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Physician's Abandonment of Patient

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Plaintiff patient's petition alleged that the defendant physician, after he had agreed to give plaintiff, who at this time was pregnant, the necessary prenatal care to deliver her child and to give her the necessary postnatal care, refused to visit plaintiff when her labor pains set in. Instead, defendant advised and assured plaintiff's husband that plaintiff would not have her baby until two weeks later. On later occasions, defendant again refused to visit plaintiff and when urgently requested to come at once to her bedside flatly refused and told plaintiff's husband that he did not have to come and in fact would have nothing further to do with plaintiff's case. Subsequently, the husband attempted to obtain a physician but was unable to do so, thus plaintiff had to bear her child in her home without the aid of any physician.[1]

The above factual situation represents an increasing problem in the medical field: that of abandonment of one's patient. A recent case has stated the theory as follows: "[a]n abandonment consists of a failure by the physician to provide service to the patient when it is still needed in a case for which the physician has assumed responsibility and from which he has not been properly relieved."[2] Stated another way "abandonment of a patient is the unilateral severance by the physician of the professional relationship between himself and the patient without reasonable notice at a time when continuing medical attention is still a necessity."[3] Two ideas become readily apparent from these definitions. First, is the rule that a physician has a duty to treat a patient so long as the professional relationship between them lasts. It must be shown that at some time during the course of the patient's present illness a relationship existed between the parties. A physician who has seen a patient for one illness is not generally obliged to continue to treat the patient once the treatment for that complaint is completed. He is not obliged to treat the patient for succeeding illnesses unrelated to the first and is usually not liable for abandonment if he refuses to do so.[4] However, a physician

1. Norton v. Hamilton, 92 Ga. App. 727, 89 S.E.2d 809 (1955).

2. Brandt v. Grubin, 131 N.J. Super. 182, 187, 329 A.2d 82, 87 (1974). *See also* Clark v. Wichman, 72 N.J. Super. 486, 179 A.2d 238 (1962). For cases on the failure by the physician to provide service to the patient when it is still needed, *see* Mucci v. Houghton, 57 N.W. 305 (Iowa 1894); Fortner v. Koch, 272 Mich. 273, 261 N.W. 762 (1935); Nelson v. Farrish, 143 Minn. 368, 173 N.W. 715 (1919); Welch v. Frisbie Memorial Hosp., 9 A.2d 761 (N.H. 1939); Burnett v. Layman, 133 Tenn. 323, 181 S.W. 157 (1915); Young v. Jordan, 106 W. Va. 139, 145 S.E. 41 (1928); Howell v. Biggart, 152 S.E. 323 (W. Va. 1930).

3. 3 Proof of Facts 2d, *Abandonment of Patient*, vol. 3, p. 123, Lawyers Co-operative Publishing Co., Rochester, N.Y. (1974).

4. Skodje v. Hardy, 288 P.2d 471 (Wash. 1955).

who is considered by the patient to be his family physician might be guilty of abandonment if he is consulted in an emergency by the patient and does not make a proper referral.[5] The physician also has the right to limit his relationship with the patient as long as the limitations are made clear to the patient at the outset of the relationship and a refusal to exceed the limitations does not constitute abandonment.[6]

Thus, the physician-patient relationship is critical in assessing whether or not a malpractice action resulting from abandonment will lie,[7] and is the first element of proof in an abandonment case. If there is lacking a contractual relationship, then an abandonment suit cannot be maintained.[8]

The second idea to be gleaned from the definitions is that adequate notice to the patient of withdrawal is extremely significant. Before a physician makes his announced withdrawal effective he must allow sufficient time for the patient to locate another physician who is willing to accept the case.[9] Failure to give such notice and thereby exercise that care required by law, will render the physician liable in tort.

