again, the significance of this distinction is unclear.

The court focused on public policy and concluded that a physician's duty is to the patient, not to third parties.¹⁰⁷ The patient's underlying medical condition which might impair driving yields a duty to warn the patient, not others.¹⁰⁸

4. Pennsylvania

The Supreme Court of Pennsylvania, in *Estate of Witthoef v. Kiskaddon*,¹⁰⁹ refused to recognize an ophthalmologist's duty to a nonpatient injured victim of an automobile accident caused by a patient.¹¹⁰ Apparently, "the ophthalmologist failed to inform his patient . . . of the patient's poor visional acuity . . ."¹¹¹

Curiously, the court determined the ophthalmologist "did not cause or aggravate a medical condition that affected the patient's driving and the patient was necessarily aware of her medical condition."¹¹² Even if the patient knew of her visual impairment, the physician's failure to warn against driving, or recommending driving with limitations, could contribute to an increased risk of injuring a nonpatient victim.

The court rather simply held that the nonpatient victim was not a "foreseeable victim."¹¹³ The court would not "stretch" the concept of foreseeability to encompass absolute and endless liability of physicians.¹¹⁴

102. *See id.* at 454 (holding physicians owe no duty to warn nonpatient third parties).

103. *See id.* at 454-55 (reciting facts alleged by plaintiff leading up to collision).

104. *Id.* at 454.

105. *See Cichos*, 933 N.W.2d at 454-55 (noting patient's eyesight below minimum vision standards required to operate vehicle).

106. *See id.* at 455 (finding cases supporting duty to third parties not persuasive).

107. *See Cichos v. Dakota Eye Inst., P.C.*, 933 N.W.2d 452, 459 (N.D. 2019).

108. *Id.* at 459.

109. 733 A.2d 623 (Pa. 1999).

110. *Id.* at 630.

111. *Id.* at 624 (noting possible liability posed by failure of ophthalmologist to inform patient).

112. *Id.* at 630.

113. *Est. of Witthoef*, 733 A.2d at 630.

114. *See id.* (noting liability in this case would unjustly create absolute liability for patient actions).

5. Iowa

Twice in 2003, the Supreme Court of Iowa rejected opportunities to recognize a physician's duty to protect the nonpatient public from injuries caused by patients.¹¹⁵ These cases are significant in that they represent various medical treatment contexts previously discussed—physician awareness of a patient's medical condition which may impair driving ability, physician treatment of a medical condition which may impair driving ability, as well as the prescription of necessary medication to address the medical condition.¹¹⁶

In *Schmidt v. Mahoney*, the defendant-physician treated a patient for a seizure, in part, by prescribing her medication.¹¹⁷ The physician "was aware of instances in which [the patient] lost control of her motor vehicle because of oncoming seizures."¹¹⁸ The physician not only failed to warn the patient "of the dangers involved in driving a motor vehicle with her seizure disorder," he even "affirmatively advised her that such driving on her part could be safely undertaken."¹¹⁹ The patient then suffered a seizure while driving, lost control of her vehicle, and collided with the nonpatient plaintiff's automobile, injuring the plaintiff.¹²⁰

The Iowa Supreme Court, concerned with public policy and protecting the physician-patient relationship, held that the imposition of a physician's duty to protect the general public could cause a physician to treat a patient unnecessarily aggressively by restricting the patient from "[engaging] in any other activity in which a seizure could possibly harm a third party."¹²¹ In turn, recognizing a duty to a nonpatient third party under these circumstances would shift the physician's focus from the patient's well-being to concerns of potential liability.

In *Kolbe v. State*, a patient with a significant vision impairment struck and injured a bicyclist while driving an automobile.¹²² The patient's ophthalmologists were aware that the patient could only see with peripheral vision, yet they "had given opinions to the Iowa Department of Transportation (IDOT) stating [that the patient] was competent to drive."¹²³ IDOT authorized the patient to drive, with restrictions.¹²⁴

115. *Schmidt v. Mahoney*, 659 N.W.2d 552, 556 (Iowa 2003) (holding no duty to warn patients of dangers involved in driving with seizure disorder); *Kolbe v. State*, 661 N.W.2d 142, 150 (Iowa 2003) (holding physician not liable to cyclist for accidents of patients).

116. *See supra* notes 28-29 and accompanying text (listing medical conditions known to impair driving ability); *supra* notes 38-39 and accompanying text (describing medications and treatments likely to impair driving ability).

117. *See Mahoney*, 659 N.W.2d at 553 (stating background facts alleged by plaintiff).

118. *Id.*

119. *Id.*

120. *Id.*

121. *See Schmidt v. Mahoney*, 659 N.W.2d 552, 555 (Iowa 2003) (noting overly restrictive recommendations contrary to public policy).

122. *Kolbe v. State*, 661 N.W.2d 142, 143-45 (Iowa 2003).

123. *Id.* at 143-44.

124. *Id.* at 144.

