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Notes

Express Contracts to Cure: The Nature of Contractual Malpractice

The term "malpractice"¹ is often used to refer to any cause of action arising from acts or omissions of a physician or surgeon. Properly, it is applicable only to cases of negligent or improper conduct and thus should serve as the foundation for actions in tort.² However, the term has also been applied to actions arising out of contract.³

Those courts which have addressed the issue have held that a physician and his patient have the same general liberty to enter into contracts as do other parties,⁴ and that breach of such a contract will give rise to a cause of action, irrespective of negligence on the part of the physician.⁵ Courts have stressed that the agreement to cure or ad-

¹ Malpractice has been defined as "[t]he treatment of a disease by a physician or surgeon in an unskilful manner, or in a manner contrary to accepted rules, causing injurious results to the patient." B. MALOY, *THE SIMPLIFIED MEDICAL DICTIONARY FOR LAWYERS* 460 (3d ed. 1960). For the purposes of this note, malpractice actions based on such conduct will be referred to as "negligent malpractice actions."

² Negligent malpractice actions are predicated upon a failure to exercise requisite medical skill and are tortious in nature. *Colvin v. Smith*, 276 App. Div. 9, 92 N.Y.S.2d 794 (1949). The traditional malpractice action is brought on a tort theory of breach of a legally imposed standard of diligence and skill derived from the doctor-patient relationship. *Whitesell v. Hill*, 101 Iowa 629, 70 N.W. 750 (1897), *discussed in* 5 U. CHI. L. REV. 156 (1937).

³ Actions arising from a physician's breach of an express contract to cure, administer treatment, or obtain a specified result are loosely referred to as "contractual malpractice actions."

Suits against physicians are not limited to one theory of recovery. *Cf.* FED. R. CIV. P. 8(e)(2), IND. TRIAL R. 8(E)(2). Thus it is not unusual to include both a "negligent malpractice" count and a "contractual malpractice" count in the same suit. *See, e.g., Guilmet v. Campbell*, 385 Mich. 57, 188 N.W.2d 601 (1971), where a physician was found not negligent yet liable on a contract count. *See also* notes 34-45 *infra* & text accompanying.

⁴ *Noel v. Proud*, 189 Kan. 6, 367 P.2d 61 (1961); *Phelps v. Donaldson*, 243 La. 1118, 150 So. 2d 35 (1963); *Alexander v. Alton Ochsner Medical Foundation*, 276 So. 2d 794 (La. App. 1973) (by implication); *Sullivan v. O'Connor*, 296 N.E.2d 183 (Mass. 1973); *Stewart v. Rudner*, 349 Mich. 459, 84 N.W.2d 816 (1957); *Robias v. Finestone*, 308 N.Y. 543, 129 N.E.2d 330 (1955); *Colvin v. Smith*, 276 App. Div. 9, 92 N.Y.S.2d 794 (1949); *Kernodle v. Elder*, 23 Okla. 743, 102 P. 138 (1909); *Brooks v. Herd*, 144 Wash. 173, 257 P. 238 (1927).

⁵ *Coon v. Vaughn*, 64 Ind. 89, 91 (1878):

In such a case, we do not think the negation of negligence on the part of the plaintiff is necessary. Indeed, the undertaking, though sounding in tort, is founded in contract—to do a certain thing upon a consideration—and the breaches are

minister a prescribed treatment must be express.⁶ In addition, the contract must be supported by consideration.⁷ In some instances, such agreements may even require consideration beyond that paid for the physician's normal services.⁸ This note will explore the theoretical bases of liability in contractual malpractice actions and suggest ways in which contract theory may be profitably employed in a malpractice setting. Specifically, this note will examine three issues which are present in all such cases and thus underlie the proper application of a contract approach: (1) enforceability of the contract, (2) proof of the contractual intent of the parties, and (3) the measure of liability for breach.

"Express contract" is used in this note to refer to a contract for a specific result, cure, or designated treatment. This is distinguished from an "implied contract" to exercise requisite skill and care.⁹ Express con-

alleged.

See also *Giambози v. Peters*, 127 Conn. 380, 16 A.2d 833 (1940); *Safian v. Aetna Life Ins. Co.*, 260 App. Div. 765, 24 N.Y.S.2d 92 (1940).

⁶ Because of the potential magnitude of liability and the ease of fabrication of claims, proof of the existence of the contract must be clear. See, e.g., *Sullivan v. O'Connor*, 296 N.E.2d 183 (Mass. 1973); *Hackworth v. Hart*, 474 S.W.2d 377 (Ky. 1971). See also cases cited in Annot., 43 A.L.R.3d 1221, 1230-33 (1972); *id.* (Supp. 1974). Many courts have stated that physicians do not warrant the results of their work, and that such agreements will not be implied. See *id.* In fact, it has been suggested that the requirement of an express agreement be given statutory embodiment. Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457, 1480 (1973) [hereinafter cited as *Contractual Aspects*]. But where an express contract is well pleaded, the availability of a parallel remedy in tort is no bar. See, e.g., *Staley v. Jameson*, 46 Ind. 159 (1874); see also note 3 *supra*. But cf. *Barnhoff v. Aldridge*, 327 Mo. 767, 38 S.W.2d 1029 (1931).

⁷ See Annot., 43 A.L.R.3d 1221, 1233 (1972).

⁸ *Rogala v. Silva*, 16 Ill. App. 3d 63, 305 N.E.2d 571 (1973); *Gault v. Sideman*, 42 Ill. App. 2d 96, 191 N.E.2d 436 (1963) (dictum); *Wilson v. Blair*, 65 Mont. 155, 211 P. 289 (1922). See generally 61 AM. JUR. 2d *Physicians, Surgeons and Other Healers* § 149 (1972). But cf. *Doerr v. Villate*, 74 Ill. App. 2d 332, 220 N.E.2d 767 (1966).

These cases deal with the formation of a bilateral contract formed through the exchange of a promise to pay for a promise (or guarantee) to cure, treat, etc. This situation is distinguished from the case of an implied warranty, where the patient's promise to pay the normal service fee is given in exchange for the physician's implied promise to treat with requisite skill and care. See note 9 *infra*. The distinction is perhaps best drawn by examining the concept of an "additional consideration" requirement for the physician's guarantee. This requirement presupposes a double transaction in contractual malpractice cases: (1) the exchange of a promise to pay a normal fee for the physician's promise (implied) to administer appropriate treatment with the requisite skill and care, and (2) a promise by the patient to give consideration above the normal fee in exchange for the express guarantee of cure by the physician.

⁹ It has been suggested that reference to this "implied" duty under a contract label creates confusion with respect to applicable statutes of limitation and the appropriate measure of damages. Accordingly, the contract theory should be abandoned insofar as it merely implies an agreement to exercise the standards of skill and care required by tort law. D. LOUISELL & H. WILLIAMS, 1 MEDICAL MALPRACTICE ¶ 8.03, at 199 (1973) [hereinafter cited as MEDICAL MALPRACTICE].

The Supreme Court of North Carolina has offered the terms "status" and "relation"

tracts generally fall into two categories: (1) contracts which provide that the physician will render a specified amount of service, in terms of time or a diagnostic or therapeutic objective, for a certain amount of money;¹⁰ and (2) contracts of a medical nature which provide that the physician will effect a cure, obtain a specified result, administer a prescribed treatment, or refrain from employing a certain procedure.¹¹

THE DIMENSIONS OF THE PROBLEM

The increasing volume of medical malpractice litigation in recent years has placed heavy burdens upon courts and the health professions.

Malpractice suits have increased by leaps and bounds in recent years, by about eight to ten percent per year. As every judge knows, they are difficult to try and have a sweeping effect on the medical profession and the public. Doctors become extremely cautious, hospitalize patients for minor matters, order unnecessary tests and X-rays and refuse to handle some cases at all. Further, insurance rates have increased . . . and inexperienced doctors cannot obtain coverage at all unless connected with a firm.¹²

Indeed, in the past few years many insurance companies have with-

to describe the relationship of the doctor and his patient:

While the law of contracts is applied as between a patient and his physician or surgeon, when a person consults a physician or surgeon, seeking treatment for a physical ailment, real or apparent, and the physician or surgeon agrees to accept him as a patient, it does not create a contract in the sense that term is ordinarily used. Usually there is no specification or particularization as to what the physician shall do. The patient selects, and commits himself to the care of, the doctor because he is confident the doctor possesses the requisite skill and ability to treat—and will treat—his physical ailment and restore him to normal good health. The physician, after diagnosing the ailment, prescribes the treatment or the medicine to be administered; but the patient is under no legal obligation to follow the physician's instructions. Thus it is apt and perhaps more exact to say it creates a status or relation rather than a contract.

Kennedy v. Parrott, 243 N.C. 355, 360, 90 S.E.2d 754, 757 (1956).

Where courts accept an implied contract theory, the standards of performance in contract are substantially the same as in tort. Compare W. PROSSER, HANDBOOK OF THE LAW OF TORTS 162 (4th ed. 1971), with RESTATEMENT OF CONTRACTS § 314, Illustration 7 (1932). At least 25 states have rules that such a malpractice action must be brought in tort and not in "implied" contract. Comment, *The Implied Contract Theory of Malpractice Recovery*, 6 WILLAMETTE L.J. 275, 278 n.22 (1970).

¹⁰ See, e.g., Klein v. Williams, 194 Miss. 699, 12 So. 2d 421 (1943) (contract to provide medical services for the employees of a mill). See also MEDICAL MALPRACTICE ¶ 8.10, at 225.

¹¹ See, e.g., Robins v. Finestone, 308 N.Y. 543, 127 N.E.2d 330 (1955) (defendant promised to cure plaintiff by a specific method, in a specific time); Stewart v. Rudner, 349 Mich. 459, 84 N.W.2d 816 (1957) (defendant contracted to perform a Caesarean section on the plaintiff and did not; child was stillborn). See also MEDICAL MALPRACTICE ¶ 8.10, at 225.