Actually, there are two situations in which abandonment will occur. First, is by breach of contract where there is a complete intentional withdrawal from the case. Here determination of liability revolves around whether the patient was given sufficient notice of the physician's intent to withdraw. Second, abandonment occurs under negligence theory where the physician fails to observe the patient's problems with sufficient care[10] to realize that further treatment is necessary so that the effect on the patient is an equally serious denial of treatment. In this situation, as opposed to the first, there is no intention to abandon.[11]

Even if abandonment can be proved to have occurred it should be noted and emphasized that unless the act is the proximate cause of damage to the patient, the amount of recovery is inevitably extremely small. Thus, if a patient who has been abandoned consults another physician promptly, thus causing minimal delay in necessary treatment

5. *See supra* note 3, at 126.

6. Rodgers v. Lawson, 170 F.2d 157 (D.C. Cir. 1948) geographical limitations-physician did not make house calls; Childers v. Frye, 201 N.C. 42, 158 S.E. 744 (1931); McNamara v. Emmons, 36 Cal. App. 2d 199, 97 P.2d 503 (1939).

7. "As a man consents to bind himself so shall he be bound." 3 ELLIOT ON CONTRACTS § 1891 (1913).

8. *See* Shapira v. United Med. Serv., Inc., 15 N.Y.2d 200, 205 N.E.2d 293, 257 N.Y.S.2d 150 (1965).

9. *See* McManus v. Donlin, 23 Wis. 2d 289, 127 N.W.2d 22 (1964); Burnett v. Layman, supra note 2, at 325.

10. Sanders v. Lischkoff, 188 So. 815 (Fla. 1939); Beck v. German Klinik, 78 Iowa 696, 43 N.W. 617 (1889); Wambold v. Brock, 19 N.W.2d 582 (Iowa 1945); Johnson v. Vaughan, 370 S.W.2d 591 (Ky. 1963); Doan v. Griffith, 402 S.W.2d 855 (Ky. 1966); O'Neill v. Montefiore Hosp., 11 App. Div. 2d 132, 202 N.Y.S.2d 436 (1960).

11. *See supra* note 3, at 124.

and his recovery from his illness is not impeded, damages, except for mental anguish, are usually minimal. A mere showing of negligence on the part of the physician is not sufficient to sustain the action.[12]

Once the plaintiff decides to maintain an action against the physician, he has certain elements of proof to maintain. First, as mentioned above, he must prove that a physician-patient relationship existed, and this proffer of proof will most likely include an agreement, express or implied,[13] by the physician to treat the patient until the latter has recovered. Second, the plaintiff must prove that there was a failure on the part of the physician to attend the patient and that such abandonment damaged the patient's condition (proximate cause). In addition, if the physician deviated from the normal standard of care, then it would be beneficial to the plaintiff's case to prove such neglect.

Once the proof has been proffered and the trial has finally begun, the question of expert testimony becomes a very interesting and important consideration not only for trial purposes but also from the plaintiff's point of view. As is well known, expert testimony is considered an indispensable prerequisite to the establishment of liability on matters concerning questions of due care and skill under particular circumstances. An exception to this long-standing rule arises in the area of abandonment in a specific situation. Expert testimony is not essential to the establishment of negligence on the part of the physician where the matters complained of are of such common knowledge that they might be fairly interpreted by the jury without the benefit of expert evidence.[14] The case of *Gross* v. *Partlow*[15] states the rule thusly:

> There are instances where facts alone prove the negligence and where it is unnecessary to have the opinions of persons skilled in the particular science to show unskilled and negligent treatment. . . . It is therefore not necessary that a case of malpractice be proved by direct and positive evidence, and that it may be proved by a chain of circumstances from which the ultimate fact required to be established is reasonably and naturally inferrable.[16]

Thus, expert testimony will be required only where the nature of abandonment is extremely technical. Further, the fact that expert testimony is

12. A causal connection was held to exist in the following cases: Maltempo v. Cuthbert, 504 F.2d 325 (5th Cir. 1974); Lathrope v. Flood, 135 Calif. 458, 67 P. 683 (1902); Meiselman v. Crown Heights Hosp., Inc., 285 N.Y. 389, 34 N.E.2d 367 (1941); Wilson v. Martin Mem. Hosp., 232 N.C. 362, 61 S.E.2d 102 (1950); Ricks v. Budge, 91 Utah 307, 64 P.2d 683 (1902); Vann v. Harden, 87 Va. 555, 47 S.E.2d 314 (1948).