The Supreme Court of Iowa framed the “central issue” as follows: “[W]hether a physician owes a duty to persons not within the physician/patient relationship.”¹²⁵ The court further identified the potential beneficiary of the duty in question as “unknown third parties.”¹²⁶

The court then referred to the recipe for creating a legal duty via the following ingredients: “[t]he relationship between the parties; . . . [r]easonable foreseeability of harm to the person who is injured; and . . . [p]ublic policy considerations.”¹²⁷ The court easily disposed of the special relationship factor, noting none existed between the injured victim and the physicians.¹²⁸ The court quickly dismissed foreseeability in this case, finding the plaintiffs “failed to show it was reasonably foreseeable that [the nonpatient] would be injured by [the patient].”¹²⁹

The court then honed in on public policy as the key factor in determining if the patient’s physicians owed a duty to the nonpatient victim.¹³⁰ Concluding that a “physician’s first loyalty and duty [is] to his or her patient,” the court held that a physician does not owe a “duty to protect all third parties who might come into contact with the physician’s patient.”¹³¹ Such a broad duty would compromise the physician’s loyalty to the patient.¹³² This, of course, is a classic public policy approach to the consideration of a legal duty. Public policy will not permit potentially limitless physician liability, presumably even if the injury and victim are foreseeable.

6. Massachusetts

In *Medina v. Hochberg*,¹³³ the Supreme Judicial Court of Massachusetts held that a physician did not owe a nonpatient motorist a duty to warn a patient not to drive based on an underlying medical condition alone.¹³⁴ *Medina* did not involve the physician’s administration or prescription of medication to the patient that could alter the patient’s driving ability.¹³⁵ Under that scenario, in an earlier decision, a plurality of the court concluded that a physician could be liable to an injured nonpatient third party for the failure to warn the patient of the side effects of a prescription medication (prescribed by the treating physician) that include a

125. *Id.* at 145.

126. *Kolbe*, 661 N.W.2d at 145.

127. *See id.* at 146 (explaining factors courts consider when imposing legal duty).

128. *See Kolbe v. State*, 661 N.W.2d 142, 146 (Iowa 2003) (concluding no special relationship between physicians and driving public).

129. *Id.* at 147.

130. *See id.* at 148-49 (reiterating previous policy considerations from cases involving physicians, patients, and injured third parties).

131. *Id.* at 149.

132. *See Kolbe*, 661 N.W.2d at 149 (explaining how physician duty to unknown third persons too broad and compromises physician’s loyalty).

133. 987 N.E.2d 1206 (Mass. 2013).

134. *See id.* at 1212.

135. *See id.* (noting patient posed risk due to underlying seizure condition not medication).

driving impairment.¹³⁶ As this Article has previously mentioned—and will do so yet again in concluding remarks—this distinction is curious.¹³⁷ A treating physician’s knowledge of an underlying medical condition that may impair driving is as significant as the prescription for, or administration of medication that may impair driving. In either circumstance, the physician has valuable information which would require the physician to warn the patient.

Medina involved a patient who suffered a seizure while driving, lost control of his vehicle, and struck the plaintiff, causing him serious injuries.¹³⁸ The plaintiff’s claim against the treating physician alleged the physician breached a duty owed to the plaintiff, the nonpatient victim, to control the patient’s behavior and to warn the patient to refrain from driving.¹³⁹ The treating physician was a neurologist, who earlier advised the patient to refrain from driving for six months following a seizure, the time period required by state law.¹⁴⁰ The patient followed the advice but suffered other seizures, for which he was medicated by the physician.¹⁴¹ The seizures occurred less frequently and dangerously, and the physician advised that he could drive.¹⁴² The patient was seizure free by the time he suffered another seizure while driving, causing the accident which injured the plaintiff.¹⁴³

The Supreme Judicial Court of Massachusetts recognized that whether a duty of care exists is a question of law, “to be determined by reference to existing social values and customs and appropriate social policy.”¹⁴⁴ The court quickly dispensed with the notion that the physician had a duty to control the patient to prevent harm to a third party.¹⁴⁵ The court distinguished the prescription medication scenario in *Coombes* (previously addressed) and concluded that “a physician does not owe a duty to nonpatients to warn his or her patients of the dangers of driving posed by a patient’s underlying medical condition.”¹⁴⁶

7. New Jersey

In 2019, the Superior Court of New Jersey, Appellate Division, addressed an interesting non-*Tarasoff* claim involving a psychiatrist-defendant. In *Vizzoni v.*

136. See *Coombes v. Florio*, 877 N.E.2d 567, 572 (Mass. 2007) (Ireland, J., concurring) (concluding physician owes duty to everyone foreseeably put at risk by failure to warn).

137. See *supra* notes 82, 106 and accompanying text (criticizing courts for distinguishing between driving impairments caused by underlying conditions and prescription medication); see also *infra* Part V (questioning rationale for distinction between driving impairments caused by underlying conditions and prescription medications).

138. *Medina*, 987 N.E.2d at 1207.

139. *Medina v. Hochberg*, 987 N.E.2d 1206, 1207-08 (Mass. 2013).

140. *Id.* at 1208.

141. *Id.* at 1208-09.

142. *Id.* at 1209.

143. See *Medina*, 987 N.E.2d at 1209.

144. *Id.* (explaining duty of care question for court).

145. *Medina v. Hochberg*, 987 N.E.2d 1206, 1210 (Mass. 2013).

146. *Id.* at 1211-13.

