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Volume 94 | Issue 4 Article 9

June 1992

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Rebecca C. Moore, *Dimarco v. Lynch Homes-Chester County, Inc.: How Far Should West Virginia Go in Extension of Physician Liability for Transmission of Communicable Disease*, 94 W. Va. L. Rev. (1992).
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DIMARCO V. LYNCH HOMES-CHESTER COUNTY, INC.: HOW FAR SHOULD WEST VIRGINIA GO IN EXTENSION OF PHYSICIAN LIABILITY FOR TRANSMISSION OF COMMUNICABLE DISEASE?

I. INTRODUCTION

In everyday practice, a physician has the difficult task of correct diagnosis and treatment of communicable diseases.[1] When a patient presents with communicable disease symptoms, the physician's immediate action is to attend to that individual's needs. However, the

1. A communicable disease is a disease "the causative agents of which may pass or be carried from one person to another directly or indirectly." BENJAMIN F. MILLER, M.D. & CLAIRE BRACKMAN KEANE, R.N., B.S., ENCYCLOPEDIA AND DICTIONARY OF MEDICINE AND NURSING 281 (1972); *See generally* ABRAM S. BENENSON, CONTROL OF COMMUNICABLE DISEASES IN MAN (15th ed. 1990) (descriptions of approximately two hundred communicable diseases).

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physician must also consider the extent to which the communicable disease may spread and who may be subsequently affected.

This article focuses on when physician liability for malpractice to a patient will be extended to third person non-patients who have contracted a communicable disease from the physician's patient. A dearth of case law exists and decisions turn on the specific facts involved. Therefore, this article will combine chronological, factual, and theoretical analysis to plot judicial response to non-patient party claims.[2]

Most importantly, this article attempts to provide physicians and lawyers who advise physicians with a basis on which to determine appropriate practice policies. By anticipating situations of potential extended liability, physicians may to some extent limit liability while providing quality patient care.

Section II provides a background of tort principles applicable to medical malpractice actions. Next, Section III presents some of the limited case law of non-patient actions against physicians. Section IV specifically addresses non-patient claims against physicians for communicable disease infection by the physician's patient. Section V will examine a recent Pennsylvania decision[3] appearing to expand physician liability in this area, followed by analysis of subsequent comments by the lower court that may qualify the holding. Section VI will then turn to the effect of reporting statutes in communicable disease cases and current legislation in West Virginia.

The West Virginia courts to date have not been faced with a communicable disease case and little direction is available in case law to predict how courts will respond. Discussion in Section VII

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2. Communicable disease cases have been examined in this manner most frequently with regard to duty to warn possible AIDS contacts and confidentiality. *See generally* Harold L. Hirsh, *A Visitation With Aids*, 37 MED. TRIAL TECH. Q. 1 (1990); Holly A. Rosencranz & Warren G. Lavey, *Treating Patients With Communicable Diseases: Limiting Liability For Physicians and Safeguarding the Public Health*, 32 ST. LOUIS U. L.J. 75 (1987); Frederick R. Fahrner, Comment, *The Physician's Duty to Warn Non-Patients: AIDS Enters the Equation*, 5 COOLEY L. REV. 353 (1988); Joseph D. Piorkowski, Jr., Note, *Between a Rock and a Hard Place: AIDS and the Conflicting Physician's Duties of Preventing Disease Transmission and Safeguarding Confidentiality*, 76 GEO. L.J. 169 (1987); Siobhan Spillane, Note, *AIDS: Establishing a Physician's Duty to Warn*, 21 RUTGERS L.J. 645 (1990).

3. DiMarco v. Lynch Homes-Chester County, Inc., 583 A.2d 422 (Pa. 1990).

encourages a moderate approach in extension of physician liability to prevent adoption of a broad rule that may require future modification.

II. Basic Tort Principles of Medical Malpractice

Traditional tort law requires four elements to sustain a cause of action in negligence: 1) a duty recognized by the law requiring a person to conform to a certain standard of conduct for the protection of others against unreasonable risks; 2) a breach of that duty; 3) a reasonably close causal connection between the resulting injury and the conduct; and 4) resulting injury or damage.[4] These elements apply to the hybrid negligence action of medical malpractice, with the determination of the physician's duty always a question of law.[5] If the court finds that a duty exists, the jury may then determine whether the doctor has acted with the level of learning and skill commonly possessed by members of the profession in good standing,[6] and if the doctor's negligence proximately caused the plaintiff's injury.