13. *See* Lawson v. Conaway, 37 W. Va. 159, 16 S.E. 564 (1892).

14. Annot., 57 A.L.R.2d 432, 444 (1958).

15. 190 Wash. 489, 68 P.2d 1034 (1937).

16. *Id.* The jury naturally inferred that plaintiff was discharged before his condition justified it.

not needed to make a prima facie case affords the plaintiff a distinct advantage.

If the plaintiff is successful at trial in proving that the physician abandoned him then what damages can he recover? Firstly, if the patient is employed he can recover loss of income as the result of the prolongation of the illness from which he would have recovered more quickly had he not been abandoned. Secondly, the patient can recover any decrease in permanent earning capacity. Thirdly, he can recover medical expenses made necessary by the abandonment. Lastly, the patient can recover for pain, suffering, fright and mental anguish caused by the act. Damages for mental anguish are recovered more frequently than for pain or fright because of the psychological effects of being left alone without assistance while incapacitated.[17]

Though it may appear that the patient has a strong case against the physician, the latter is not without his defenses when a claim of abandonment is maintained against him. The first claimed justification concerns an intervening illness of the physician. Such illness will excuse a unilateral termination of the physician-patient relationship but only if the physician notifies the patient of his inability to continue the treatment so as to give the latter a reasonable opportunity to secure another physician or have the physician provide for a competent substitute. In one case, *Warwick* v. *Bliss*,[18] a physician, who had undertaken the treatment of plaintiff's fractured leg, was obliged to leave the vicinity because of his own ill health. However, he left plaintiff in the charge of another physician who continued the treatment. The *Warwick* court held that there was no ground for a complaint of abandonment where there was nothing to show that the substitute physician was not equally as capable and skillful as defendant or that plaintiff suffered in any manner because of the change in doctors.[19]

Lack of cooperation by the patient may be a second factor to justify unilateral termination by the physician. If an office patient comes to the physician's office and while there receives careful and skillful treatment, but then fails to return for further treatment and in consequence thereof suffers injury, the patient is not entitled to maintain an action against the physician because of his own default and misfeasance.[20] The case of

17. There are more cases of abandonment against obstetricians than any other type of medical practitioner because of the psychological factors involved. Thus, the physician's duty to an obstetrical patient is absolute. *See* Norton v. Hamilton, *supra* note 1; Hood v. Moffett, 109 Miss. 757, 69 So. 664 (1915).

18. 46 S.D. 622, 195 N.W. 501 (1923).

19. *Id.* at 504.

20. Roberts v. Wood, 206 F. Supp. 579 (S.D. Ala. 1962), physician could not be charged with having abandoned his patient where physician had instructed patient to return in two weeks and where patient and not physician had decided that the previous visit would be patient's last; Dashiell v. Griffith, 84 Md. 363, 35 A. 1094 (1896); Urru-

Fleishman v. *Richardson-Merrell, Inc.*[21] provides an interesting set of facts in this area. There the patient claimed that the physician did not warn her of the side effects of a certain drug and because of his failure she continued to use the drug and subsequently developed cataracts. The prescription itself only authorized two refills, but the plaintiff continued to take the medication even after the prescription ran out. One year later she stopped taking the drug because of a radio report she heard concerning its side effects. Plaintiff sued on the theory that a physician has a continuing duty to make periodic calls to follow the progress of the patient under his care and to notify the patient of the dangerous propensities of a drug which he has prescribed as soon as he knows or should have known of them. The court disagreed with plaintiff's contention and held that no abandonment had occurred. The court reasoned that the patient herself dispensed with the physician's services and thus terminated the relationship many months before the warning was heard. The court also stressed the fact that she continued taking the drug after the prescription expired, and once this expired the physician was no longer under a duty to follow her progress.