B.M.D.,¹⁴⁷ a psychiatrist's patient, suffering from depression for which she was medicated by the psychiatrist, drove an SUV and subsequently struck and killed a bicyclist.¹⁴⁸ The bicyclist's estate filed a negligence claim against the psychiatrist-defendant, for whom the trial court granted summary judgment.¹⁴⁹

At the time of the collision, the psychiatrist had been treating and prescribing medications to the patient for thirteen years.¹⁵⁰ Occasionally, the patient altered her medication dosages without seeking the psychiatrist's input.¹⁵¹ The patient claimed that the defendant-psychiatrist did not warn "her against driving after ingesting her medication."¹⁵²

The psychiatrist successfully moved for summary judgment on the theory that he did not have a duty to the plaintiff as a non-readily identifiable victim.¹⁵³ In response, the plaintiff produced expert reports, one of which opined that the patient's driving ability was impaired at the time of the accident, presumably due to the side effects of the medications.¹⁵⁴ The motion for summary judgment was granted.¹⁵⁵ The psychiatrist did not owe the victim a duty of care.¹⁵⁶

The Appellate Division focused its analysis on foreseeability, specifically on the risk of harm and the defendant's knowledge of foreseeable victims.¹⁵⁷ Under the court's calculus, the establishment of victim foreseeability is the condition precedent to "considerations of fairness and policy [which] govern whether the imposition of a duty is warranted."¹⁵⁸

Despite the court's determination "that a prescribing physician [does not owe] a duty to warn their patient of adverse side effects of medications for the benefit of third parties," it noted that the defendant did have a duty to warn his patient of the side effects of his prescribed medications.¹⁵⁹ That, of course, is not controversial, and could have ended the analysis.

It did not. The court, apart from finding no duty of care to the patient for the benefit of a third party, embarked on a causation discussion related to whether the prescribed medications caused injury to the nonpatient by impairing the

147. 212 A.3d 962 (N.J. 2019).

148. *Id.* at 965-66.

149. *Id.*

150. *Id.* at 966.

151. *Vizzoni*, 212 A.3d at 966.

152. *Id.*

153. *Vizzoni v. B.M.D.*, 212 A.3d 962, 967 (N.J. 2019).

154. *See id.*

155. *Id.* at 969.

156. *Id.*

157. *See Vizzoni*, 212 A.3d at 970.

158. *See id.* at 971 (connecting foreseeability and duty).

159. *See Vizzoni v. B.M.D.*, 212 A.3d 962, 969 (N.J. 2019) (holding physician under no duty to warn of side effects for benefit of third parties); *see also id.* at 974 (recognizing duty owed to patient).

patient's driving.¹⁶⁰ The court found that evidence missing.¹⁶¹ Presumably, then, had the defendant-psychiatrist known he had prescribed psychiatric medications with the side effect of impaired driving; the patient drove while impaired due to the medication; and ultimately injured a nonpatient, unidentified victim; the psychiatrist could be liable to the victim. Under these circumstances, it appears as if liability could attach, even had the psychiatrist warned the patient not to drive due to a possible driving impairment related to the medication. If this is so, the psychiatrist would face liability even if he had discharged his duty to his patient, unless the duty is then to directly advise the patient not to drive as opposed to advising the patient that the medications could impair the ability to drive.

B. Duty Owed to Unidentifiable Nonpatient Victims

I. New York

The other side of the argument is well represented by the Court of Appeals of New York's opinion in *Davis v. South Nassau Communities Hospital*.¹⁶² Here, a patient received treatment by defendant-physicians at the defendant-hospital, including intravenous pain medication and benzodiazepine, both of which carry serious side effects that may impair driving ability.¹⁶³ The patient was not warned that these medications would or could impair her ability to drive.¹⁶⁴

Shortly after the patient's treatment and hospital discharge, she drove her automobile, veered into oncoming traffic, and hit a bus driven by the nonpatient plaintiff.¹⁶⁵ Plaintiff sued the defendants, alleging that they did not warn the patient "of the effects of such medication; and that the accident occurred while [the patient] was affected by such medication."¹⁶⁶ The complaint was dismissed and the dismissal was affirmed on appeal, as "the allegations did not support a duty of care owed by the defendants to the injured plaintiff."¹⁶⁷ These facts squarely presented to the Court of Appeals the opportunity to determine whether the defendant medical providers owed a nonpatient plaintiff the duty to warn a patient about potential side effects that might impair driving.¹⁶⁸

160. *See id.* at 969, 977-78 (distinguishing facts of case at hand from precedent cases). The court analyzed previous cases in which patients received intravenous medication or experienced unconsciousness at the wheel and noted that here, because impairment while driving was not caused by medication, the psychiatrist was not liable. *See id.* at 977-78.

161. *See id.* at 975, 977 (noting no evidence to support defendant impairment during crash).

162. 46 N.E.3d 614 (N.Y. 2015).

163. *See id.* at 617 (noting mental and physical risks associated with taking medication).

164. *See id.* at 616 (delineating both opioid and benzodiazepine drug provided to patient).

165. *See id.* at 617 (stating time of accident involving plaintiff).

166. *Davis*, 46 N.E.3d at 617.

167. *See id.* at 618 (quoting *Davis v. South Nassau Cmty. Hosp.*, 989 N.Y.S.2d 500, 502 (N.Y. App. Div. 2014)).

168. *See Davis v. South Nassau Cmty. Hosp.*, 46 N.E.3d 614, 616 (N.Y. 2015) (summarizing issue of third-party liability).