Medical malpractice cases appear to be unique because the plaintiff must present expert testimony concerning causation in order to establish a prima facie case.[7] Also, a physician-patient relationship provides the foundation on which to base a malpractice action.[8] No West Virginia case has held a physician liable to another without a sufficient physician-patient relationship.[9]

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4. William L. Prosser, Handbook of the Law of Torts § 30, at 143 (4th ed. 1971); *see also* Restatement (Second) of Torts § 281 (1965).

5. Prosser, *supra* note 4, § 53, at 324.

6. *Id.* § 32, at 162. *See also* W. Va. Code § 55-7B-3 (Supp. 1992). The plaintiff must prove that "[t]he health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances."

7. Michael J. Farrell, *The Law of Medical Malpractice in West Virginia*, 82 W. Va. L. Rev. 251, 251 (1979). *See also* Hinkle v. Martin, 256 S.E.2d 768 (W. Va. 1979) (res ipsa loquitur does not apply to medical malpractice).

8. Rand v. Miller, 408 S.E.2d 655, 656 (W. Va. 1991); *See also* Weaver v. Union Carbide Corporation, 378 S.E.2d 105 (W. Va. 1989) (lack of professional relationship forecloses malpractice claim).

9. Michael J. Farrell, *The Law of Medical Malpractice in West Virginia*, 82 W. Va. L. Rev. 251, 255 (1979); *See* Rand v. Miller, 408 S.E.2d 655 (W. Va. 1991).

Generally, a duty to protect another does not exist merely by one's realization that action on his or her part is necessary to protect the other.[10] However, an exception to this rule occurs when a special relationship exists between the parties.[11] Some courts have recently used special relationships to bypass the need for a physician-patient relationship in communicable disease malpractice actions brought by non-patients.

An additional tort theory that allows extension of liability is applicable when a person has undertaken to perform services to another, either gratuitously or for consideration, that he should recognize as necessary for the protection of a third party.[12] Liability may be found if the third party suffers harm as a result of reliance on the undertaking.[13] Courts have previously applied this theory in communicable disease cases, but the recent decision of *DiMarco v. Lynch Homes-Chester County, Inc.* has brought it to the fore.[14]

III. Extension of Physician Liability In Situations Other Than Communicable Diseases

Generally, courts have continued to require the direct physician-patient relationship before allowing malpractice action against a doctor. For example, in *Peace v. Weisman*,[15] a Georgia court sustained the summary judgment for the physician in a wife's malpractice action to recover for the death of her husband. In a disability determination examination for the Georgia Department of Human Resources, the physician did not reveal abnormal chest x-ray results directly to the patient.[16] The doctor reported the abnormalities only to the state.[17] The patient subsequently died of lung cancer.[18] The

10. Restatement (Second) of Torts § 314 (1965) reads: "The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action."

11. Restatement (Second) of Torts § 314A (1965).

12. Restatement (Second) of Torts § 324A (1965).

13. *Id.*

14. DiMarco v. Lynch Homes-Chester County, Inc., 583 A.2d 422 (Pa. 1990).

15. 368 S.E.2d 319 (Ga. Ct. App. 1988).

16. *Id.* at 320.

17. *Id.*

18. *Id.*

court held that under a malpractice claim, privity "continues to be an essential ingredient" and therefore, the wife's claim was barred.[19]

However, courts have used two legal theories in allowing malpractice actions against physicians by third person non-patients outside of a direct physician-patient relationship, including foreseeability of injury and special relationships.[20]

Foreseeability of injury is frequently used by courts in determining physician duty in cases concerning operation of motor vehicles by patients under treatment. In 1983, the Texas court in *Gooden v. Tips*[21] addressed the issue of a physician's duty in prescribing consciousness altering medications. The court granted a cause of action against the doctor when he failed to warn his patient not to drive while under the influence of Quaalude, the prescribed tranquilizer.[22] The court found that the physician could foresee possible injury to the driving public and a duty arose to use reasonable steps under the circumstances (here, a warning not to drive)[23] to reduce the likelihood of injury to others.[24] However, the court stopped short of requiring the doctor to control the patient's behavior.[25] In cases involving prescription drugs, the physician has special knowledge of the effects of the medication which are not known to the patient.[26] The physician, therefore, must instruct the patient regarding reasonable precautions to be taken.[27]

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19. *Id.* at 321.