However, in the case of *Lathrope* v. *Flood*[22] a claim of lack of cooperation by the patient was unsuccessful. There defendant was employed to attend plaintiff during her first pregnancy. He visited her at various times and on the final visit he deemed it the proper time to employ instruments to aid in the delivery of the child. The physician attempted to deliver whereupon plaintiff shrank back causing the defendant to drop the instrument. Thereupon, defendant threatened the plaintiff that if she did not cease screaming he would quit the case. He attempted to employ the instruments two more times, however, the patient failed to cooperate, so he abruptly left the house. One hour later another physician was obtained and he found the plaintiff's condition was not such as to require the use of instruments at that time. The court in its decision made the following remarks: "[s]uch conduct [on the part of the physician] evidenced a wanton disregard, not only of professional ethics but of the terms of his actual contract."[23] Further, the court stated that the facts showed negligence in its character amounting well nigh to brutality.[24]

Throughout the cases a problem has existed concerning whether or not a physician is justified in abandoning the patient if the latter fails to pay his bills. Invariably, the courts have held that failure of the patient

tia v. Patino, 297 S.W. 512 (Texas Civ. App. 1927), where the patient obstinately refused to follow the treatment prescribed by the physician.

21. 94 N.J. Super. 90, 226 A.2d 843 (1967).

22. 6 Cal. Unrep. 637, 63 P. 1007 (1901).

23. *Id.* at 637, 63 P. at 1008; *See also* Thaggard v. Vafes, 119 So. 647 (Ala. 1928).

24. *Id.* at 637, 63 P. at 1008.

to pay for the physician's services does not justify the physician in terminating the relationship at least where the patient still needs medical attention.[25] This involves an ethical problem. Is it within sound medical practice for the physician to say "I am not going to take care of you until that account is taken care of?" A physician's medical ethics would be seriously questioned were he to act in such a manner.

When does the physician's obligation of continuing attention terminate? First, it is terminated by the cessation of the necessity which gave rise to the relationship of physician and patient[26] (recovery by the patient), by mutual consent of the parties,[27] by the discharge of the physician by the patient,[28] or by the physician's withdrawing from the case after giving the patient reasonable notice so as to enable him to secure other medical attention.[29]

Another consideration which should not be neglected is the effect of special or limited employment on the part of the physician. As in the case of contracts generally such a limitation may become part of the contract of employment either by an express provision to this effect or by implication. It appears to be well settled that a physician who is employed only for a specific occasion or service is under no duty to continue his visits or treatment thereafter, and is consequently not liable for abandonment if he ceases treatment of his patient after performing the specific service.[30]

In the case of *Brandt* v. *Grubin*[31] a patient visited the physician

25. Becker v. Janinski, 15 N.Y.S. 675 (Common Pleas of New York City, Trial Term 1891); Ricks v. Budge, *supra* note 12 (Folland dissenting).

26. *See* McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950); Gray v. Davidson, 15 Wash. 2d 257, 130 P.2d 341 (1942).

27. *See* Fortner v. Koch, *supra* note 2.

28. Brown v. Dark, 119 S.W.2d 529 (Ark. 1938), when a physician has been discharged by a patient he is relieved of responsibility if his treatment of the case was proper up to the time of discharge. However, if after the discharge the physician volunteers and offers advice which deceives or misleads the patient, he is responsible for injuries arising therefrom. Carpenter v. Blake, 75 N.Y. 12 (1818).

In addition, even though the patient terminates the relationship, if the situation is such that medical care will be required, the physician has the duty to warn him of the necessity of obtaining further medical care and is obliged to provide the patient's succeeding physician with sufficient information on the case to permit continuation of treatment.

For his own protection, the physician should write the patient a letter confirming the discharge and asserting the need for continuing treatment. *See* Brandt v. Grubin, 131 N.J. Super. 182, 329 A.2d 82 (1974).

29. However, it is no excuse for a physician who agreed to treat one person that at the time treatment became necessary he could not leave another patient. *See* Hood v. Moffett, *supra* note 17; Young v. Jordan, *supra* note 2.

30. *See* Harris v. Fall, 177 F. 79 (7th Cir. 1910); McNamara v. Emmons, *supra* note 6; Sheridan v. Quarrier, 127 Conn. 279, 16 A.2d 479 (1940); Miller v. Blackburn, 170 Ky. 263, 185 S.W. 864 (1916); Nelson v. Farrish, *supra* note 2; Nash v. Royster, 189 N.C. 408, 127 S.E. 356 (1925).