In determining that New York would, indeed, recognize a duty to a nonpatient, the Court of Appeals emphasized that the defendants administered medication to the patient “without warning [the patient] about the disorienting effect of those drugs . . . creat[ing] a peril affecting every motorist in [the patient’s] vicinity.”¹⁶⁹ The court did not believe that recognizing a duty to the nonpatient, under these circumstances, placed a heavy burden on medical providers.¹⁷⁰ In fact, to discharge the duty, “the medical provider need do no more than simply warn that patient of those dangers.”¹⁷¹ Of course, a medical provider owes this duty to a patient in order to obtain informed consent to treat the patient.¹⁷² The duty recognized by the Court of Appeals does not require medical providers to prevent the patient from leaving a treatment facility or driving.¹⁷³ Again, the duty owed to the patient is the duty to warn.¹⁷⁴ It may be fair to conclude that the court made the injured nonpatient a third-party beneficiary of the duty owed to the patient.

The dissent invoked foreseeability, noting that physicians “cannot foresee or predict with whom their patients will come into contact.”¹⁷⁵ Frankly, this could have ended the dissent’s discussion, but it did not. The dissent also urged that creating this duty would not affect a patient’s decision to drive.¹⁷⁶ Additionally, the dissent urged that the recognition of a duty to an injured nonpatient “will adversely interfere with the physician-patient relationship” by causing the physician to be conflicted between proper patient treatment and potential third-party liability.¹⁷⁷

The moral of this “story” in New York is quite simple. A physician’s duty to a nonpatient victim under the facts of *Davis* is discharged by a proper warning to the patient (and medical chart notation of the warning).¹⁷⁸ The physician cannot warn the unidentifiable public.

2. South Carolina

In *Hardee v. Bio-Medical Applications of South Carolina*,¹⁷⁹ a case of first impression, the Supreme Court of South Carolina recognized a medical provider’s duty to warn a patient when a procedure could hinder the patient’s driving

169. See *id.* (highlighting administration); *id.* at 622 (stressing lack of warning and creation of risk).

170. See *id.* at 623-24 (commenting on defendant’s duty).

171. *Id.*

172. *Davis*, 46 N.E.3d at 623.

173. *Id.* at 624.

174. *Davis v. South Nassau Cmty. Hosp.*, 46 N.E.3d 614, 624 (N.Y. 2015).

175. See *id.* (Stein, J., dissenting) (noting physicians cannot foresee people their patients encounter).

176. See *id.* (acknowledging extension of duty will have little effect on conduct resulting in harm).

177. *Id.* at 632-33 (noting potential adverse effect on physician-patient relationship).

178. See *Davis*, 46 N.E.3d at 622 (concluding physician’s duty to nonpatient victims met by warning patient of drug effects).

179. 636 S.E.2d 629 (S.C. 2006).

ability, which would inure to the benefit of a nonpatient motorist victim.¹⁸⁰ Here, the patient received extensive hemodialysis treatment for diabetes.¹⁸¹ Shortly after a dialysis session, presumably without having been warned about the effects of the treatment, the patient began to drive home and collided with the nonpatient victims.¹⁸²

Not only did the court recognize the medical provider's duty to warn the patient, it also recognized a duty "to those persons in the general field of danger (that is, the motoring public) which should reasonably have been foreseen by [the medical provider] when it administered the treatment."¹⁸³ The court further noted that the duties owed to the patient and the motoring public were identical.¹⁸⁴ Therefore, if the duty to the patient is properly discharged by a warning, so too is the duty owed to the motoring public.

That these duties are coextensive does not diminish the weight of the duty to the motoring public. The court in *Hardee* approved a potentially unlimited pool of claimants. Proximate cause which is reliant, at least in part, on a foreseeability analysis, operates to limit the extent of potential liability. Here, potential liability to an unlimited universe of nonpatient motorists became South Carolina's reality.

3. *West Virginia*

In *Osborne v. United States*,¹⁸⁵ the Supreme Court of West Virginia recognized a nonpatient medical negligence claim pursuant to the West Virginia Medical Professional Liability Act.¹⁸⁶ Here, the physician treated the patient with medications for pain.¹⁸⁷ The patient caused a motor vehicle collision when his vehicle collided with the victim's vehicle, and traces of the pain medication were found in his system.¹⁸⁸

Initially, the court determined that a claimant need not be a patient pursuant to the aforementioned statute.¹⁸⁹ That discussion occupies the bulk of the majority opinion.¹⁹⁰ The court concluded by stating that the statute "permits a third party to bring a cause of action against a health care provider for foreseeable

180. *Id.* at 631-32.

181. *See id.* at 630 (explaining patient treated three times per week for four hours).

182. *See id.* (describing events giving rise to claim).

183. *See Hardee*, 636 S.E.2d at 631 (summarizing and adopting appellant's assertion of duty owed by medical provider).

184. *Id.* at 632 (noting identical duties to patient and third parties).

185. 567 S.E.2d 677 (W. Va. 2002).

186. *See id.* at 679 (concluding statute creates liability for foreseeable injuries to third parties caused by physician's negligent treatment); *see also* W. VA. CODE § 55-7B-1 (2015).

187. *See Osborne*, 567 S.E.2d at 679 (describing seventeen-year period over which physician prescribed defendant medication).

188. *See id.* at 679-80 (stating plaintiffs sued Dr. Srichai and his employer in response to injuries sustained).

189. *See id.* at 684-85 (comparing Legislature's narrow definition of "person" with common meaning of "person").