20. *See* Frederick R. Fahrner, Comment, *The Physician's Duty To Warn Non-Patients: AIDS Enters the Equation*, 5 COOLEY L. REV. 353 (1988).

21. 651 S.W.2d 364 (Tex. Ct. App. 1983); *See also* Duvall v. Goldin, 362 N.W.2d 275 (Mich. Ct. App. 1984) (doctor's failure to diagnose or properly treat epilepsy may foreseeably create risk of harm to third party).

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

23. *Id.*

24. *See* Kaiser v. Suburban Transportation System, 398 P.2d 14 (Wash. 1965) (cause of action against doctor who did not warn bus driver patient of drowsiness associated with medication for nasal condition who then had accident resulting in plaintiff's injury).

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

26. Timothy H. Norton, *Joy v. Eastern Maine Medical Center: Extension of a Physician's Duty to Third Parties*, 40 MAINE L. REV. 207, 215 (1988).

27. *See, e.g.*, Freese v. Lemmon, 210 N.W.2d 576 (Iowa 1973) (physician negligently advised patient with undiagnosed seizure disorder that he could drive an automobile). *But see* Davis v. Mangelsdorf, 673 P.2d 951 (Ariz. Ct. App. 1983) (dismissed for failure to state a cause of action against physician for advise to epileptic patient to discontinue anticonvulsant 17 years before auto accident injuring plaintiff).

In a related situation, a California court, in *Myers v. Quesenberry*,[28] allowed a cause of action against the physicians by an injured pedestrian who was struck by a car driven by a female patient whom the doctors had directed to go immediately to a nearby hospital. The diabetic patient was emotionally distraught after learning from the doctors that she was carrying a dead fetus and required surgical abortion.[29] The court reasoned that, as a practical matter, the doctors could not have warned the plaintiff. However, warning the impaired patient not to drive would have fulfilled their duty to third persons foreseeably injured.[30] The court recognized a duty to take "reasonable [steps] under the circumstances to protect . . . foreseeable victims . . . of [the patient's] dangerous conduct."[31] To prevail, the plaintiff must present sufficient evidence of the inadequate warning, or lack of any warning, given to the patient.[32]

Generally, however, when a doctor gives adequate warning to a patient, a duty to an injured third person is not established. In *Cartier v. Long Island College Hospital*,[33] the New York court held the doctor had no duty to the injured plaintiff when an intoxicated alcoholic, treated as an outpatient, lost control of his car and struck the plaintiff. The court believed common knowledge dictated not operating a vehicle while intoxicated.[34] Moreover, the doctor warned the alcoholic not to drive.[35] Therefore, when a doctor adequately warns a patient not to engage in potentially dangerous activity, the doctor will most likely not be held liable for injury to a third person.

Within the concept of foreseeability of harm, courts have found special relationships outside the physician-patient relationship sufficient to support a cause of action such as in the Michigan decision

28. 144 Cal. Rptr. 733 (Cal. Ct. App. 1983).

29. *Id.* at 734.

30. *Id.* at 735.

31. *Id.* at 736.

32. *See* Joy v. Marston, 581 A.2d 418 (Me. 1990) (plaintiff injured in vehicular accident allowed cause of action against patient's treating physician but did not prevail because of inconsistent evidence of warning not to drive).

33. 490 N.Y.S.2d 602 (N.Y. App. Div. 1985).

34. *Id.* at 604.

35. *Id.*

of *Welke v. Kuzilla*.[36] The plaintiff's wife was killed when the patient, who was driving the doctor's car and had been injected with an unknown substance by the doctor, collided with the deceased.[37] Conversely, recently in *Klein v. Morgen*,[38] a federal district court sitting in Colorado did not find a special relationship sufficient for a wife and child to recover under a medical malpractice theory, when a physician did not timely complete the physician statement required for the husband's application for disability and life insurance.[39] Additionally, the court found no evidence that the physician knew that the wife and child were named beneficiaries—thereby precluding a finding of duty.[40]

In summary, courts addressing extension of physician liability outside the traditional physician-patient relationship have relied on decisions such as these and communicable disease cases. The use of foreseeability of injury and special relationships provides a fragile framework on which courts hang the specific facts of the case.