¹² Van Valkenburg, *Can Our Courts Be Saved?*, 50 MICH. ST. B.J. 75 (1971).

drawn altogether from the field of malpractice coverage.¹³

It can be predicted that the growing volume of malpractice litigation,¹⁴ coupled with the increasing difficulty of obtaining liability insurance,¹⁵ will give rise to a "toughening" of the tort standards of proof required in medical actions. Such a judicial reaction to the malpractice dilemma would make the contract action even more attractive, because breaches of contract are easier to prove than torts and because statutes of limitation for contracts often provide a longer period in which to bring suit than do statutes of limitation for torts.¹⁶

At present, however, the courts attempt to cope with the increasing

¹³ See STAFF OF SUBCOMM. ON EXECUTIVE REORG. OF THE SENATE COMM. ON GOV'T OPERATIONS, 91ST CONG., 1ST SESS., *MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN 2* (Comm. Print 1969).

¹⁴ In 1970, on an average working day, the 26 or so major malpractice insurance companies opened approximately 70 medical malpractice claim files, or about 18,000 files for the year. About 70 percent of these files, or about 12,600 annually, represent actual claims asserted by patients. U.S. DEP'T OF HEALTH, EDUCATION, & WELFARE, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 6 (1973) [hereinafter cited as COMMISSION REPORT].

¹⁵ See notes 13-14 *supra* & text accompanying. Furthermore, it appears reasonable to conclude that few insurers in the field will voluntarily undertake coverage of the physician's guarantees of results, even for much increased premiums, because the inherent risk is so unpredictable that rational rate setting is impossible. *Contractual Aspects, supra* note 6, at 1474-75.

¹⁶ See, e.g., *Conklin v. Draper*, 229 App. Div. 227, 241 N.Y.S. 529, *aff'd*, 254 N.Y. 620, 173 N.E. 892 (1930).

Absent an express contract the gravamen of the malpractice action is tortious. See cases cited note 2 *supra*.

It is true that usually a consensual relationship exists and the physician agrees impliedly to treat the patient in a proper manner. Thus, a malpractice suit is inextricably bound up with the idea of breach of implied contract. However, the patient-physician relationship, and the corresponding duty that is owed, is not one that is completely dependent upon a contract theory. . . . On principle then, we consider a malpractice action as tortious in nature whether the duty grows out of a contractual relation or has no origin in contract.

Kozan v. Comstock, 270 F.2d 839, 844-45 (5th Cir. 1959).

However some courts still allow actions brought under either a tort or a contract theory, even where no express agreement exists. Compare *Wolfe v. Virusky*, 306 F. Supp. 519 (S.D. Ga. 1969), *rev'd on other grounds*, 470 F.2d 831 (5th Cir. 1972), with *Billings v. Sisters of Mercy*, 86 Idaho 485, 389 P.2d 224 (1964).

The time for commencement of actions for negligent malpractice is often limited by special statutes, and a number of malpractice statutes limit the time during which the action may be commenced regardless of the label attached to the action (*i.e.*, contract or tort). See, e.g., CAL. CIV. PRO. CODE § 340.5 (West Supp. 1973) (four years, or one year after discovery, whichever occurs first); IND. ANN. STAT. § 34-4-19-1 (Code ed. 1973) (two years); MASS. GEN. LAWS ANN. ch. 260, § 4 (Supp. 1974) (three years). See D. HARNY, *MEDICAL MALPRACTICE 247-70* (1973). See also Note, *Medical Malpractice: A Survey of Statutes of Limitation*, 3 SUFFOLK U.L. REV. 597 (1969).

Nineteen jurisdictions now have limitation statutes expressly applicable to malpractice actions: Ala., Ark., Cal., Colo., Conn., Ill., Ind., Ky., Maine, Mass., Mich., Minn., Mo., Neb., N.H., N.Y., N.D., Ohio, S.D. *MEDICAL MALPRACTICE, supra* note 9, ¶ 13.01, at 363-64 (Supp. 1973).

volume by applying various legal doctrines. Unfortunately, they have applied these doctrines unevenly. The availability of the contract remedy¹⁷ is not alone responsible for the confusion. Traditional tort concepts, such as *res ipsa loquitur*, yield uneven results when applied to the medical arts.¹⁸ One possible solution would be to treat the field of malpractice as *sui generis*, generating its own rules of liability apart from traditional tort and contract notions.¹⁹ Yet, the application of

¹⁷ Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, in COMMISSION REPORT, Appendix 87, at 128-29, Table III-57, contains a tabulation of the frequency of application of key legal issues and doctrines in appellate malpractice decisions. Warranty/contract breach was found to be a key issue in 1.7% of the pre-1950 decisions examined. This increased to 2.0% for those decisions rendered between 1950 and 1960, and rose to 4.6% for the period 1961-1971. The average number of legal doctrines applied in each case varied between 2.04 and 2.16 for the three periods examined.

Similarly, warranty/contract breach was deemed significant to the outcome of malpractice appeals in 0.7% of the cases examined prior to 1950, 1.6% for the 1950-1960 period, and 2.7% for the period 1961-1971. *Id.* at 129-30, Table III-58.

¹⁸ "The Commission FINDS that some courts have applied certain legal doctrines for the purpose of creating or relieving the liability of health professionals. The Commission further FINDS that such special doctrines, or the application thereof, are no longer justified." COMMISSION REPORT at 31 (emphasis in original).

Among those legal doctrines which have been applied unevenly in malpractice actions the commission listed:

- (1) the doctrine of informed consent to treatment,
- (2) the discovery rule under the statute of limitations,
- (3) the terms of the statute of limitations,
- (4) the doctrine of *res ipsa loquitur*,
- (5) liability for breach of express contracts.

Perhaps the most important area of increasing litigation where legal doctrines have been abused to the detriment of the medical professions is the area of informed consent. Courts have imposed an affirmative duty of disclosure upon physicians, whether or not the patient has inquired as to specific risks. *See Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). The patient must be adequately informed of potential risks so that his consent to a given procedure can be an "effective" or "informed" one. *See* COMMISSION REPORT at 29-30.

¹⁹ A limited statutory plan for imposed arbitration has recently been enacted in New Hampshire for all liability claims against professionals (including lawyers), without regard to the amount of the claim. N.H. REV. STAT. ANN. ch. 519-A (Supp. 1973). The decision of the arbitrator is not final; it may be accepted or rejected by the parties, who may thereafter settle or sue.

In Philadelphia County and Allegheny County in Pennsylvania, the courts have instituted a rule requiring arbitration for all tort disputes involving less than \$10,000. Again the arbitration is not binding and either party may demand a court trial. COMMISSION REPORT at 92.

The *Commission Report* recommends more widespread use of imposed arbitration as an alternative method for resolving small malpractice disputes providing the arbitration mechanisms have certain characteristics and do not pre-empt contractual arbitration agreements. *Id.* at 93-94. *See generally id.*, Appendix, at 214-449 (five articles); Winiakoff, *Medical-Legal Screening Panels as an Alternative Approach to Medical Malpractice Claims*, 13 WM. & MARY L. REV. 695 (1972).

The advantages of arbitration, either by agreement or by statute, are that it (1) speeds handling of claims, (2) saves time of the parties, witnesses, and their legal counsel, (3) permits the use of sophisticated expert decisionmakers, (4) promotes informal proceedings in which the technical rules of evidence may be relaxed, (5) assures that

contract theory has not contributed to the confusion to an extent justifying the exemption of doctors from the common law of contracts.

THE DUAL NATURE OF THE CONTRACT ACTION

Various arguments have been offered against ever enforcing express agreements to cure, treat, or obtain a specified result. Some courts have concluded that such contracts retard the advancement of medical science and, as such, are contrary to public policy.²⁰ It has also been suggested that such contracts, if enforced, would foster the practice of "defensive medicine"²¹ and would discourage the physician from

the decision rendered is final with a very limited potential for appeal, (6) encourages a fact-finding procedure without the emotional overtones and adversary atmosphere of a courtroom.

Critics of arbitration claim that (1) arbitration will encourage small or nuisance claims, (2) a more sophisticated tribunal might place greater value on loss of income and pain and suffering than a jury would, (3) an arbitration procedure might lead to more compromise judgments rather than to clear decisions of fault or no-fault, (4) the nonpublic nature of the process avoids the pressure of publicity as a device for stimulating improvements in health-care practices. COMMISSION REPORT at 94.

Another proposal calls for implementation of a no-fault recovery system for medical injuries. See Roth and Rosenthal, *Non Fault Based Medical Injury Compensation Systems*, in COMMISSION REPORT, Appendix, at 450; Ehrenzweig, *Compulsory "Hospital-Accident" Insurance: A Needed First Step Toward the Displacement of Liability for "Medical Malpractice,"* 31 U. CHI. L. REV. 279 (1964).

Just as negligence actions would disappear under a strict liability, or no-fault recovery system, presumably the contract action would also be eliminated in part. If injured, the complainant would be required to show only that he was injured while receiving medical care, regardless of negligence or express contract on the part of the physician.

²⁰ This argument has most often been voiced with respect to contracts to perform, or warranties of, a sterilization. See Annot., 43 A.L.R.3d 1221, 1251 (1972). However it has been held in a variety of circumstances that such contracts are not, per se, unenforceable. See cases cited *id.* at 1252-55.

A more perplexing problem may be whether or not the court should allow the jury to find damages for breach where the patient is "blessed" by the birth of a normal and healthy child. Some courts have held that there are no damages due to the breach in cases of consequent birth of a normal child. *E.g.*, Christensen v. Thornby, 192 Minn. 123, 255 N.W. 620 (1934); Shaheen v. Knight, 11 Pa. D. & C.2d 41, 6 Lycoming Rptr. 19 (1957); Ball v. Mudge, 64 Wash. 2d 247, 391 P.2d 201 (1964). *But see* Custodio v. Bauer, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967). Another court has held that the birth of a normal child would not preclude recovery because the birth was not a factor vitiating liability but rather one which merely mitigates damages. Jackson v. Anderson, 230 So. 2d 503 (Fla. App. 1970).

An argument in favor of enforcing contracts to cure, which is applicable to sterilization cases, was presented by the court in McQuaid v. Michou, 85 N.H. 299, 157 A. 881 (1932):

[I]f the promise were held illegal, a patient ignorant of its illegality would be misled in placing reliance on it, while if he were aware of its lack of binding force, his knowledge would tend to prevent confidence in it and the gain of freedom of statement would be lost in its known irresponsibility. The proposed policy is not perceived to have any healing value sufficient to demand its adoption. *Id.* at 302-03, 157 A. at 883.