190. *See id.* at 683-85 (applying common, ordinary, and accepted meaning of ambiguous word).

injuries that were proximately caused by the health care provider's negligent treatment of a tortfeasor patient."¹⁹¹

A vigorous dissent emphasized the lack of a physician-patient relationship between the medical provider and victim and questioned foreseeability vis-à-vis an unidentified nonpatient victim.¹⁹² It concluded by noting that, "[e]very doctor in West Virginia who prescribes any type of medication to a patient is now potentially liable to countless unknown third parties because of that prescription."¹⁹³ Of course, the dissent's observation here concisely summarizes the public policy argument against recognition of the duty.

4. *Indiana*

Two Supreme Court of Indiana opinions require attention, one in a medical liability case, *Cram v. Howell*,¹⁹⁴ and one in a nonprofessional negligence case, *Goodwin v. Yeakle's Sports Bar & Grill*.¹⁹⁵ In *Cram*, the defendant-physician administered a vaccine to a patient in the physician's office, causing the patient to experience loss of consciousness there.¹⁹⁶ Apparently, the physician did not appropriately monitor or warn the patient about a driving impairment.¹⁹⁷ Thereafter, the patient operated a motor vehicle, lost consciousness, and fatally collided with the nonpatient victim.¹⁹⁸ After the trial court dismissed the complaint, this appeal followed.¹⁹⁹

In a brief opinion, the Indiana Supreme Court focused on foreseeability, noting the physician's awareness that the medication he administered to the patient caused the patient's loss of consciousness and that it was "reasonably foreseeable that the patient, if permitted to drive in this condition, would injure third persons."²⁰⁰ The physician "owed a duty of care to take reasonable precautions in monitoring, releasing, and warning his patient for the protection of unknown third persons potentially jeopardized by the patient's driving upon leaving the physician's office."²⁰¹

Nineteen years later, in *Goodwin v. Yeakle's Sports Bar & Grill*, a nonmedical negligence tort case, the Indiana Supreme Court revisited the formula for

191. See *Osborne v. U.S.*, 567 S.E.2d 677, 684-85 (W. Va. 2002) (announcing broader applicability of West Virginia Professional Liability Act).

192. See *id.* at 686 (Maynard, J., dissenting) (alleging majority opinion ignores longstanding foreseeability principle of tort law).

193. See *id.* at 687 (noting majority's mistake holding broad applicability of rule).

194. 680 N.E.2d 1096 (Ind. 1997).

195. 62 N.E.3d 384 (Ind. 2016).

196. *Cram*, 680 N.E.2d at 1097 (describing effect of physician's vaccine administration).

197. See *id.* (explaining basis of patient's negligence claim).

198. See *id.* (connecting negligence to alleged harm and injury).

199. See *id.* (describing trial court's dismissal of plaintiff's complaint).

200. *Cram v. Howell*, 680 N.E.2d 1096, 1098 (Ind. 1997) (highlighting physician's actual knowledge of impact of vaccination on patient alleged in complaint).

201. *Id.*

determining foreseeability as it relates to duty.²⁰² The court “acknowledge[d] [that] the concept of foreseeability as a component of duty is not universally embraced.”²⁰³ Ultimately, the court determined that “for purposes of determining whether an act is foreseeable in the context of duty we assess ‘whether there is some probability or likelihood of harm that is serious enough to induce a reasonable person to take precautions to avoid it.’”²⁰⁴

This test is of no particular value to physicians. It is debatable that warning a patient about a driving impairment is tantamount to taking a precaution to avoid a likely harm. Again, if an eventual automobile accident caused by a patient is foreseeable, imposing limitless liability to an identifiable public may offend public policy.

5. *Maine*

The Supreme Judicial Court of Maine has recognized a physician’s duty to the driving public arising from the provision of medical treatment not involving medication in *Joy v. Eastern Maine Medical Center*.²⁰⁵ Here, the facts were quite simple: A patient received emergency room care for an eye abrasion and was treated with an eye patch placed over the injured eye.²⁰⁶ Allegedly, the patient was not warned to avoid driving.²⁰⁷ Thereafter, the patient, while driving an automobile, collided with the plaintiff, who was driving a motorcycle.²⁰⁸

The Supreme Judicial Court, on appeal, vacated and remanded summary judgment entered in favor of the defendant health care providers.²⁰⁹ The court recognized “the general requirement that when a doctor knows, or reasonably should know that his patient’s ability to drive has been affected, he has a duty to the driving public as well as to the patient to warn his patient of that fact.”²¹⁰ Again, the duty to warn the patient may not be burdensome, but potential liability to a limitless, unknown public places a heavy burden on the physician.

6. *Alabama*

The Supreme Court of Alabama, in *Taylor v. Smith*,²¹¹ recognized a physician’s duty to a nonpatient deriving from a duty owed to a patient.²¹² Here, the

202. 62 N.E.3d 384, 391 (Ind. 2016) (adopting different frameworks for evaluating foreseeability in duty and proximate cause contexts).

203. *Id.* at 389.

204. *Id.* at 392 (quoting *Satterfield v. Breeding Insulation Co.*, 266 S.W.3d 347, 367 (Tenn. 2008)).

205. 529 A.2d 1364, 1365-66 (Me. 1987) (explaining holdings from other jurisdictions and extending rationale to case not involving medication).

206. *See id.* at 1365.

