Forced Detentions—
A Duty?

By Aahren Rodriguez DePalma

Hospitals and other health care providing facilities must take measures to prevent their duty to protect patients from being extended beyond the facility’s doors.

Medical malpractice claims require proof of traditional negligence elements—duty, breach, causation, and injury—and revolve around an act or omission by a provider during treatment. A plaintiff typically alleges that a defendant negligently provided treatment—be it surgery, diagnosis, or medication prescription, among others—or that the provider failed to act and this failure caused injury. A plaintiff’s attorney then typically retains an expert who testifies to the applicable standard of care, thus establishing the duty owed by the health care provider to the plaintiff. Eventually, a plaintiff’s attorney offers evidence that the health care provider’s act or omission breached this duty.

Now, in a significant attempt to extend medical malpractice theories, plaintiffs’ attorneys have started to attempt to move beyond traditional medical malpractice allegations to expand health care providing facilities’ duties to patients, and as such, their liability. These attorneys argue that, after a health care providing facility has completed a medical procedure on a patient with the reasonable care due that patient, a provider’s duties now extend beyond the doors of the facility. According to some plaintiffs’ attorneys, a health care providing facility now also owes a duty to restrain an otherwise healthy patient from leaving the premises and subsequently injuring him- or herself. While a provider such as a hospital owes a duty to a patient to protect that patient while he or she is under its care, this duty is limited to circumstances within the provider’s control. 41 C.J.S. Hospitals §35 (2006). A hospital does not have a duty to protect patients from their own acts once they leave the hospital. Specifically, the duty to protect does not impose a duty to restrain otherwise healthy patients from leaving the premises and later injuring themselves. Regardless of how plaintiffs’ attorneys attempt to classify it, that duty does not exist.

As discussed in this article, hospitals and other health care providing facilities do not owe a duty to patients to protect the patients from injuring themselves once they stop providing care to those patients. Similarly, a health care providing facility does not owe a duty, nor does it have the ability, to restrain patients from leaving its premises and subsequently injuring themselves. Finally, a health care providing facility can avoid potential liability for those injuries that patients inflict on themselves by having them sign a general, “against
medical advice” release before leaving the premises if the patients insist on departing despite the circumstances. Releases not only may bar subsequent medical malpractice claims by patients, but they may also bar wrongful death claims brought by patients’ survivors if the patients die after leaving and injuring themselves.

**Protecting Patients from Themselves**

The duty that a health care facility or a hospital owes to a patient is separate and distinct from that owed by a physician. A health care facility’s or a hospital’s duties do specifically include a duty of protection. 41 C.J.S. Hospitals §35 (2006). The extent and character of this duty of protection, as generally defined, depends on the circumstances of each particular case. As with any liability in tort, the scope of a hospital’s duty to safeguard the welfare of its patients is circumscribed by those risks which are reasonably foreseeable.

It is a hospital’s duty to protect a patient from dangers that may result from the patient’s physical and mental incapacities, as well as from external circumstances peculiarly within the hospital’s control. Thus, a hospital is under a duty to exercise reasonable care to protect a patient from injuring himself or herself, and from harm inflicted by third persons.

41 C.J.S. Hospitals §35 (2006); see also Gleason v. Louisiana Dept. of Health & Hosps., 33 So.3d 961, 967–68 (La. Ct. App. 2010). Clearly, while patients are within the care of the health care providing facility, it has a duty to protect them not just from themselves but from any injuries or harm inflicted by third parties.