²¹ "Defensive medicine" refers to "the alteration of modes of medical practice, in-

reassuring the distraught and fearful patient. One judge has suggested that the enforcement of these contracts in the physician-patient context presumes that enforcement of like agreements is required in the context of other confidential relationships where such enforcement may work injustice.²² One may also argue that because medicine is an inexact and developing science, a cure is often impossible despite the most skillful efforts of the physician. It seems unwise to punish a physician where he has manifested no blameworthy conduct, particularly because actions based upon breach of contract are usually not covered by malpractice insurance.²³

duced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted." COMMISSION REPORT at 14 (emphasis in original).

The Commission Report further defined the two principal forms which defensive medicine may take:

Positive Defensive Medicine is the conducting of a test or performance of a diagnostic or therapeutic procedure which is not medically justified but is carried out primarily (if not solely) to prevent or defend against the threat of medical-legal liability.

Negative Defensive Medicine occurs when a physician does not perform a procedure or conduct a test because of the physician's fear of a later malpractice suit, even though the patient is likely to benefit from the test or procedure in question.

Id.

A third form of defensive medicine practice involves professional reluctance to publish case reports of adverse effects of diagnostic and therapeutic procedures for fear they will be used as evidence in a subsequent lawsuit. See generally Bernzweig, *Defensive Medicine*, in COMMISSION REPORT, Appendix, at 38-40; *Project—The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939; *Suing the Doctor: A Rising Problem*, 70 U.S. NEWS & WORLD REP. 70 (March 8, 1971); STAFF OF SUBCOMM. ON EXECUTIVE REORG. OF THE SENATE COMM. ON GOV'T OPERATIONS, 91ST CONG., 1ST SESS., MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN 2 (Comm. Print 1969).

²² See *Guilmet v. Campbell*, 385 Mich. 57, 188 N.W.2d 601 (1971) (Black, J., dissenting). A hypothetical situation presented by Justice Black concerns an indignant client who insists in court that his attorney promised, for consideration, a damage verdict and judgment for no less than a specified amount, or promised a decree saving client's home from foreclosure, or promised a successful contest of a well or a successful action against an insurer. *Id.* at 90, 188 N.W.2d at 617.

The most vexing case arises from a common situation in which an attorney recommends to his client that he not accept an offered settlement. The attorney will surely use optimistic words with respect to the results of subsequent negotiation or litigation, and if these words may be construed to be warranties of success, then the attorney may be liable for a subsequent breach of this "express contract." See *Sifers v. Horen*, 22 Mich. App. 351, 177 N.W.2d 189 (1970).

²³ Annot., 43 A.L.R.3d 1221, 1227 (1972). See *Safian v. Aetna Life Ins. Co.*, 260 App. Div. 765, 24 N.Y.S.2d 92 (1940), *aff'd*, 286 N.Y. 649, 36 N.E.2d 692 (1941); *Berman v. Aetna Life Ins. Co.*, 256 App. Div. 916, 10 N.Y.S.2d 800 (1939). Some policies cover the physician regardless of the theory of recovery. Letter from David R. Edwards, Counsel, Aetna Life and Casualty Co., to Gary L. Birnbaum, Aug. 19, 1974 (on file with the INDIANA LAW JOURNAL). Cf. *McGee v. United States Fidelity & Guar. Co.*, 53 F.2d 953 (1st Cir. 1931). The New York cases may be distinguished on the grounds that they

Notwithstanding these arguments, courts have recognized and enforced such contracts, although they often appear reluctant to allow recovery in the absence of clear proof that an express agreement actually has been made.²⁴ This reluctance may be based upon judicial recognition of the peculiar dual nature of contractual malpractice. An analysis of the spectrum of contractual malpractice cases will suggest that courts have been correct in enforcing such contracts. For analytic purposes, the extremes of this spectrum, in terms of similarity to commonplace bargaining situations, may be designated as "primary" and "secondary" cases. The primary-secondary form of analysis is employed, not because cases fit the extremes, but because the extreme cases illustrate the factors competing in the normal hybrid action.

The "Primary" Case

The "primary" case refers to a situation in which the patient is neither under a compulsion to obtain medical treatment, nor under a compulsion to seek the services of a particular physician. Thus, the physician employed, the time and place of the treatment, the costs, the specific guarantees, and any agreement to administer a prescribed treatment are all variables subject to negotiation between the patient and the doctor.

In this context an express contract would arise from the following hypothetical colloquy:

Patient: Doctor, I would like to have my nose shortened one inch.

Doctor: That shouldn't present any problem. It will cost \$1,000.

involved policies which prohibited the physician from entering into special contracts to cure.

A New York court has held that a physician is not covered for contractual liability by an insurance contract covering claims arising out of "malpractice, error or mistake." The court noted:

If a doctor makes a contract to effect a cure and fails to do so, he is liable for breach of contract even though he use the highest possible professional skill. Insurance of such a contract would protect only medical charlatans. The honorable member of the medical profession is more keenly conscious than the rest of us that medicine is not an exact science, and he undertakes only to give his best judgment and skill. He knows he cannot warrant a cure.

Safian v. Aetna Life Ins. Co., 260 App. Div. 765, 768, 24 N.Y.S.2d 92, 95 (1940). *Contra*, *Sutherland v. Fidelity & Cas. Co.*, 103 Wash. 583, 175 P. 187 (1918).

²⁴ See cases cited note 6 *supra*. See also cases cited in Miller, *The Contractual Liability of Physicians and Surgeons*, 1953 WASH. U.L.Q. 413, 416 n.16; and in Annot., 43 A.L.R.3d 1221, 1229-33, 1244-46 (1972).

Patient: I want you to promise that I will look just like this picture when you are finished.

Doctor: I really can't promise that.

Patient: I will give you \$2,000 if you guarantee the result.

Doctor: I accept.

Although this colloquy does not include all possible characteristics of a "primary" situation, it does serve to illustrate a situation closely approximating the "pure primary" case.

Reasons for enforcing an express agreement reached in this context may be suggested. Once the patient has made the decision to seek the services of a particular physician, the content and form of the agreement are predominantly in the control of the physician. To the extent that only the physician can assess the inherent risks, his own skills, the technologies available to his profession, and his ability to absorb the potential liability, he assumes a superior bargaining position. Based on his assessment of the situation (including the patient's ability to pay), the physician establishes a price for his services. At this point the patient, lacking the information available to the physician, can only accept or reject the offer.²⁵ The argument that enforcing an agreement made in this context fosters defensive medicine practices is not persuasive.²⁶

In reliance upon the promise of the physician, the patient has either postponed or forfeited the opportunity to seek professional assistance elsewhere. In return, the physician has promised to administer a

²⁵ It is a rare situation (perhaps where the patient is a physician) in which the perception of risks and knowledge of procedures and instrumentalities available is balanced between the parties.

²⁶ This conclusion follows from analysis of the definition of "defensive medicine" provided by the *Commission Report* at note 21 *supra*. Defensive medicine is a mode of medical practice itself induced by the threat of liability. It is predicated upon the physician's "pre-operative" attempt to establish a good defense in the case of a subsequent negligence action and upon the physician's inability to protect against all possible, and often unforeseeable, consequences of his work. See *id.*, *Positive Defensive Medicine*. These rationales have little force in the primary case where the threat of a subsequent negligent malpractice suit bears no relevance to the issue of enforceability of express contractual guaranties. The issue is merely breach of contract regardless of the cause of the breach. The problem of defensive medicine exists in the primary case only to the extent that it exists in any medical situation, *i.e.*, to encourage physicians to employ (or not employ) certain procedures as safety measures against subsequent negligence actions. The defensive medicine dilemma thus presents no support for the contention that contractual guaranties of cure should not be found or that they should not be enforced.

Furthermore, it must be remembered that the physician, in warranting good results, has contractually assumed the risk that some unforeseen complication will arise during the course of treatment, and he faces potential contractual liability for the consequences of such a complication even if he employs the highest degree of care.

specified treatment or to obtain a specified result. No public policy seems to be served by denying binding effect to express agreements made in this manner.²⁷

It has been suggested that the doctor be permitted to include an exculpatory clause in the agreement to obtain a specific result.²⁸ Such a clause might protect the interests of the charlatan rather than those of the skilled physician. Courts may find such clauses contrary to public policy and refuse to enforce them.²⁹

On the other hand the principles that allow physicians to enter into express contracts should also allow them to disclaim an express contract. It would be inconsistent for the law to prohibit physicians from disavowing contractual liability,³⁰ and there appears to be no policy reason why exculpation from liability under express warranties should not be permitted (although it is at least arguable that the superior bargaining position of the physician necessitates careful scrutiny of any such exculpatory provision). If the doctor has no contractual intent there is no justification for prohibiting him from so stating, in writing, so as to avoid misconstruction of subsequent words of therapeutic reassurance. Indeed *Guilmet v. Campbell*³¹ seems to require such exculpatory clauses in order to protect the interests of the medical profession.³² An analysis of *Guilmet* will illustrate the "bargaining" atmosphere in which an enforceable contract might arise.³³

²⁷ See Annot., 43 A.L.R.3d 1221, 1227 (1972).

²⁸ Miller, *supra* note 24, at 420. Miller's discussion concerns an agreement which would absolve the physician of any and all liability whether based on negligence or purported representation. This discussion seems too broad. The law with respect to exculpation from negligence in this context appears to be both firm and correct in denying enforcement of such clauses. See, e.g., *Tunkl v. Regents of Univ. of Cal.*, 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963).

²⁹ Cf. *Hales v. Raines*, 162 Mo. App. 46, 141 S.W. 917 (1911) The court held an exculpatory clause contrary to public policy where it sought to expunge liability for the physician's negligence. However, exculpation was allowed with respect to risks attending nonnegligent treatment, at least suggesting the possibility of relief from contract liability for injuries resulting despite the employment of due skill and care. *Id.* at 66-67, 141 S.W. at 923.