207. *See id.*

208. *See id.* at 1364.

209. *See Joy*, 529 A.2d at 1364.

210. *Id.* at 1366.

211. 892 So. 2d 887 (Ala. 2004).

212. *Id.* at 897 (holding treatment center director owed duty of care to third parties foreseeably injured).

patient was opioid addicted and received outpatient methadone treatment.²¹³ Following treatment, the patient drove home.²¹⁴ On the day in question, the patient apparently caused an automobile collision with the automobile driven by a nonpatient.²¹⁵ A lawsuit ensued and the trial court entered summary judgment for the defendant-physician based upon the absence of a duty owed “to a third party non-patient.”²¹⁶

The Supreme Court of Alabama rather easily determined that “a vehicle accident was reasonably foreseeable” based on various factors, including the patient’s “persistent substance abuse.”²¹⁷ After referring to the various jurisdictions which have recognized a physician’s duty to “non-patient members of the driving public,” Alabama’s highest court similarly recognized this duty.²¹⁸ This duty “derives from the physician’s duty to the patient.”²¹⁹ Therefore, an appropriate warning to the patient—advising of driving risks (and a corresponding chart entry)—should fully discharge the duty.

7. Tennessee

The Supreme Court of Tennessee in *Burroughs v. Magee*²²⁰ recognized a physician’s duty of care to a nonpatient to warn a patient driver of adverse effects of the patient’s medication.²²¹ In *Burroughs*, a physician prescribed a muscle relaxant and a barbiturate to a patient.²²² These drugs “act as depressants on the central nervous system and can affect a patient’s ability to safely operate a motor vehicle.”²²³ There was conflicting evidence as to whether the physician warned the patient not to drive.²²⁴

213. *See id.* at 889.

214. *See id.* at 890 (noting patient’s trip home took approximately ninety minutes).

215. *See Taylor*, 892 So. 2d at 890 (indicating patient’s automobile crossed into oncoming traffic and collided with nonpatient’s automobile).

216. *See id.* at 891 (noting plaintiff on appeal arguing trial court erroneously concluded no duty).

217. *Taylor v. Smith*, 892 So. 2d 887, 892 (Ala. 2004).

218. *See id.* at 893-94 (reviewing other state courts extending duty, including Hawaii, Maine, New Mexico, Oregon, Texas, and Wisconsin); *see also* *McKenzie v. Haw. Permanente Med. Grp., Inc.*, 47 P.3d 1209, 1221-22 (Haw. 2002) (asserting physicians have duty to warn of adverse drug impacts on driving ability); *Joy v. E. Me. Med. Ctr.*, 529 A.2d 1364, 1366 (Me. 1987) (requiring physician duty to warn about patient’s eye patch, though patient unaware of risks); *Wilschinsky v. Medina*, 775 P.2d 713, 717 (N.M. 1989) (extending duty to physicians to warn “persons injured” by patient injected with unpredictable drugs); *Zavalas v. State*, 861 P.2d 1026, 1028 (Or. Ct. App. 1993) (refusing to exclude physicians from liability for injuries patients cause to third parties); *Gooden v. Tips*, 651 S.W.2d 364, 369 (Tex. Ct. App. 1983) (holding circumstances warrant physician liability where negligent “diagnosis or treatment . . . contributes to plaintiff’s injuries”); *Schuster v. Altenberg*, 424 N.W.2d 159, 166 (Wis. 1988) (expanding duty to psychotherapy and psychotherapist’s duty to detain patients dangerous to selves, others).

219. *Taylor*, 892 So. 2d at 896 (emphasis omitted).

220. 118 S.W.3d 323 (Tenn. 2003).

221. *See id.* at 324-25 (holding physician violated duty of care when foreseeable probability of harm to patient).

222. *See id.* at 325.

223. *Id.*

224. *See Burroughs*, 118 S.W.3d at 326 (noting physician and patient’s conflicting deposition testimonies).

In its analysis, the court invoked duty and foreseeability, stating that “[a]ll persons have a duty to use reasonable care to refrain from conduct that will foreseeably cause injury to others.”²²⁵ The court also referred to public policy concerns when recognizing a tort duty that the general public is entitled to protection from the conduct of others.²²⁶ The court identified five factors to consider in making a determination as to the existence of a physician’s duty: the “foreseeable probability of the harm or injury occurring,” “the possible magnitude of the potential harm or injury,” “the importance or social value of the activity engaged in by defendant,” “the usefulness of the conduct to defendant,” and “the feasibility of alternative, safer conduct and the relative costs and burdens associated with that conduct; the relative usefulness of the safer conduct; and the relative safety of the alternative conduct.”²²⁷ Certainly, the conduct referred to by the court is the physician’s prescription of medications for the patient, without warning the patient that the medications may cause driving impairments.

Ultimately, the court held that the prescribing physician owed the patient a duty to warn of the driving risks associated with the medications.²²⁸ This duty to warn did inure to the benefit of the nonpatient plaintiff. Again, presumably, the duty to the nonpatient victim would be discharged by an appropriate warning to the patient (and corresponding chart entry).