But the duty to protect a patient from third parties does have bounds and does not require a hospital to guarantee the patient’s safety against all possible risks. In N.X. v. Cabrini Med. Ctr., the plaintiff was sexually assaulted by a surgical resident while recovering from the effects of anesthesia. 280 A.D.2d 34, 35 (N.Y. App. Div. 2001) aff’d as modified sub nom. N.X. v. Cabrini Med. Ctr., 765 N.E.2d 844 (N.Y. 2002). In addition to claims for medical malpractice, battery, lack of informed consent, and intentional infliction of emotional distress, the plaintiff also alleged that the hospital failed to adequately safeguard her interests. Id. at 36. In assessing the hospital’s duty to safeguard the patient, the court found that “a hospital unquestionably has a duty to exercise reasonable care and diligence to safeguard a patient from harm inflicted by third persons, measured by the capacity of the patient to provide for his or her own safety.” Id. at 40. The court went on to limit the scope of this duty, holding that it “is not boundless and does not require a hospital to guarantee the patient’s security against any possible risk, regardless of how remote.” Id.

A hospital or other health care providing facility “is bound to exercise toward a patient such reasonable care as the patient’s known condition may require, the degree of care being in proportion to the patient’s known physical and mental ailments.” St. Francis Reg’l Med. Ctr., Inc. v. Hale, 752 P.2d 129, 133 (Kan. Ct. App. 1988); see also Hofflander v. St. Catherine’s Hosp., Inc., 664 N.W.2d 545, 561–62 (Wis. 2003). And “[o]bservations and information known to or readily perceivable by hospital staff that there is a risk of harm to a patient under the circumstances can be sufficient to trigger the duty to protect.” N.X. v. Cabrini Med. Ctr., 765 N.E.2d at 849–50.

While a hospital’s duty to protect a patient from self-inflicted injuries typically arises when a patient suffers from a mental disorder, it also includes a duty to protect a patient from becoming injured due to the patient’s physical condition, but that duty is proportionate to the patient’s physical condition and needs. In Robbins v. Jewish Hosp. of St. Louis, 663 S.W.2d 341 (Mo. Ct. App. 1983), the plaintiff was admitted to the hospital for a drug overdose. The plaintiff—who suffered from lameness and muscle spasms in her left leg for which she required a leg brace and weakness on her left side and arm—fell while getting out of bed and suffered a broken hip. In dismissing the hospital’s cross-appeal the court held that “having accepted plaintiff as a patient, the defendant owed her the specific duty of exercising reasonable care to protect her from injuring herself. Defendant’s duty in this regard was proportionate to her needs, that is, such reasonable care and attention as her known [physical] condition required.” Id. at 346.

Most courts agree that hospitals or other health care providing facilities admit-
addition to the right to leave such hospital as specified in this chapter."); Conn. Gen. Stat. Ann. §17a-506 (West 2011) (“Any person desiring admission to a hospital for care and treatment of psychiatric disabilities may be admitted as a patient without making formal or written application therefor if the superintendent deems such person clinically suitable for such admission, care and next of kin, or person entitled to his custody, shall be released immediately.”); N.Y. Mental Hyg. Law §9.15 (McKinney 2011) (“Such person may be admitted as a patient without making formal or written application therefor and any such patient shall be free to leave such hospital at any time after such admission.”).

While these statutes are primarily concerned with patients undergoing treatment for mental health issues, it follows that the same logic applies to otherwise competent, voluntary patients attempting to leave hospitals of their own volitions.

In health care arenas other than the mental health arena, the law does not expressly define the right to leave a hospital or other medical facility when undergoing treatment for physical ailments. But this right to leave is likely included within the well-established right to refuse medical treatment: “[M]ost courts have based a right to refuse treatment either solely on the common-law right to informed consent or on both the common-law right and a constitutional privacy right.” Cruzan by Cruzan v. Dir., Missouri Dept. of Health, 497 U.S. 261, 271, (1990). The Supreme Court in Cruzan found that “[t]his is the first case in which we have squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a “right to die.” Id. at 277. The Court further held that “the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.” Id. at 278. When a patient leaves a hospital before completing treatment or against medical advice, that patient in effect exercises the right to refuse medical treatment. Because patients have this well-established right to refuse medical treatment, hospitals cannot justify detaining patients who have refused further treatment and wish, instead, to leave.