³⁰ *Contractual Aspects*, *supra* note 6, at 1475.

³¹ 385 Mich. 57, 188 N.W.2d 601 (1972), discussed *infra* notes 34-45 & text accompanying.

³² Professor Tierney suggests a disclaimer which might read as follows: "The physician gives no guarantee that the treatment recommended will cure the patient or improve his health, or that his health after treatment will be better than, or as good as, it was before." *Contractual Aspects* at 1478.

³³ The key question is still the intention of the parties, or, more precisely, the question may be the plaintiff's perception of the physician's intent. For example, in *Guilmet v. Campbell*, the doctor clearly did not intend to give a guarantee. See 385 Mich. at 70, 188 N.W.2d at 606. Modern contract theory, however, does not require subjective intent to bind the promisor. RESTATEMENT OF CONTRACTS § 20 (1932). Professor Tierney, in

The "Primary" Case in Practice

*Guilmet v. Campbell*³⁴ presents a fact situation which serves as an example of the "primary" case. In the fall of 1963 the plaintiff suffered nearly fatal bleeding through a peptic ulcer. In January 1964, he went to see the defendant surgeon, "curious about an operation, if I should have one, or if I shouldn't have one."³⁵ The surgeon never indicated that an operation was necessary. The defendant testified that prior to the operation the plaintiff was in excellent physical health and that the operation was not an emergency.³⁶ The plaintiff testified that in the course

his excellent article on the *Guilmet* case, notes that section 20 of the RESTATEMENT is qualified by section 71(c): "If either party knows that the other does not intend what his words or acts express, this knowledge prevents such words or other acts from being operative as an offer or an acceptance." *Contractual Aspects* at 1462 n.16. He questions whether a patient should know that the physician's words are not to be relied upon as a guarantee because no honorable physician warrants a cure. See note 23 *supra*. This view requires, of course, a priori acceptance of the proposition that no honorable physician warrants a cure. Whether or not this be the case, it may be preferable to say that in the primary case a physician *might* warrant a cure in exchange for additional compensation.

Professor Tierney concludes that even though section 71(c) requires actual knowledge on the part of the plaintiff, it is arguable that such knowledge should be imputed to the patient because, again, no reputable surgeon would warrant a cure in the light of the "common knowledge of the uncertainty which attends all surgical operations" *Hawkins v. McGee*, 84 N.H. 114, 116, 146 A. 641, 643 (1929).

The courts are generally very wary of interpreting words against the physician, basically because of the aspect of therapeutic reassurance. To look only at the mere words used by the physician and to ignore the surrounding circumstances behind the utterance is clearly a mistake. Thus in *Marvin v. Talbot* [216 Cal. App. 2d 383, 30 Cal. Rptr. 893 (1963)] the words "I will make a new man out of you" were held to be insufficient, while in *Bailey v. Harmon* [74 Colo. 390, 222 P. 393 (1924)] a promise to make the plaintiff "a model of harmonious perfection" was held to be a term of the contract."

Note, *Establishing the Contractual Liability of Physicians*, 7 U.C. DAVIS L. REV. 84, 97 (1974) (footnotes omitted).

Note also that in *Bria v. St. Joseph's Hosp.*, 153 Conn. 626, 220 A.2d 29 (1966), the physician said he would see that "whatever was necessary was done," *id.* at 629, 220 A.2d at 30, and the court held that this was not a warranty to personally guarantee that no unexpected or unusual consequences would result. *Id.* at 632, 220 A.2d at 32.

³⁴ 385 Mich. 57, 188 N.W.2d 601 (1971), *aff'g* 16 Mich. App. 322, 167 N.W.2d 79 (1969). A thorough and critical review of this case may be found in *Contractual Aspects*, *supra* note 6.

³⁵ 385 Mich. at 62, 188 N.W.2d at 603.

³⁶ *Id.* at 62, 188 N.W.2d at 603. The facts of this case have been simplified for analysis. When plaintiff suffered nearly fatal bleeding from his ulcer in 1963, he was being treated by a Dr. Klewicki. It was Dr. Klewicki who recommended the surgeons Kenneth N. Campbell and Joseph A. Arena, the defendants in the principal case. *Id.* at 61, 188 N.W.2d at 603.

For the purposes of this analysis the statements in the text are adopted from the majority opinion of Justice Kavanagh. In the actual case the situation may have more closely approximated an emergency situation than the "primary" case which the majority portrays. Justice Black, in an Addendum (June 21, 1971) to his unusually strong and pointed dissent, notes that when Dr. Campbell was summoned in December 1963, Mr. Guilmet was in or near *extremis* suffering from ulcerous internal bleeding which had sent him to the hospital in an unconscious state. Subsequently, at the hospital and then

of consultation, the physician made numerous references to the ease of the operation,³⁷ the lack of need for future medication,³⁸ and the postoperative health of the patient.³⁹ The physician contended that these were not words of guarantee or contractual intent.⁴⁰

On the day following the operation a specialist in thoracic surgery examined the plaintiff and diagnosed that a ruptured esophagus, due to surgical trauma, had resulted from the operation.⁴¹ Eventually the plaintiff endured three subsequent operations, the insertion of tubes to drain excess fluid, and hepatitis. These procedures resulted in bodily scars, an 82-pound weight loss, physical weakness, and other effects.⁴²

On these facts the trial judge submitted the case to the jury,⁴³ which

at home, the defendant was nursed slowly to that state of health which would permit the operation as recommended. At the time of the operation the plaintiff's stomach was found to be so diseased that 80 percent of it had to be removed. *Id.* at 95, 188 N.W.2d at 619 (Black, J., dissenting).

³⁷ According to the plaintiff's testimony, at the first consultation with the defendant the following conversation took place:

"Q. What was the conversation as you recall it?

"A. Well, he explained to me how they do this operation, and at that time he told me that him and his associate, Dr. Arena, were specialists, and *there was nothing to it at all. It was a very simple operation according to them.*"

Id. at 62, 188 N.W.2d at 603 (emphasis supplied by the court).

³⁸ "Q. What was the discussion about the future use of medication?

"A. Well, he said, '*after this operation, you can throw your pillbox away, your Maalox you can throw away,*' and then he come up with an example.

"Q. Give the example.

"A. The example was that '*In twenty years if you could figure out what you spent for Maalox pills and doctors [sic] calls, you could buy an awful lot. Weigh it against an operation.*'"

Id. at 63, 188 N.W.2d at 604 (emphasis supplied by the court).

³⁹ "A. . . . He told me, he said, '*Once you have an operation, it takes care of all your troubles,*' and he said, '*You can eat as you want to, you can drink as you want to, you can go as you please.*'"

385 Mich. at 62, 188 N.W.2d at 603.

"Q. Was there any discussion as to where it would take place, how long you'd be convalescing in the hospital?

"A. He said, '*Beaumont Hospital.*' I'd probably be in four to five days and *then I'd be off work maybe another two to three weeks.*"

Id. at 63, 188 N.W.2d at 603 (emphasis supplied by the court).

⁴⁰ The doctors' contention is at least partially supported by the leading case of *Hawkins v. McGee*, 84 N.H. 114, 115, 146 A. 641, 643 (1929), which held that "prediction as to the probable duration of the treatment and plaintiff's resulting disability, and the fact that these estimates were exceeded would impose no contractual liability upon the defendant." This principle would appear to cover the alleged statement by Dr. Campbell that Mr. Guilmet would be out of work "three to four weeks at the most." 385 Mich. at 68, 188 N.W.2d at 606. See *Contractual Aspects* at 1465-66.

⁴¹ 385 Mich. at 64, 188 N.W.2d at 604. Dr. Wood testified that the mortality rate from a ruptured esophagus is 50 to 75 percent.

⁴² *Id.* at 64, 188 N.W.2d at 604.

⁴³ The judge overruled a defense motion for a directed verdict and sent the case to the jury, stating in his ruling:

"Turning to the matter of contract, it is true the Plaintiff Richard Guilmet,

returned a verdict of "no negligence" on a tort count, but awarded the plaintiff \$50,000 for breach of contract. The Michigan Court of Appeals⁴⁴ and the Michigan Supreme Court⁴⁵ affirmed.

As in the conceptual "primary" case, the plaintiff in *Guilmet* was under no compulsion to proceed with the operation at any specific time or under the supervision of any one surgeon. Whether the contract to cure was actually offered and accepted was correctly deemed a matter for jury determination as it would be in any clearly commercial transaction.⁴⁶ In such a situation once a jury has determined the existence of an offer, acceptance, and breach, there is no reason why a contract should not be enforced and a damage remedy afforded the injured party.

The "Secondary" Case

Simply stated, the "secondary" case situation is an emergency situation. The patient is under an immediate compulsion to use a particular physician at a certain time, at a specified place, and at a designated price, without bargaining, for fear that delay might have serious consequences. As opposed to the "primary" case where the physician was free to set the terms of the contract and the patient was free to reject those terms, the "secondary" case lacks this "bargaining" atmosphere.

Furthermore, in an emergency situation the physician has a pro-

in his testimony, direct testimony, said that he talked with Dr. Campbell and Dr. Campbell said the operation would take care of all his troubles, and he could do as he pleased afterwards; that it was a simple operation, said that he performed it very often and he would be out of work four weeks and there was no danger.

"Now again, this Court would doubt whether those statements were all made, particularly after having listened to the Doctor, and while it is true that the Doctor is not required to guarantee his work, I suppose there is no reason why a medical doctor can't do that if he wishes, as well as any other person, so there is testimony here from which the Jury might reasonably infer that a contract was made to do these things as Mr. Guilmet testified

"Well, the record indicates, according to my notes that Plaintiff Richard Guilmet had a conversation with Dr. Campbell prior to the operation, . . . if this be the conversation and if the Jury accepts it, they would be in position to conclude that this Defendant Doctor had assured the plaintiff of the success of his operation, and having failed in that respect, they would be liable for damages."

Id. at 65-66, 188 N.W.2d at 604-05 (quoting the trial judge's instructions) (emphasis added by the supreme court).

⁴⁴ 16 Mich. App. 322, 167 N.W.2d 798 (1969).