Generally, if a physician provides a patient circumstantially reasonable advice regarding dangerous activities or when injury to a non-patient is strictly economic, the physician's liability will most likely not be extended to non-patients. Special relationships sufficient to extend liability will be fact specific and, therefore, difficult to predict.

IV. The Evolution of Communicable Disease Cases

Courts have recognized actionable negligence in the direct spread of contagious disease between a contagious patient and another. For example, the New Jersey Superior Court in *Earle v. Kuklo*[41] allowed a cause of action against a landlord for renting an upstairs apartment to a family without informing them that the landlord and her family

36. 375 N.W.2d 403 (Mich. Ct. App. 1985); *See also* Tarasoff v. Regents of the Univ. of California, 551 P.2d 334 (Cal. 1976) (psychotherapist has a limited duty to warn only readily identifiable victims of specific threats of violence from a patient in a therapeutic relationship).

37. *Welke*, 375 N.W.2d at 404.

38. 760 F. Supp. 1403 (D. Colo. 1991).

39. *Id.* at 1409.

40. *Id.*

41. 98 A.2d 107 (N.J. Super. Ct. App. Div. 1953).

were infected with tuberculosis.[42] A later born child contracted the disease by coming in close contact with the landlord.[43] The court held that anyone who negligently exposes another to his or her communicable disease may be liable for damages, if the other subsequently contracts the disease.[44] Additionally, courts have used various intentional tort theories in recognizing a cause of action in situations involving sexually transmitted diseases between partners.[45]

A limited number of cases have been decided concerning a physician's duty to non-patients in the context of communicable diseases. Depending on the factual situation, a physician treating a patient for a communicable disease may be under a duty to diagnose the disease and to relay the information to those at risk. The 1899 New Hampshire decision of *Edwards v. Lamb*[46] constitutes the earliest communicable disease case to allow a negligence action against a physician outside a physician-patient relationship. The physician assured the patient's wife there would be no danger in attending to her husband's seeping wounds.[47] The wife, having "pricks on her fingers",[48] became infected with septic poisoning.[49] The court found a duty upon the doctor, even though unaware of the breaks in the wife's skin, to prevent the spread of the disease.[50] Thus, the court held the doctor liable because his affirmative action of assurance opened the wife to contamination.[51]

The next case to consider a physician's duty to protect non-patients from communicable disease came twenty years later, when the Minnesota Supreme Court decided *Skillings v. Allen*,[52] in which

42. *Id.* at 108.
43. *Id.*
44. *Id.* at 109.
45. Robert Craig Waters, *Liability Under Florida Law for Exposing Others to Infectious Disease*, FLA. B.J., Nov. 1990, at 36. In addition to negligence, some cases have used intentional tort theories such as assault or battery, fraud, and intentional infliction of emotional distress in bringing a cause of action for transmission of disease. *Id.*
46. 45 A. 480 (N.H. 1899).
47. *Id.* at 480.
48. *Id.* at 481.
49. *Id.*
50. *Id.*
51. *Id.*
52. 173 N.W. 663 (Minn. 1919).

the court held that the patient's parents could bring a cause of action[53] after contracting scarlet fever. The parents had relied on the advice of the physician that they would be at no risk in visiting their daughter in the hospital or in taking her home.[54] The court stated that one becomes responsible for the direct consequences of one's acts when it is obvious that injury will be caused by lack of one's due care.[55] Reporting the case of scarlet fever to the state board of health did not fulfill the physician's total duty.[56] Furthermore, since parents are naturally in closer contact with a child than anyone else, there exists a duty to protect parents by advising them correctly.[57]

The duty to family members and those in close contact with a contagious patient appeared again in *Davis v. Rodman*.[58] The court held that a physician owed a duty to correctly instruct and advise family members and those likely to be brought in contact with the patient, who are ignorant concerning the character of the disease.[59] In finding this duty within the existing duty of attendance to an infectious patient, the court stated a physician is "not to negligently do any act that would tend to spread the infections."[60] Forty nine years after *Davis*, a Florida appellate court found in *Hofmann v. Blackmon*[61] that a physician has a duty to inform persons in charge of a minor child, who is a member of the immediate family and living with a contagious person, of precautionary steps to be taken to prevent the child from contracting the disease.[62] The physician's failure to diagnose the disease did not negate this duty.[63] The decision in *Hofmann* has been frequently cited in later contagious dis-