Case law on restraining patients from leaving medical facilities or on controlling patients focuses primarily on patients with mental health issues who subsequently injure third parties after they have been released. However, the rationale applied by the courts in the cases denying that hospitals have a duty to restrain and control patients to protect third parties and the general public remains applicable when discussing a duty to restrain patients from leaving and injuring themselves.

A particularly illustrative case is Hoehn v. U.S., 217 F. Supp. 2d 39 (D.D.C. 2002). In that case a 70-year-old breast cancer patient’s oncologist advised the patient a week before her first chemotherapy treatment that “it was not necessary for her to arrange for alternate transportation” and “that she could drive herself home ‘if she felt OK.’” Id. at 41. This was repeated on the day of her treatment as well. After receiving treatment, the patient, Mrs. Wiscott, drove herself home, blacked out, and struck the plaintiff’s vehicle. Id. at 42. The plaintiff sued the hospital where Mrs. Wiscott received chemotherapy under the Federal Tort Claims Act alleging that the hospital “negligently deviated from reasonable and minimal standards of medical care by: (1) failing to prohibit Mrs. Wiscott from driving her motor vehicle, (2) failing to suggest alternate transportation for her, and (3) permitting Mrs. Wiscott to drive her motor vehicle.” Id. at 44.

In reaching a decision, the court distinguished between the duty to control a medicated patient and the duty to warn a heavily medicated patient of the perils involved in driving while heavily medicated. Respecting the duty to control, the court relied on section 319 of the Restatement (Second) of Torts, which states that “One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm.” Id. at 46. Because Mrs. Wiscott was a voluntary outpatient the court found that the hospital had not “take[n] charge” of her “within the meaning of Section 319,” and the hospital “had no right or ability to control her.” The court concluded that the hospital “owed no duty to unidentified third parties to control Mrs. Wiscott and prevent her from driving upon release.”

In Leavitt v. Brockton Hosp., Inc., 907 N.E.2d 213 (Mass. 2009), a police officer struck by a vehicle while responding to a separate, pedestrian-automobile accident sued a hospital for his injuries. The pedestrian was a patient of the hospital who was walking home at the time of the accident. The court held that “absent a special relationship with a person posing a risk, there is no duty to control another person’s con-
duct to prevent that person from causing harm to a third party.” *Id.* at 216. The court stated that it has “not previously recognized, and do(es) not now recognize, a duty to a third person of a medical professional to control a patient... arising from any claimed special relationship between the medical professional and the patient.” *Id.* at 217. After citing a laundry list of cases from other jurisdictions the court concluded that “[t]he hospital owed no duty to [the plaintiff] to control or detain the [pedestrian] patient.” *Id.* at 218.

In the words of one court, “A hospital is not an insurer of its patients against all injuries inflicted by themselves.” *Hoflander v. St. Catherine’s Hosp., Inc.*, 664 N.W.2d 545, 561–62 (Wis. 2003); *Sylvestor v. Nw. Hosp. of Minneapolis*, 53 N.W.2d 17, 19 (Minn. 1952); *Marvel v. County of Erie*, 307 A.D.2d 732 (N.Y. App. Div. 2003). Nor must it follow a nonexistent “requirement that [the patient’s] activities be monitored 24 hours per day.” *Marvel*, 307 A.D.2d at 734. And a “hospital is not required to take precautions for its patients’ safety such as will make it impractical for it to operate its business.” *Burns v. Forsyth County Hosp. Auth., Inc.*, 344 S.E.2d 839, 846 (N.C. Ct. App. 1986).

This is because “[r]equire a facility to be liable for any irrational behavior [by a patient] would impose an unreasonable burden on the [caregiver] and frustrate the objective of providing patients with a therapeutic environment free from prison-like restrictions.” *Hoflander*, 664 N.W.2d at 573.