⁴⁵ 385 Mich. 57, 188 N.W.2d 601 (1971).

⁴⁶ The qualitative distinction between a physician-patient relationship and that of a shopkeeper and his customer is significant, in the theoretical "primary" case, only to the extent that it is to be considered by the fact-finder in construing the words of the parties. *Guilmet v. Campbell*, 385 Mich. 57, 70, 188 N.W.2d 601, 607 (1971).

fessional obligation to aid the patient,⁴⁷ including therapeutic reassurance when it is required.⁴⁸ In addition, without prior examination, the physician may know little more about the illness than the disabled patient. He can not calculate the eventual costs of his services, nor can he make allowance for the possibility of postoperative legal actions.

Policy factors might now determine that, as a matter of law, a contract cannot arise in a purely "secondary" case. Although it has been argued that the line between a promise and an opinion is not "so narrow and shadowy" that the doctor is unable to choose one expression in clear distinction from another,⁴⁹ this line may indeed be too indistinct in an emergency situation. It may not be a simple matter for the doctor to make it clear to a suffering patient that he cannot guarantee good results.⁵⁰ Furthermore, psychological care and comfort may be instrumental in preparing the patient for the ordeal of emergency surgery.

⁴⁷ A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

W. CURRAN & E. SHAPIRO, *LAW, MEDICINE, AND FORENSIC SCIENCE* 524-25 (2d ed. 1970), quoting American Medical Association, *Principles of Medical Ethics*, Section 5.

⁴⁸ The essential factor here is *not* analysis, but *results*, *i.e.* helping the patient. To help the patient, the object is first to relieve his symptoms, to make him comfortable again, to restore his sense of well-being. This is an empirical approach, to use the philosophers' concept. And the truth is that very often in medicine this is all that the physician can accomplish even when he is sure of his diagnosis. There aren't as many outright "cures" in medicine as lay people imagine.

W. CURRAN & E. SHAPIRO, *supra* note 47, at 67.

⁴⁹ Argument is advanced that contracts to cure are against public policy. The reason suggested is that their enforcement tends to dissuade a doctor from encouraging his patients and giving them hope as an important aid to their improvement or recovery, in the fear that his words will be taken as a promise. The line between a promise and an opinion is not so narrow and shadowy that language may not be well chosen to express one in clear distinction from the other, and it is a simple matter for a doctor to make it definite that he guarantees no good results.

McQuaid v. Michou, 85 N.H. 299, 302, 157 A. 881, 883 (1932).

⁵⁰ Despite the statement of some courts that the two are quite distinct, there appears to be a "gray area" where a statement could be deemed to be either a contract or a mere reassurance. This is further complicated by the fact that in many cases the doctor is the only person present at the time, other than those intimately concerned with the patient's health by reason of family ties. Such persons could easily, through honest error brought about by the extreme circumstances and emotions involved, import more meaning to the physician's statements than they actually carry; furthermore, there is in such circumstances a strong possibility of error in the recollection, by either party, of the actual statements made.

Annot., 43 A.L.R.3d 1221, 1226-27 (1972); *cf.* Bailey v. Harmon, 74 Colo. 390, 222 P. 393 (1924) (plastic surgeon promised to make his patient "a model of harmonious perfection").

Indeed, therapeutic reassurance may be of such psychological value that it actually increases the probability of cure.⁵¹ These factors which militate against finding contractual agreements may best be illustrated by analysis of a "secondary" fact situation.

The "Secondary" Case in Practice

The "secondary" case can be illustrated by hypothesizing a set of facts similar to those in *Guilmet*.⁵² Assume that one evening the patient began to suffer massive internal bleeding caused by a peptic ulcer. He was rushed to the hospital where he was met by his physician who informed him that an immediate operation was necessary. As in *Guilmet*, the patient inquired about the possibility of recovery and the doctor responded that after the operation "you can throw away your pillbox," "it's a simple operation," and "you'll be out of work two to three weeks at most." The patient thus gave his permission to proceed and the physician performed the required operation. Complications arose despite the skill of the surgeon, and the patient eventually brought an action for alleged breach of an express agreement to cure. To hold the physician, in this context, contractually liable for words which might be construed as no more than therapeutic reassurance is to discourage the physician from comforting the distraught and fearful patient and from accepting cases where cure is improbable, for fear that some utterance in the course of therapy might be construed as a guarantee of cure. It has been argued that many operations which might save lives will not be performed, either because of professional wariness or because of the inability of the surgeon to mentally prepare his apprehensive patient for making an affirmative decision.⁵³

If a court can determine that a set of facts constitutes a "secondary" case, the parties' words should not be construed as words of contract. Few if any cases, however, can be clearly categorized as "primary" or "secondary." Thus, the law must seek a means to reconcile those factors which favor the finding of contracts in "primary" situations and those which militate against finding such agreements in "secondary" situations. This can be accomplished through the introduction of a corroborative evidence rule.⁵⁴

⁵¹ See generally Cannon, "Voodoo" Death, 44 AM. ANTHRO. (N.S.) 169, 180 (1942).

⁵² *Guilmet v. Campbell*, 385 Mich. 57, 188 N.W.2d 601 (1971), discussed *supra* notes 34-45 & text accompanying.

⁵³ *Id.* at 89, 188 N.W.2d at 616 (Black, J., dissenting).

⁵⁴ This rule might be adopted by the courts as a rule of procedure, or by the legislature as a substantive requirement of the cause of action, in response to the growing burden of malpractice litigation.

A PROPOSAL: A CORROBORATIVE EVIDENCE RULE

Under present procedures the existence of an express contract to cure is a question of fact. Determination of this issue is left to the jury which usually must rely solely upon its appraisal of the credibility of the parties. It is possible that allowing the jury to determine the existence of a contract in all circumstances permits a large number of plaintiffs' verdicts where policy seems to demand otherwise.⁵⁵ In addition, jury bias may serve to inflate damage awards.⁵⁶

In cases of high "secondary" character the law must be ready to protect the interests of the physician. In "primary" cases the laws must recognize the right of the parties to contract freely. Note, however, that with the possible exceptions of cosmetic surgery, dental work and sterilization, there are virtually no medical agreements to cure which can be classified as derivatives of "primary" bargaining situations. One court which sought to balance these factors noted:

These questions involve not only an interpretation of legal history, but a balancing of the legal policies of protecting the public in its dealings with the medical practitioner, and of protecting the practitioner in the pursuit of his highly essential profession from the fraudulent minded.⁵⁷

This balancing process may be accomplished in a variety of ways: (1) the courts could refuse to find contractual intent on the part of the physician and thereby refuse to enforce any alleged agreement; (2) the

⁵⁵ But see H. KALVEN & H. ZEISEL, *THE AMERICAN JURY* 64 (1966). In the personal injury cases examined, Kalven and Zeisel found jury verdicts for plaintiffs in 56 percent of the cases studied. Significantly, however, the judge-jury disagreement was distributed evenly in two directions. In 12 percent of the cases it was the jury which was more favorable to the plaintiff and in 10 percent of the cases the judge viewed the plaintiff's case more favorably. Nevertheless it is difficult to extrapolate these results into the area of malpractice, where, in addition to the obvious injury to the plaintiff, the jury is bound to be influenced by the commonly known existence of medical liability insurance, and by the apparent breach, by the defendant, of a special, professional, fiduciary relationship which existed between the parties.

⁵⁶ See, e.g., *Atlantic Coast Line R.R. Co. v. Withers*, 192 Va. 493, 510, 65 S.E.2d 654, 663 (1951), where the court quoted from an earlier Virginia decision: "The settled rule is that . . . there is no legal measure of damages in cases involving personal injuries. . . ."

"[T]he cardinal premise of common law personal injury damages is that they be not limited by schedule but be computed de novo for each individual case. There is in brief no standard man, no reasonable man afoot in the law of damages. . . . [T]he jury is of necessity left free to price the harm on a case by case basis." Kalven, *The Jury, the Law, and the Personal Injury Damage Award*, 19 OHIO ST. L.J. 158, 160 (1958) (footnotes omitted). See generally Jaffe, *Damages for Personal Injury: The Impact of Insurance*, 18 LAW & CONTEMP. PROB. 219 (1953).

⁵⁷ *Zostautas v. St. Anthony DePadua Hosp.*, 23 Ill. 2d 326, 328, 178 N.E.2d 303, 304 (1961).

legislature could draft a statute requiring all such agreements to be in writing;⁵⁸ or (3) the courts could require an additional consideration, above the physician's fee, in exchange for the promise to cure.⁵⁹

However, to implement any of these proposals would be to give undue weight to the policy of protecting physicians at the expense of the policy of "freedom of contract." The patient's cause of action would be either prohibited altogether or restricted to situations in which the patient can produce written documentation of the agreement.

A possible resolution of these competing policies rests on procedural compromise. The physician must be able to accept the improbable-cure case, to psychologically prepare his patient for affirmative decision-making, and to cater to the emotional needs of the distraught and fearful patient without fear of subsequent legal action. On the other hand there is no apparent reason why contracts to cure cannot be made. The patient must retain the right to enforce such agreements upon breach by the physician. Both of these interests can be protected through a rule which places a heavier evidentiary burden on the patient.⁶⁰

This burden would require the plaintiff to produce some evidence corroborating the existence of the contract, such as a writing, proof of additional consideration, or testimony of witnesses relating to the formation of the contract. Plaintiff's testimony alone would be insufficient. Failure to meet this burden would result in a directed verdict for the physician.

It must be conceded, however, that the suggested approach sacrifices the reliance interest of the patient in order to protect the medical profession. Normally, where the defendant has made a promise on which the plaintiff has relied to his detriment, the defendant may be estopped from denying the enforceability of his promise. The plaintiff may thus sue on the promise, even in the absence of consideration. Thus the action of the plaintiff may be said to flow from his reliance interest

⁵⁸ In his discussion of the *Guilmet* case, Professor Tierney concludes that as long as decisions like *Guilmet* stand, physicians will have ample incentive to enter defensive written agreements with their patients. *Contractual Aspects*, *supra* note 6, at 1479. See also note 32 *supra*. He suggests that perhaps the time has come for state legislatures to review the rights and duties of professionals and those who deal with them, and to ensure by statute that a professional will be held to have warranted a particular result only on the clearest proof. *Contractual Aspects* at 1480. The rule suggested herein can be viewed simply as a proposed definition of what constitutes "clearest proof" under Professor Tierney's statute.