8. *Hawaii*

The Supreme Court of Hawaii recognized a physician’s duty to warn a patient regarding the effects of medication on driving ability in *McKenzie v. Hawaii Permanente Medical Group*.²²⁹ Here, a psychiatric patient fainted while driving an automobile, apparently due to a reaction to a prescribed medication.²³⁰ The automobile then struck the plaintiff on the sidewalk.²³¹ The plaintiff claimed that the attending physician “negligently prescribed [medication], negligently prescribed an excessive dose of [medication], and failed to give [the patient] sufficient warning of its side effects.”²³²

The court’s duty of care analysis began with a reference to policy considerations as fundamental to the determination of a tort duty.²³³ Thereafter, in addressing the potential duty to warn the patient, the court noted:

225. *Id.* at 328 (citation omitted).

226. *See Burroughs v. Magee*, 118 S.W.3d 323, 330, 333 (Tenn. 2003) (explaining public policy considerations provide source of legal protections expressed through concept of duty).

227. *Id.* at 331-33 (quoting *McCall v. Wilder*, 913 S.W.2d 150, 153 (Tenn. 1995)).

228. *Id.* at 335.

229. 47 P.3d 1209, 1221-22 (Haw. 2002) (recognizing duty exists when reasonable patient not warned or aware of risks).

230. *Id.* at 1210 (providing case background).

231. *Id.* at 1211 (describing automobile accident).

232. *Id.*

233. *See McKenzie*, 47 P.3d at 1214 (introducing policy considerations in duty of care analysis).

It appears obvious that warning a patient not to drive because his or her driving ability may be impaired by a medication could potentially prevent significant harm to third parties. . . . Furthermore, a physician already owes a duty to his or her patient under existing tort law to warn the patient of such a potential adverse effect. Thus, imposition of a duty for the benefit of third parties is not likely to require significant changes in prescribing behavior.²³⁴

Unsurprisingly, the court recognized the existence of the physician's duty to the nonpatient victim of the accident.²³⁵

9. Washington

In *Kaiser v. Suburban Transportation System*,²³⁶ a passenger on a bus was injured when the bus driver, a patient, lost consciousness while driving the bus, causing the bus to collide with a telephone pole.²³⁷ Apparently, the loss of consciousness was due to medication prescribed for the bus driver's nasal condition.²³⁸ The trial court dismissed the claim against the physician.²³⁹

The Supreme Court of Washington referred to "evidence in the record that the doctor failed to warn his patient . . . of the dangerous side effects of drowsiness or lassitude that may be caused by the taking of this drug [prescribed by the physician]."²⁴⁰

The court referred to foreseeability, noting that the doctor would "be liable if the jury finds he failed to give warning of the side effects of the drug, since the harm resulting to the [injured nonpatient passenger] was in the general field of danger, which should reasonably have been foreseen by the doctor when he administered the drug."²⁴¹ The court reversed the dismissal of the claim against the physician by the nonpatient victim.²⁴²

10. Wisconsin

In *Schuster v. Altenberg*,²⁴³ the Supreme Court of Wisconsin recognized that, for the benefit of a nonpatient third party, a psychotherapist has a duty to warn a patient that medication may impair their ability to drive.²⁴⁴ Apparently, the

234. *Id.* at 1219.

235. *See McKenzie v. Haw. Permanente Med. Grp., Inc.*, 47 P.3d 1209, 1221-22 (Haw. 2002) (holding nonpatient third party owed duty under specific circumstances).

236. 398 P.2d 14 (Wash. 1965).

237. *See id.* at 15.

238. *See id.* (noting side effects of prescribed drug may lead to loss of consciousness).

239. *See id.* (explaining lower court dismissal for lack of sufficient evidence).

240. *Kaiser*, 398 P.2d at 16 (acknowledging sufficiency of evidence to address doctor's negligence).

241. *Id.* at 16.

242. *Kaiser v. Suburban Transp. Sys.*, 398 P.2d 14, 16 (Wash. 1965) (reversing and remanding for new trial).

243. 424 N.W.2d 159 (Wis. 1988).

244. *See id.* at 163 (recognizing psychotherapist's duty to appropriately warn patient of medication side effects).

patient suffered a “psychotic condition.”²⁴⁵ The patient was then involved in a serious automobile accident, and, allegedly, was not warned by the physician of medication side effects, including driving impairment.²⁴⁶

The court referred to duty and foreseeability under Wisconsin law: “[A] ‘duty’ exists when it is established that it was foreseeable that an act or omission to act may cause harm to someone.”²⁴⁷ The court referred to various public policy considerations, some of which have been mentioned earlier in this Article.²⁴⁸ Ultimately, the court held that Wisconsin law did not preclude a claim against the physician for the benefit of a nonpatient victim.²⁴⁹

11. *New Mexico*

The Supreme Court of New Mexico, in *Wilschinsky v. Medina*,²⁵⁰ also recognized a physician’s duty to nonpatients to warn patients of the side effects of medications administered by the physician to patients when a side effect of the medication is driving impairment.²⁵¹ The court extended the scope of the duty “to persons injured by patients driving automobiles from a doctor’s office when the patient has just been injected with drugs known to affect judgment and driving ability.”²⁵² The dissent correctly noted that such an expansive duty would “significantly enlarge a physician’s potential liability” and make a physician’s treatment decisions more difficult.²⁵³

V. COMMENTARY

This Article has largely focused on courts of last resort and their decisions to reject or recognize a physician’s duty to warn a patient for the benefit of an injured nonpatient third party who becomes a plaintiff in a claim against the physician for failure to warn a patient regarding driving impairments. These

245. *See id.* at 160 (noting patient’s medical condition).