Requiring a hospital or other medical facility to restrain an otherwise healthy patient from leaving its premises not only violates that patient’s rights as discussed above, but it also imposes an unreasonable burden on a medical facility to take precautions to protect the patient after the patient leaves the facility. Furthermore, if a hospital or other medical facility attempted to restrain a patient from leaving, it could face a claim for false imprisonment and additional liability from that claim.

So, how can a medical facility avoid liability in the event a patient leaves the facility and later tries to sue the facility arguing that it bears responsibility for something that happens after the patient leaves?

**Informed Consent Doctrine**

The informed consent doctrine prevents plaintiffs from claiming that health care providing facilities owe a duty to protect patients once they leave the premises. Justice Cardozo summarized this doctrine by stating that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.” *Cruzan by Cruzan v. Dir., Missouri Dept. of Health*, 497 U.S. 261, 269 (1990) (citing *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914). And this doctrine is “firmly entrenched in American tort law.” *Cruzan*, 497 U.S. at 269 (citing W. Keeton, D. Dobbs, R. Keeton, & D. Owen, *Prosser and Keeton on Law of Torts* §32, at 189–192 (5th ed. 1984); F. Rozovsky, *Consent to Treatment, A Practical Guide* 1–98 (2d ed. 1990)). Furthermore, "the logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." *Cruzan*, 497 U.S. at 270.

Under this theory, patients have the right to receive sufficient information about medical treatment to make informed decisions about their bodies and medical care, and they have the right to refuse that treatment if they disagree with it. Therefore, restraining a patient from actually leaving when he or she wants to leave, even if the patient may injure him- or herself, is effectively forced hospitalization. Even if no one performs a physical procedure on the patient during the detention someone could argue that a medical facility forcibly detaining a patient violated the patient’s right to refuse treatment, and the patient did not offer informed consent. Informed consent statutes, as with statutes governing a patient’s right to leave, are state-specific, and attorneys should review them before proceeding on this theory. See, e.g., Del. Code Ann. tit. 18, §6852 (West 2011) (“No recovery of damages based upon a lack of informed consent shall be allowed in any action for medical negligence unless:… (2) The injured party proved by a preponderance of evidence that the health care provider did not supply information regarding such treatment, procedure or surgery to the extent customarily given to patients, or other persons authorized to give consent for patients by other licensed health care providers in the same or similar field of medicine as the defendant.”); Haw. Rev. Stat. §671-3 (2011); Ind. Code Ann. §34-18-12-3 (West 2011) (“The explanation given in accordance with section 2(3) of this chapter must include the following information: (1) The general nature of the patient’s condition. (2) The proposed treatment, procedure, examination, or test”); Ky. Rev. Stat. Ann. §304.40-320 (West 2010); Neb. Rev. Stat. §44-2816 (2010) (“Failure to obtain informed consent shall include failure to obtain any express or implied consent for any operation, treatment, or procedure in a case in which a reasonably prudent health care provider in the community or similar communities would have obtained an express or implied consent for such operation, treatment, or procedure under similar circumstances.”); Neb. Rev. Stat. §44-2820 (2010); N.Y. Pub. Health Law §2805-d (McKinney 2011) (“Lack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical, dental or podiatric practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.”); N.C. Gen. Stat. Ann. §90-21.13 (West 2008); Or. Rev. Stat. Ann. §677.097 (West 2011); 40 Pa. Stat. Ann. §1303.504 (West 2011) (“Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient’s authorized representative prior to conducting the following procedures”); Tex. Civ. Prac. & Rem. Code Ann. §74.101, 74.104–74.106 (Vernon 2011).