⁵⁹ See note 8 *supra*; cf. Jaffe, *supra* note 56, at 224.

⁶⁰ At present the patient need only contend the words of the physician constituted words of contract and that he was "damaged" by breach of the contract. The jury then balances this contention with the physician's denial of contractual intent. See text accompanying notes 34-45 *supra*.

in the promise. Policy seems to require the sacrifice of this interest in contractual malpractice cases.

Protection of the reliance interest would allow any patient who has suffered nonnegligent injury to claim that the words of the physician constituted a guarantee of successful treatment. Subsequent reliance upon the alleged promise would then be sufficient to send the question of contract to the jury.

Admittedly, the proposed corroborative evidence rule presents some significant opportunity for fraud on the part of the patient. In fact, opportunity for fraud exists in the trial of most negligence actions, and it is unfair to presume that most contractual malpractice actions are brought by other than honest people angered by the failure of treatment. In addition, it must be remembered that the corroborative proof serves merely to get the plaintiff's cause of action past the judge, and that a jury is sure to view with suspicion the corroboration of an oral agreement by a spouse or close relative.⁶¹

Another problem arising from application of this rule is that it may prevent actions against charlatans where there is no proof of an agreement other than the testimony of the plaintiff. However, alternative remedies exist in such cases.⁶² In addition, a rule awarding punitive damages for deliberate misrepresentation might also be adopted.⁶³

Despite these problems, the corroborative evidence rule presents the benefits of (1) permitting the patient and physician to contract freely, (2) protecting society's interests in a responsive and responsible medical profession, while (3) maintaining the patients' cause of action against unethical medical practitioners.

To summarize, contractual malpractice cases may be analytically classified as "primary" or "secondary." This classification is defined by the "bargaining" atmosphere in which the alleged contract arises. It

⁶¹ A similar proposal is made in Note, *Establishing the Contractual Liability of Physicians*, 7 U.C. DAVIS L. REV. 84 (1974), which presents an excellent compilation and discussion of all cases which have been decided on a contract basis. The notewriter suggests one solution, which has been employed by some courts, in allowing recovery only on the express terms of the contract, e.g., where specific words such as "guarantee" or "cure" are used in the contract. (The note, however, seems to ignore the fact that most contracts are oral, and a determination of just what was spoken is often the dispositive question of fact.) The utterance of one word, "cure," is often sufficient to get the case to trial, but it is not clear whether or not it is sufficient to assure liability. See, e.g., *Burns v. Barenfield*, 84 Ind. 43 (1882). See also cases cited 7 U.C. DAVIS L. REV. 84, 97 n.52 (1974).

⁶² Among those theories which might be employed in particular situations are fraud, misrepresentation, or deceit. The theory of battery could also be employed, since the consent of the patient to the touching would be vitiated by the misrepresentation.

⁶³ See *Miller*, *supra* note 24, at 428 n.61.

must be remembered that the usual case is a hybrid, not fitting either of the defined classifications clearly. In order to deal with such cases the law must balance the parties' right to contract freely with the public's interest in maintaining the integrity of the medical profession. This may be accomplished through the introduction of a corroborative evidence rule which imposes a heavier burden on the patient-plaintiff's ability to reach the jury.

Once the existence of a contract has been established an appropriate damage standard must be applied. The determination of what standard to apply, and whether the resultant damage award should include compensation for pain and suffering, has not been uniformly resolved.

THE MEASURE OF DAMAGES

No single rule of damages is applicable in all contractual malpractice cases. It is the function of the court to weigh the freedom of contract factors which support an argument for a "benefit of the bargain" damage measure against those policy factors which favor limiting the physician's liability. The court has at its discretion reliance⁶⁴ and expectancy⁶⁵ measures, the application of which depends upon the facts of each case.

The Expectancy Measure

Contract law generally seeks to place the injured party in as good a position as he would have assumed upon full performance of the contract.⁶⁶ This includes compensation for any consequential damages

⁶⁴ The reliance "measure" is to be distinguished from predicated recovery on a reliance "interest" theory. The reliance measure is simply a means to limit damages by not awarding compensation for the lost expectancy of the plaintiff. Losses are restricted to expenditures made in reliance upon the promise.

The reliance interest is a rationale for awarding damages where the plaintiff has changed his position in reliance upon the defendant's promise. The reliance interest may of course be protected by granting reliance measure damages which are designed to place the plaintiff in as good a position as he was in before the promise was made, but not to compensate the plaintiff for lost expectation. Recovery based on a reliance interest theory, however, need not be limited to reliance measure damages.

⁶⁵ Fuller and Perdue define expectation interest in terms of the value of the expectancy created by the promise:

[W]ithout insisting on reliance by the promisee or enrichment of the promisor, we may seek to give the promisee the value of the expectancy which the promise created. We may in a suit for specific performance actually compel the defendant to render the promised performance to the plaintiff, or, in a suit for damages, we may make the defendant pay the money value of this performance. Here our object is to put the plaintiff in as good a position as he would have occupied had the defendant performed his promise.

Fuller & Perdue, *The Reliance Interest in Contract Damages*, 46 *YALE L.J.* 52, 54 (1936).

⁶⁶ *RESTATEMENT OF CONTRACTS* § 329 & comment *a* (1932).

which were reasonably foreseeable at the time the contract was made.⁶⁷ This measure is designed to protect the expectancy interest of the plaintiff. Thus, in *Hawkins v. McGee*,⁶⁸ a leading case in which a physician promised to convert a damaged hand into a perfect one through use of a skin grafting process, the Supreme Court of New Hampshire held that the measure of damage was the difference between the value of the perfect hand as promised and the value of the damaged hand after the operation.⁶⁹

One writer has noted that the expectancy standard is based on commercial considerations, which are foreign to the physician-patient relationship and that such a standard runs counter to the psychological and economic bases of the patient's complaint.⁷⁰ At the same time this compensatory standard imposes an inordinately severe penalty upon a blameless physician and, in essence, leaves the precise determination of damages to the strained imagination of the fact-finder. Hypothetical application of the expectancy measure, for example, to a case where the physician allegedly promised to cure a disease which was eventually determined to be an incurable cancer, illustrates the severity of the expectancy measure.⁷¹ However, the possibility of encountering an incur-

⁶⁷ *Hadley v. Baxendale*, 9 Ex. 341, 156 Eng. Rep. 145 (1854); RESTATEMENT OF CONTRACTS § 330 (1932).

⁶⁸ 84 N.H. 114, 146 A. 641 (1929).

⁶⁹ *Id.* at 118, 146 A. at 644 (1929). A nonsuit was ordered on a negligence count without exception and the action was brought in assumpsit.

Hawkins is the leading case on contractual malpractice. *Contractual Aspects*, *supra* note 6, at 1463. The case is reproduced in a number of casebooks on the law of contracts, e.g., M. FREEDMAN, CONTRACTS 8-11 (1973); L. FULLER & M. EISENBERG, BASIC CONTRACT LAW 1-4 (3d ed. 1972); F. KESSLER & G. GILMORE, CONTRACTS 111-13 (2d ed. 1970); I. MACNEIL, CASES AND MATERIALS ON CONTRACTS 14-17 (1971).

⁷⁰ Miller, *supra* note 24, at 424-26.

⁷¹ Miller states:

One might well speculate as to what would be the award of damages under a similar rule where a physician promised to cure his patient of a disease which later turned out to be incurable cancer. Ostensibly the jury would be charged that the measure of damages would be the difference between a healthy patient as promised and one in the plaintiff's present pathetic condition. It must be borne in mind that even the highest degree of skill and care displayed by the defendant in his treatment of the plaintiff would have no bearing in the ultimate result as long as he failed to fulfill his promise, nor even, as mentioned previously, would the fact that defendant believed at the time that the condition was incurable.

Id. at 426-27 (footnote omitted). It has been suggested that the physician might decide to defend such an action on either of two bases: (1) the contract was void from the outset due to impossibility of performance, or (2) that the contract was voidable due to mistake. *Id.* at 427 n.55.

Miller concludes that the physician could not escape liability on either ground. With reference to the first proposition, the physician has had the opportunity to examine the patient and when he undertakes to effect a cure, he necessarily undertakes the risk of complications. Similarly, liability could not be escaped on the basis of mistake since the

able disease is a bargained-for risk, and the physician would, presumably, set his fee accordingly during the course of negotiation. There is ample authority to support the view that parties may bind themselves to what is, in fact, impossible. "It is only where the promisor has no reason to know of the facts to which the impossibility is due, and where he does not agree to bear the risk of their existence, that the formation of a contract is prevented."⁷²

Despite the flaws of the expectancy measure in the medical context, the logic of recognizing the contractual malpractice action seems to require the application of the normal contract standard.

The Reliance Measure

New York courts have been the most consistent in applying a reliance measure.⁷³ Damages are restricted to payments made to the physician, expenditures made for nurses and prescribed medication, and "other damages that flow from the breach."⁷⁴

Fuller and Perdue suggest that there are certain impulses which cause judges to seek alternatives to the expectancy damage measure. They further suggest that the following four considerations are concealed in the objection that damages calculated under the expectancy standard are too "uncertain":

- (1) a desire not to broaden unduly the liability of a defaulter by making "remote" injuries compensable;
- (2) a desire not to impose on the defendant a liability felt to be disproportionate to the gains which he stood to make from the contract;
- (3) a desire to restrict the liability imposed on the "innocent" defaulter in comparison

mistake involved would be unilateral in nature; therefore the transaction is not made voidable. *Id.* at 427 n.55 (citing RESTATEMENT OF CONTRACTS § 503 (1932)).

⁷² RESTATEMENT OF CONTRACTS § 456 comment c (1932) states: "Parties deal with reference to unknown existing factors in the same way they do with supervening events, and so does the law." *Id.* at 847-48.