246. *See id.* at 161-62 (describing basis of negligence claim).

247. *Schuster*, 424 N.W.2d at 165 (citing *A.E. Inv. Corp. v. Link Builders, Inc.*, 214 N.W.2d 764, 766 (Wis. 1974)) (discussing when physician’s duty exists under Wisconsin tort law).

248. *See id.* at 167 (noting six factors frequently cited in other jurisdictions for public policy considerations); *see also supra* note 57 and accompanying text (analogizing physician’s duty to uphold medical ethics); *supra* note 75 and accompanying text (outlining four policy factors considered by Connecticut Supreme Court when imposing duty of care); *supra* notes 78-81 and accompanying text (summarizing Connecticut Supreme Court’s public policy reasoning for not imposing duty of care); *supra* note 121 and accompanying text (noting physicians may unreasonably restrict patient’s medication if duty of care imposed); *supra* note 133 and accompanying text (acknowledging imposing duty of care may destroy physician’s loyalty to client); *supra* note 227 and accompanying text (acknowledging risk-utility policy arguments).

249. *See Schuster v. Altenberg*, 424 N.W.2d 159, 167, 175-76 (Wis. 1988) (holding no public policy reasons support finding appellant failed to state legally cognizable allegations).

250. 775 P.2d 713 (N.M. 1989).

251. *Id.* at 717 (holding physician owed duty to “driving public”).

252. *Id.*

253. *Id.* at 720 (Scarborough, J., dissenting) (noting imposition of duty places significant burden on physicians).

impairments may relate to an underlying medical procedure, medication prescribed or administered by a physician, or medication which a patient has taken for a period of time of which the physician has knowledge.²⁵⁴ These distinct scenarios are significant to some courts, although it is not clear why this is so.²⁵⁵ If a physician is aware that a patient has a medical condition, is administered or takes medication that may impair the patient's ability to drive, the physician certainly has a duty to warn the patient of the potential impairment. The question is whether the duty to warn inures to the benefit of a nonpatient third-party victim of a patient's driving impairment. The answer to this question implicates the potential tort liability of physicians (assuming the failure to warn the patient). The driving public and pedestrian public are immense, unidentifiable entities.²⁵⁶

As this Article has noted, vehicular accidents are ubiquitous, and medical conditions and medications which may impair driving ability are many.²⁵⁷ Motor vehicle accidents are generally foreseeable but the identity of an injured third party is not.

Earlier in this Article it was suggested that, perhaps, the concept of the third-party beneficiary in contract might be useful in understanding an expanded physician's duty, yielding a duty to a nonpatient victim.²⁵⁸ That a physician's duty to warn a patient may inure to the benefit of a nonpatient does not fit well within contract law. There is no classic contractual relationship between a physician and patient insofar as the duty of care is concerned. Unless a physician promises results, the appropriateness of medical treatment is governed by the standard of care—a tort concept—not the law of contract. The physician-patient relationship does not implicate an intent to benefit a third party²⁵⁹ beyond a physician's ethical obligation to have concern for society. Therefore, the recognition of an extended physician's duty does not seem analogous with the right of a contractual third-party beneficiary.

In a sense, courts must determine whether to subject physicians to a duty that could expose them to an unlimited universe of claimants. There is sufficient case

254. See, e.g., *Hardee v. Bio-Med. Applications of S.C., Inc.*, 636 S.E.2d 629, 631-32 (S.C. 2006) (recognizing duty to warn where medical procedure hinders patient's driving abilities); *Burroughs v. Magee*, 118 S.W.3d 323, 325 (Tenn. 2003) (noting medication physician prescribed affects patient's ability to drive safely); *Vizzoni v. B.M.D.*, 212 A.3d 962, 966 (N.J. 2019) (describing thirteen-year treatment relationship in which psychiatrist prescribed various medications); see also *Taylor v. Smith*, 892 So. 2d 887, 892 (Ala. 2004) (concluding collision reasonably foreseeable given methadone-treatment-center director's knowledge of patient's "persistent substance abuse").

255. See *supra* Section IV.A (presenting cases from states in which courts declined to impose duty).

256. See *LEROY & MORSE*, *supra* note 4, at 1 (noting dramatic and continuing increase in number of older drivers).

257. See *supra* Part II.

258. See *supra* note 17 and accompanying text (introducing third-party liability).

259. See David M. Summers, *Third Party Beneficiaries and the Restatement (Second) of Contracts*, 67 CORNELL L. REV. 880, 888 (1982) (introducing Restatement's "intent to benefit" test).

law to support either the rejection or recognition of a physician's duty to an unknown, nonpatient injured third party.²⁶⁰

VI. CONCLUSION

It seems fair to suggest that courts should reject a physician's duty to an unknown nonpatient victim, injured by a patient's driving impairment. Otherwise, physicians may face expansive liability. On the other hand, it is reasonable to note that if the physician discharges the duty to warn the patient, the physician also discharges the duty to the nonpatient victim.

Perhaps, therefore, it is most important that physicians understand that a split of authority exists and that they may practice medicine in a jurisdiction which recognizes the duty.

260. See *supra* Section IV.A (highlighting cases rejecting physician's duty to unidentifiable nonpatient victims); *supra* Section IV.B (highlighting cases recognizing physician's duty to unidentifiable nonpatient victims).