As the right to refuse medical treatment and leave against medical advice is “the logical corollary of the doctrine of informed consent,” it follows that when a patient leaves a hospital against medical advice, the hospital must inform the patient of the risks associated with leaving. *Cruzan*, 497 U.S. at 270. Case law supports this approach: “The doctrine of informed consent provides that a patient has a right to be informed of the value and possible consequences of a treatment and to refuse or consent to that treatment.” *United States v. Charters*, 829 F.2d 479, 491 (4th Cir. 1987). The disclosures made by a physician in obtaining a patient’s informed consent must “enable a reasonable person under the same or similar circumstances...
When a patient leaves a hospital before completing treatment or against medical advice, that patient in effect exercises the right to refuse medical treatment.

A General Release Protects a Medical Facility

A hospital generally can avoid liability by executing a general liability release before a patient leaves the premises. Whether in the form of a stand-alone liability release or incorporated into an “against medical advice” (AMA) form, such a release from liability must be general in nature to avoid liability for self-inflicted harm or harm suffered once a patient leaves a hospital’s or other medical facility’s care.

A general liability release is “not restricted by its terms to particular claims or demands” and “ordinarily covers all claims and demands which have matured at the time of its execution and which were within the contemplation of the parties.” 76 C.J.S. Release §71 (2011). Unless specific terms are excepted from the release, a general liability release disposes of the entire subject matter involved. Id. As liability releases are contractual, they are “interpreted according to the general principles of contract construction.” Acstar Ins. Co. v. Harden, 16 F. App’x 213, 216 (4th Cir. 2001); see also Bell BCI Co. v. United States, 570 F.3d 1337, 1341 (Fed. Cir. 2009); PMX Indus., Inc. v. LEP Profit Int’l, 31 F.3d 701, 703 (8th Cir. 1994). And “[i]f the language is clear and unambiguous, a court should interpret the release according to its plain meaning.” Acstar, 16 F. App’x at 216; see also Raytheon Co. v. United States, 96 Fed. Cl. 548, 553 (Fed. Cl. 2011). If the terms are ambiguous, however, a trier of fact can use extrinsic or parol evidence to determine the meaning of a liability release. Id.

As noted, a general liability release has the benefit of encompassing all possible claims or demands. Therefore, separate liability releases or AMA forms are not required for each act undertaken by a patient, whether terminating treatment early or demanding to leave a facility. If a health care providing facility doesn’t keep the terms and scope general, it increases the risk of liability because its specific terms may not properly cover an injury that occurs after the execution of the liability release and requiring the facility to have a patient execute a release at every stage of treatment and discharge.

A properly executed liability release or AMA form not only bars patients from suing hospitals or other medical facilities for self-inflicted injuries or those suffered after leaving facilities against medical advice, but also in most circumstances bars their survivors from suing for wrongful death in the event that patients die after they leave against medical advice. How a court would interpret such a release in a case involving a negligence claim by a third party against to that in Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 352 (Cal. 1976), is beyond the scope of this article.

Release Survives Death to Prevent Survivor Wrongful Death Action

Traditionally, under common law “a tort victim’s cause of action was extinguished upon his or her death.” Schwarder v. United States, 974 F.2d 1118, 1129 (9th Cir. 1992) (citing Higgins v. Butcher, K.B. 1607, Yelv. 89, 80 Eng. Rep. 61). A separate cause of action did not exist for a decedent’s survivors for wrongful death under English common law, and that legal tradition became part of American common law. Id. (citing Baker v. Bolton, N.P. 1808, 1 Camp. 493, 170 Eng. Rep. 1033 and also citing Ins. Co. v. Brame, 95 U.S. (5 Otto) 754, 756, 24 L. Ed. 580 (1877) (“[A]t the common law no civil action lies for an injury which results in the death of the party injured.”)). A cause of action for damages was available only if a tort victim survived. This rule remained until 1846 when England passed the Fatal Accidents Act, also known as Lord Campbell’s Act. Id. This act created a rule establishing a separate tort cause of action for the survivors of decedents who died as the result of torts. Id. In the United States, rules similar to the one embodied in Lord Campbell’s Act were subsequently established through legislation to transform the effect of early English common law.