⁷³ See, e.g., *Robins v. Finestone*, 308 N.Y. 543, 127 N.E.2d 330 (1955); *Colvin v. Smith*, 276 App. Div. 9, 92 N.Y.S.2d 794 (1949); *Frank v. Maliniak*, 232 App. Div. 278, 249 N.Y.S. 514 (1931); *Monahan v. Devinny*, 223 App. Div. 547, 229 N.Y.S. 60 (1928); *Frankel v. Wolper*, 181 App. Div. 485, 169 N.Y.S. 15, *aff'd*, 223 N.Y. 582, 127 N.E. 913 (1918); see also *Zostautas v. St. Anthony DePadua Hosp.*, 23 Ill. 2d 326, 178 N.E.2d 303 (1961).

⁷⁴ The phrase "other damages that flow from the breach thereof" is generally stated without further explanation. *Robins v. Finestone*, 308 N.Y. 543, 546, 127 N.E.2d 330, 332 (1955); *Colvin v. Smith*, 276 App. Div. 9, 10, 92 N.Y.S.2d 794, 795 (1949).

In New York, recovery for pain and suffering is proper only in tort actions for negligent malpractice. See *Budoff v. Kessler*, 2 App. Div. 2d 760, 153 N.Y.S.2d 654 (1956); and cases cited note 73 *supra*. *Accord*, *Harrod v. Bisson*, 48 Ind. App. 549, 93 N.E. 1093 (1911); *Carpenter v. Moore*, 51 Wash. 2d 795, 322 P.2d 125 (1958). *Contra*, *Stewart v. Rudner*, 349 Mich. 459, 84 N.W.2d 816 (1957).

with that imposed on the "wilful" defaulter; (4) a desire for an easily administered rule.⁷⁵

They conclude, albeit in a different context,⁷⁶ that, although reliance losses are not immune to the objection of "remoteness," such losses make a stronger appeal to judicial sympathy than a claim for lost profits.⁷⁷ Thus, the objection of "remoteness" is applied less strictly to reliance losses.⁷⁸

It might be suggested that, in the context of medical contracts, these four considerations deserve especially great weight because certain injuries may always be considered "remote" and because of the apparent "noncommercial" character of the contract. However, if applied only in the medical context, this analysis seems to ignore the underlying rationale for allowing the contract action at all. The "primary" case⁷⁹ demonstrates that the contract action is not devoid of "commercial" aspects, and, were it not for the presence of these "commercial" aspects, the law might well be persuaded by counterbalancing policies not to enforce such agreements at all.

Use of the reliance measure suggests that no compensable damages arise from breach by nonperformance. But, in a psychological sense, the patient who contracts for a cure or treatment and then witnesses breach of this agreement by his physician suffers the loss of being "deprived" of the promised cure. The impact of this may be greater than that upon the merchant whose lost profits are protected by expectancy damages.

Fuller and Perdue list numerous reasons why the law should protect the expectation interest.⁸⁰ The most persuasive in the case of an agreement to cure is one which may be labeled "psychological."

Whether or not he has actually changed his position because of the

⁷⁵ Fuller & Perdue, *supra* note 65, at 376.

⁷⁶ Fuller and Perdue suggest that the objection that the expectancy measure is too conjectural arises in two situations: (1) where the contract relates to subject matter of uncertain value, that is, having no "market," or, (2) where the plaintiff seeks to recover business profits which were indirectly prevented by the defendant's default. The first set of cases, they note, has resulted in a special measure of damages where the value of expectancy is too uncertain to safely be measured in monetary terms, *e.g.*, adoption contracts and contracts to sell land. Thus the discussion of judicial factors favoring a reliance measure is employed primarily with respect to the discussion of lost profits. *See* text accompanying note 65 *supra*. Nevertheless, the factors enumerated present a persuasive rationale for the employment of special reliance measures in contractual malpractice situations. Fuller & Perdue, *supra* note 65, at 373-74.

⁷⁷ In the context of this note, this may be read as "lost cure."

⁷⁸ Fuller & Perdue, *supra* note 65, at 377.

⁷⁹ *See* text accompanying notes 34-45 *supra*.

⁸⁰ Fuller & Perdue, *supra* note 65, at 57-66.

promise, the promisee has formed an attitude of expectancy such that breach of the promise causes him to feel that he has been "deprived" of something which was "his."⁸¹

Surely this expectation takes on added significance where the patient has bargained for a personal, physical benefit.

Since the choice of a damage measure is influenced by competing factors, it would seem best to leave the determination of the appropriate damage measure to the court.⁸²

In the medical context, the peculiar facts and circumstances of each case make judicial discretion preferable to the application of a rigid rule. However, neither the adoption of a reliance nor an expectancy measure determines whether recovery for pain and suffering in a contract action will be allowed. It may be contended that liability for pain and suffering which "results" from the breach was an element of the agreement to which the physician voluntarily assented. As such, once the existence of a contract is proven and breach is established, the physician should be held liable for all injuries proximately caused by the breach, including damages for pain and suffering.

PAIN AND SUFFERING UNDER CONTRACTS TO CURE

The law has always been cautious in allowing damages for mental suffering and emotional distress.⁸³ The suffering of one person, under

⁸¹ *Id.* at 57.

⁸² Compare, e.g., *Robins v. Finestone*, 308 N.Y. 543, 127 N.E.2d 330 (1955), and cases cited note 73 *supra* (reliance standard), with, e.g., *Hawkins v. McGee*, 84 N.H. 114, 146 A. 641 (1929), and *McQuaid v. Michou*, 85 N.H. 299, 157 A. 881 (1932) (expectancy standard).

In cases of breach of contracts to sterilize, where such an action is maintainable, see note 20 *supra*, the reliance and expectancy measures would tend to equate. Both the condition "promised" and the status quo ante position relate to preservation of the family unit without the addition of another child. *Sullivan v. O'Connor*, 296 N.E.2d 183, 189 n.6 (Mass. 1973). See *Custodio v. Bauer*, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967); *Jackson v. Anderson*, 230 So. 2d 503 (Fla. App. 1970); cf. *Troppe v. Scarf*, 31 Mich. App. 240, 187 N.W.2d 511 (1971).

⁸³ But there is clearly a marked trend toward recovery, see W. PROSSER, HANDBOOK OF THE LAW OF TORTS, 327-28 (4th ed. 1971). The objections to damages for emotional disturbance, applicable to both actions in tort and in contract, have been thoroughly overruled in recent years. Some jurisdictions recognize the right to such recovery only in tort actions. See cases cited note 73 *supra* (New York); see also 45 N.Y. JUR. §§ 136, 159, 178 (1973). And there are authorities that state that such damages are foreign to all actions for breach of contract. *Conklin v. Draper*, 229 App. Div. 227, 241 N.Y.S. 529, *aff'd without opinion*, 254 N.Y. 620, 173 N.E. 892 (1930); *Monahan v. Devinny*, 223 App. Div. 547, 229 N.Y.S. 60 (1928); *Frankel v. Wolper*, 181 App. Div. 485, 169 N.Y.S. 15 (1918); *Frechette v. Ravn*, 145 Wis. 589, 130 N.W. 453 (1911). See generally 11 W. JAEGER, [S. WILLISTON,] A TREATISE ON THE LAW OF CONTRACTS (3d ed. 1968) § 1341.

Essentially the argument is based on the foreseeability rule of *Hadley v. Baxendale*, 9 Ex. 341, 156 Eng. Rep. 145 (1854). RESTATEMENT OF CONTRACTS § 330 (1932). A buyer of merchandise suing the seller for breach and claiming damages for disappoint-

precisely the same circumstances, would be no test for the suffering of another.⁸⁴ There is no true standard by which such injury can be measured. Yet the law has come to realize that it must protect the "personality" as well as the physical integrity of the person and that, in certain circumstances, emotional damage must be as compensable as physical damage.⁸⁵ Allowing the characterization of an action as tort or contract to determine whether emotional damage is compensable is to pay homage to the ghosts of the common law forms of action and thereby allow them to "rule us from their graves."⁸⁶ Thus the doctrinal bases of the contract action should not preclude recovery for pain and suffering.

The Dual Nature of the Injury

Pain and suffering can arise in two contexts: (1) pain and suffering (both emotional and physical) which could have resulted from even a successful treatment, and (2) needless pain and suffering encountered during treatment or from subsequent treatments which became necessary because of the initial breach.

As to the first point it has been suggested that pain and suffering is a "legal detriment" which constitutes part of the consideration given by the patient in exchange for the express guarantee.⁸⁷ This legal fiction emphasizes the determination of some courts not to place liability on the physician for pain and suffering incident to treatment. The patient in such cases is aware that such distress will result from even the most successful treatment. He too has entered the contractual agreement well aware of the uncertainty inherent in any medical procedure. In a reliance context, the counterargument is that this suffering is "wasted" by the breach and therefore must be compensable in order to restore the status quo ante.⁸⁸ If expectancy is the basis of the damage measure it could be argued that placing the plaintiff in the position he would have assumed upon complete performance still entails leaving the

ment and coincident mental anguish would probably not succeed, on the ground that the psychological injury which occurred was not fairly foreseeable by the defendant as a probable consequence of the breach. See RESTATEMENT OF CONTRACTS § 341 & comment *a* (1932).

⁸⁴ Francis v. Western Union Tel. Co., 58 Minn. 252, 262, 59 N.W. 1078, 1080 (1894).

⁸⁵ Stewart v. Rudner, 349 Mich. 459, 467, 84 N.W.2d 816, 822 (1957).

⁸⁶ Carpenter v. Moore, 51 Wash. 2d 795, 800, 322 P.2d 125, 128 (1958) (Finley, J., concurring in part and dissenting in part, from the court's holding that pain and suffering was not recoverable). The notion that the common law forms "rule us from their graves" is attributable to the British legal historian Maitland.

⁸⁷ Hawkins v. McGee, 84 N.H. 114, 118, 146 A. 641, 644 (1929).