31. 131 N.J. Super. 182, 329 A.2d 82 (1974).

whom the latter referred to a mental health clinic. Upon his recommendation, he sent a note home to the patient's family apprising them that the patient needed psychiatric care. Subsequently, the patient committed suicide, and the family sued the physician for abandonment. The court rejected the abandonment claim, and reasoned that the visit was for a specific purpose and after one visit the physician found, that because he was a general practitioner and not a psychiatrist, he was incapable of providing the requested services. The court further emphasized that the patient was referred to a source of competent medical assistance and therefore, the physician was liable neither for the actions of subsequent treating professionals nor for his refusal to become further involved with the case.

Many of the abandonment claims certainly do not appear to be just to the physician especially where he takes a vacation or refuses to treat a patient who fails to pay him. Thus, the physician should attempt to avoid a claim of abandonment and subsequent liability by taking certain steps in order to protect himself. First, the physician should make proper provision for the attendance of a competent physician during his absence in case of call. Second, he should not absent himself while his patient is in critical condition. Third, if he feels that his caseload is too demanding, then he should not accept a patient.[32] Fourth, he may limit treatment and responsibility by special contract, treat only for a specfiic ailment, or for a specific period of time. Fifth, the physician can limit himself to office practice only, operations only, or consultation only. Sixth, he should be able to recognize when the relationship with his patient terminates. This protection will substantially minimize premature discharges. Last, the physician should use his good common sense by adhering to sound medical practice.

From a reading of the cases, it appears as though the use of the abandonment theory by plaintiff's attorneys is increasing. The reasons for the rise are reflected in the frequent elimination of expert testimony and the merger of abandonment principles with contracts and negligence theories.

But what does the future hold for abandonment claims? Perhaps, on the one hand, it is foreseeable that such actions will show a gradual decline as the physician begins to make use of some of the protections listed above. But this is very unlikely especially in light of the fact that there are a shortage of doctors and an increase in the number of patients. This lopsided ratio results in less time being spent with one patient than is needed because of an overcrowded waiting room and

32. *See* Childers v. Frye, *supra* note 6; where defendant physician did not accept drunken man as his patient.

thus the strong chance of a faulty diagnosis. It must be accentuated that the press of business is not a defense against abandonment claims.

Abandonment is extremely serious. Not only does it involve a breakdown of medical ethics and dedication to the field, but it also endangers a human life. Therefore it is imperative to punish the offender more harshly in the future by either assessing punitive damages against the physician or revoking his license to practice medicine or instituting criminal charges against him. Such actions might have a deterrent effect on future charges of abandonment.

RICHARD ROSENTHAL

Criminal Aspects of Suicide in the United States

Suicide has been denounced as a great sin by some and eloquently defended as a natural right of man, as early as 1644, by the English cleric John Donne.[1] It has been a common and highly dramatic form of death throughout the history of man. In 1972, there were 24,280 reported suicides in this country, which is equivalent to a 11.7 suicide rate per 100,000 population.[2] This number of suicides was almost indentical to the number of homicides in the same year.[3] There is little doubt that the suicide rate in the United States will increase in the forthcoming years, if the historical correlation between times of economic trouble and an increased suicide rate continues.[4] Suicide has become a common form of death in the United States.

In dealing with the criminality of suicide, there are essentially three basic areas of importance: the act itself, attempted suicide, and the act of a second person aiding or encouraging a suicide. Each of these areas will be examined in detail within the various jurisdictions of the United States.

SUICIDE

At English common law, suicide was a felony with strict punishment and considered an immoral crime.[5] The punishment included a mutila-

1. J. Donne, *Biathantos* (1644).

2. U.S. Bureau of the Census, *Statistical Abstract of the United States*, #86, Table 62 (1974).

3. *Id.*

4. U.S. Bureau of the Census, *Historical Statistics of the United States*, Table Series B-114-128 (1960).

5. Hales v. Petit, 1 Plowden 253, 75 Eng. Rep. 387 (1562); State v. Willis, 255 N.C. 473, 121 S.E.2d 854 (1961).