The rule adopted by the majority of courts in the United States today is that a wrongful death action is derivative of a decedent’s injury. See Schwarder, 974 F.2d at 1129; Restatement (Second) of Judgments §46 cmt. b (1982). Because the cause of action derives from a decedent’s injury the decedent’s survivors “can sue only if the decedent would still be in a position to sue.” Restatement (Second) of Judgments §46 cmt. b (1982). This means that “an action by the beneficiaries under the wrongful death statute is permitted only if the decedent had a claim at the time of his death.” Id.

As one court elaborated, “The wrongful death action for the benefit of survivors is, like other actions based on injuries to others, derivative in nature, arising out of and dependent upon the wrong done to the injured person and thus barred when his claim would be barred. [A] judgment for or against the decedent in an action for his injuries commenced during his lifetime, or the compromise and release of such an action, will operate as a bar to any subsequent suit founded upon his death.” Schwarder, 974 F.2d at 1129 (citing William Prosser & W. Page Keeton, Law of Torts $127 at 955).

Regardless of how a state classifies wrongful death by statute, as either derivative or substantive, statutory interpretation
principles govern the effect that a wrongful death act has on a survivor’s claim. For example, Missouri’s Wrongful Death Statute specifies that

[w]henever the death of a person results from any act, conduct, occurrence, transaction, or circumstance which, if death had not ensued, would have entitled such person to recover damages in respect thereof, the person or party who, or the corporation which, would have been liable if death had not ensued shall be liable in an action for damages, notwithstanding the death of the person injured, which damages may be sued for.

Mo. Rev. Stat. §537.080.1 (2011) (emphasis added). Missouri courts interpreting the state wrongful death statute found that it creates a new cause of action as opposed to a right transmitted to someone else or “survival right.” See O’Grady v. Brown, 654 S.W.2d 904, 910 (Mo. 1983); Smith v. Brown & Williamson Tobacco Corp., 275 S.W.3d 748, 765 (Mo. Ct. App. 2008). According to Missouri courts the statute “does not condition recovery upon the existence of a right to sue at either the time of the injury or the time of death.” O’Grady, 654 S.W.2d at 910. Instead, the cause of action under the statute “will lie whenever the person injured would have been entitled to recover from the defendant but for the fact that the injury resulted in death.” Id. at 910–11 (emphasis added). Under this construction, if a decedent executed a release before dying, his or her survivors could not sue a medical facility for wrongful death because if the decedent had survived, the release would have barred him or her from pursuing a cause of action.

If a hospital’s or another medical facility’s patients execute liability releases or releases incorporated into AMA forms before they die, a majority of court jurisdictions generally will interpret the releases as barring subsequent actions brought by their survivors for those acts contemplated by the releases. See generally Schwarder, 974 F.2d at 1129 (citing numerous cases in various jurisdictions for the proposition that “a judgment for or against the decedent in an action for his injuries commenced during his lifetime, or the compromise and release of such an action, will operate as a bar to any subsequent suit founded upon his death.”).

If a liability release or AMA form including a release is general, as discussed above, a hospital other medical facility using it has some protection from future claims. Therefore, this simple and cost-effective mechanism protects a hospital from potential claims for breaching the duty to protect, as well as from an alleged duty to restrain patients against their will from leaving and subsequently injuring themselves.

**Conclusion**

In spite of the clearly enunciated rules governing a hospital’s duty to protect patients while they are under the hospital’s control, hospitals and other health care providing facilities must take measures to prevent that duty from extending beyond the facility’s doors. To impose liability on a hospital or other health care providing facility to detain or restrain an otherwise healthy and competent patient from leaving its facility when the patient has clearly expressed the desire to leave not only imposes an undue burden on the health care provider but also expands traditional liability concepts. Hospitals and other health care providing facilities must proactively take action to thwart these far-fetched claims by having liability releases ready and making sure that patients sign them before they leave if they intend to leave.