⁸⁸ Sullivan v. O'Connor, 296 N.E.2d 183, 189 (Mass. 1973).

burden of this suffering upon the patient since it was incident to even a full and successful performance of the contract.⁸⁹

Arguments may be offered for viewing the patient's distress as either "wasted" suffering and thus compensable, or as "contracted" suffering and thus not recoverable. In this context other factors become determinative. It is doubtful that either the patient or the physician, at the time of the agreement, foresaw a contract action for this suffering if the physician, proceeding with the requisite skill and care, could not achieve the specified result. This is the most persuasive case for limiting the liability of the physician by restricting the damages available.⁹⁰

Suffering beyond that envisaged by the treatment, as agreed, is not susceptible to the "legal detriment" argument.⁹¹ The best approach to this perplexing situation was taken by the Michigan Supreme Court in *Stewart v. Rudner*.⁹² The court noted that in ordinary commercial

⁸⁹ The doctrinal analysis which permits the pain and suffering question to surface under either a reliance or an expectancy measure is an interesting one. Under either measure it is arguable that the pain and suffering was accepted (that is, "given") by the patient in exchange for the implicit promise of the physician to use due skill and care or the express promise to cure. That is, the patient tacitly assumed the cost of pain arising in the course of treatment. In an action predicated on any theory of recovery, but restricted to a reliance measure of damages, it must be contended that (1) the patient only suffered the pain in reliance upon the promise to cure, and (2) even if the pain is viewed as consideration for the promise, it is wasted by the physician's breach. See text accompanying note 87 *supra*. Compare this with an expectancy measure under which the patient would contend that the purpose of the damage award is to place him in the position he would have been in upon successful completion of the treatment and that (1) the pain involved was extraneous or additional and unrelated to successful treatment and thus compensable, and (2) even if this pain would have been incident to a successful treatment it is "wasted" by the subsequent breach by the physician.

⁹⁰ See, e.g., *Sullivan v. O'Connor*, 296 N.E.2d 183, 188-89 (Mass. 1973).

⁹¹ Such suffering can not be said to have been offered in "exchange" for the agreement to cure or treat. It is barely arguable that the patient tacitly assumed the risk of all injuries and suffering resulting from the treatment, whether they be incidental to a successful treatment or not, and that this assumption of risk and coincident waiver of a possible cause of action constituted at least part of the consideration given for the agreement. Only under this strained construction of the agreement and its circumstances could "nonincidental" suffering be said to constitute a "legal detriment" given in exchange for the promise of the physician.

⁹² 349 Mich. 459, 84 N.W.2d 816 (1957), an action by a woman whose child was stillborn against a physician for failure to perform a Caesarean section as agreed.

Justice Black, who wrote the strong dissent in the *Guilmet* case, see discussion at notes 34-45 *supra*, concurred in the court's opinion authored by Justice Smith.

It is interesting to note that the law as it relates to medical contracts in Michigan is clearly a function of the composition of the high court. On May 5, 1970, Justice Black wrote the majority decision in *Guilmet* (then for reversal). One supporter of that decision was eliminated by terminal illness and another by political action on November 3 of that same year. Determination of appeal was held in abeyance for preparation of an announced minority opinion. An order for rehearing of the deadlocked appeal was eventually entered. The order eliminated the votes of the two justices who, but for the events of the previous months, would have voted for reversal. Thus, as Justice Black wryly noted in his pointed *Guilmet* dissent, "does the precedential law of Michigan swing back

contracts, damages are not recoverable for disappointment, even amounting to anguish.⁹³ But, the determinative factor is the subject matter of the agreement.⁹⁴ Where the contract is not concerned with pecuniary aggrandizement, but with matters of "moral concern and solicitude," the anguish which results from the breach is an integral and inseparable part of the contract and must be compensable.⁹⁵ In general, courts appear willing to distinguish any fact situation from the application of the no-recovery rule where such application would limit the liability of the physician at the expense of the "innocent" patient. Thus, recovery for pain and suffering has been allowed in jurisdictions adopting reliance⁹⁶ or expectancy⁹⁷ damage measures.

and forth like a two year timed metronome." *Guilmet v. Campbell*, 385 Mich. 57, 76-77, 188 N.W.2d 601, 610 (Black, J., dissenting) contains Justice Black's appraisal of these events.

⁹³ Such damages, as the defendant contended, are often deemed to be too remote. *Stewart v. Rudner*, 349 Mich. 459, 469, 84 N.W.2d 816, 823 (1957).

⁹⁴ See *Sullivan v. O'Connor*, 296 N.E.2d 183 (Mass. 1973); 1 J. SUTHERLAND, A TREATISE ON THE LAW OF DAMAGES 156-58 (1st ed. 1882); quoted in *Stewart v. Rudner*, 349 Mich. 459, 470-71, 84 N.W.2d 816, 824 (1957), states:

May damages for breach of contract include other than pecuniary elements?

—In actions upon contract, the losses sustained do not, by reason of the nature of the transactions which they involve, embrace, ordinarily, any other than pecuniary elements. There is, however[,] no reason why other natural and direct injuries might not justify and require compensation. Contracts are not often made for a purpose, the defeating or impairing of which can, in a legal sense, inflict a direct and natural injury to the feelings of the injured party. . . .

While it is true that if the breach causes no actual injury beyond vexation and annoyance, as all breaches of contract do more or less, they are not subjects of compensation, unless to the extent that the contract was made specially to procure exemption from them. To that extent, that is, where a contract is made to secure relief from a particular inconvenience or annoyance, or to confer a particular enjoyment, the breach, so far as it disappoints in respect of that purpose, may give a right to damages appropriate to the objects of the contract.

See, e.g., *Lamm v. Shingleton*, 231 N.C. 10, 14-15, 55 S.E.2d 810, 813 (1949) (action for breach of contract for failure to furnish a watertight casket and to lock the same). Cf. *McClellan v. University Club*, 327 Mass. 68, 97 N.E.2d 174 (1951); *Frewen v. Page*, 238 Mass. 499, 131 N.E. 475 (1921).

⁹⁵ When we have a contract concerned not with trade and commerce but with life and death, not with profit but with elements of personality, not with pecuniary aggrandizement but with matters of mental concern and solicitude, then a breach of duty with respect to such contracts will inevitably and necessarily result in mental anguish, pain and suffering. In such cases the parties may reasonably be said to have contracted with reference to the payment of damages therefor in the event of breach. Far from being outside the contemplation of the parties they are an integral and inseparable part of it.

Stewart v. Rudner, 349 Mich. 459, 471, 84 N.W.2d 816, 824 (1957). See *Renihan v. Wright*, 125 Ind. 536, 25 N.E. 822 (1890).

⁹⁶ *Stewart v. Rudner*, 349 Mich. 459, 84 N.W.2d 816 (1957); *Frank v. Maliniak*, 232 App. Div. 278, 249 N.Y.S. 514 (1931). *Contra*, *Carpenter v. Moore*, 51 Wash. 2d 795, 322 P.2d 125 (1958).

⁹⁷ *Sullivan v. O'Connor*, 296 N.E.2d 183 (Mass. 1973); *McQuaid v. Michou*, 85 N.H. 299, 157 A. 881 (1932); cf. *Hood v. Moffett*, 109 Miss. 757, 69 So. 664 (1915).

While damages for pain and suffering present a perplexing problem, the courts' apparent inconsistencies in approach might well be left alone.⁹⁸ It is within the purview of the court to determine whose interests should be provided for through the damage instruction in a particular case.⁹⁹ In those instances where the court deems that the public interest would best be served by limiting the liability of the physician, it should be free to do so. On the other hand, where the court feels that the plaintiff's "bargain" warrants the protection of the law, it should be able to apply an expectancy measure to the damage award and to include damages for pain and suffering where they are clearly a foreseeable consequence of the physician's breach.

CONCLUSION

A distinguished panel has recommended that legal doctrines relating to the liability of health professionals should be applied in the same manner as they are applied to all classes of defendants.¹⁰⁰ The panel included, as among those rules which have created significant confusion and uncertainty in their application to malpractice actions, a rule allow-

The *McQuaid* court reached its conclusion through a polished use of legal fiction:

Her condition due to the treatment would reflect and show such suffering, as practically a part of it, and enhance the difference between it and a condition of cure. While the excess suffering would be in evidence, it would be received only to show her condition. And such suffering as an incident of her condition and widening the difference between her condition and cure would receive allowance by reason of its inclusion in such difference.

85 N.H. at 304, 157 A. at 884. *Contra*, cases cited note 74 *supra*.

⁹⁸ Miller, *supra* note 24, at 428, suggests a flexible rule which would adjust to the interests of the parties by providing (a) a tort measure of damages for fact situations where the essential harm lies in needless actual physical injury, pain and suffering, and (b) an "out of pocket" measure of damages providing compensation for expenses and loss of time where there is a failure to perform but no physical harm.

However, even this rule may be too rigid in application. As stated above, the "flexible" approach appears to allow no compensation for the emotional suffering of a patient where there is no physical harm. Thus in a case where a doctor guarantees a cure for plaintiff's back pains and months later, after exhaustive X-ray diagnosis, concludes that no such cure is possible, the plaintiff is to be awarded only "out of pocket" damages and receives no compensation for the emotional distress which necessarily flowed from the doctors reevaluation (which constituted a breach). The emotional suffering was clearly a result of the breach of the physician's guarantee and as such was a probable and foreseeable consequence of the breach. It appears that the better view in this instance might well be that emotional distress was an inseparable part of the agreement and the doctor's guarantee necessarily included a tacit assumption of the risk that subsequent failure would lead to emotional harm. This is not to suggest that such emotional disturbance should always be compensable but that it may be necessary to compensate for such injury, even in the absence of physical harm. The court should be permitted such an option. The fact that plaintiffs are not generally compensated for emotional suffering in contract actions is merely a factor for consideration, but it should not be determinative.

⁹⁹ See text accompanying note 63 *supra* with respect to intentional misrepresentation.

¹⁰⁰ See note 18 *supra*.

ing liability based on oral guarantees of specified results of treatment.

Analysis of the spectrum of contractual malpractice cases suggests that actions for breach of express contracts should be allowed. The requirement of corroborative evidence to prove the existence of an agreement would protect the medical profession without sacrificing the plaintiff-patient's common law contract action. Once a breach has been established, the measure of damages should be determined by consideration of competing policy factors rather than upon the mechanical application of more rigid rules.

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