53. *Id.* at 664.
54. *Id.*
55. *Id.* at 663-64.
56. *Id.* at 664.
57. *Id.*
58. 227 S.W. 612 (Ark. 1921) (demurrer sustained for lack of specific facts in pleading showing causation when doctor advised parents to move typhoid infected emancipated sons into family home).
59. *Id.* at 614.
60. *Id.*
61. 241 So. 2d 752 (Fla. Dist. Ct. App. 1970).
62. *Id.* at 753. In *Hofmann*, the defendant physician had treated a man for 2 years without diagnosing his condition as tuberculosis. The man's 2 year old daughter was then diagnosed with tuberculosis of the spine after which the man was definitively diagnosed with TB. The court reversed the lower court's summary judgement and remanded for further proceedings.
63. *Id.*

ease cases as a benchmark, although the opinion gives no helpful reasoning, and simply relies on citation to the aforementioned cases.

The Ohio Supreme Court, without citing any precedent, came to the same conclusion in 1928 in *Jones v. Stanko.*[64] The court found a physician's duty extends to those who, although not members of the immediate family, rely to their detriment on direct information from the physician.[65] In *Jones*, the court held that a physician could be liable for diagnostic negligence to the estate of a neighbor who cared for and prepared for burial the patient who ultimately died of undiagnosed smallpox.[66] The neighbor had relied on the direct assurance by the physician that the patient did not have a contagious disease and that the neighbor would be at no risk for illness.[67] The court did not directly address the question of duty to the caring neighbor, but by its holding implied that when a physician gives negligent information directly to a third person, a duty arises sufficient to support a cause of action, even though the relationship is outside the classic physician-patient relationship.[68]

More recently, courts have added the special relationship exception as another tool in determining liability outside the physician-patient relationship. Imposition of duty does not occur simply because one realizes action on his part will be necessary for another's protection.[69] However, exception to this general rule occurs when a special relationship exists between the parties.[70] A Michigan appellate

64. 160 N.E. 456 (Ohio 1928).

65. *Id.*

66. *Id.* at 456.

67. *Id.*

68. *Compare* Wojcik v. Aluminum Co. of America, 183 N.Y.S.2d 351 (N.Y. Sup. Ct. 1959). Wife's cause of action allowed in negligence against husband's employers who did not inform him of tubercular condition noted on gratuitous physical examination. The husband continued to live with his family relying on the company's practice of informing employees of any irregularities noted on an exam. The court found that it was reasonably foreseeable by the company that the wife would contract TB. The examining physicians were not parties to the suit because the complaint alleged that the examinations were made by agents and employees of the company.

69. RESTATEMENT (SECOND) OF TORTS § 314 (1965).

70. RESTATEMENT (SECOND) OF TORTS § 314A (1965) notes several relationships as special; common carrier/passengers, innkeeper/guest, land owner/public invitee, one who takes custody of another who is then deprived of normal opportunities for protection. The Institute, by Caveat and in Comment b., leaves open as to whether there may be other relationships which impose a similar duty but recognizes a trend toward recognizing duty in relations of dependence or of mutual dependence.

court found this duty to exist within the physician-patient relationship when it reversed the trial court's dismissal in *Shepard v. Redford Community Hospital*.[71] Relying on mandatory authority finding physicians potentially liable in treating patients with seizures,[72] the court allowed a mother to bring an action for the death of her son.[73] The mother had been treated by the defendant physician who prescribed antibiotics for flu when the mother actually suffered from meningitis.[74] She was instructed to return if she did not improve.[75] Shortly after she returned home, her son died of spinal meningitis.[76] The court found the physician-patient relationship sufficiently "special," thereby extending the physician's duty to a foreseeable victim of his conduct, a son who was a member of her household.[77] Although recognizing the physician's concerns about confidentiality and limitless liability, the facts of the case warranted a cause of action for the mother because of the family relationship.[78]

However, an Illinois court found that a close family relationship does not always produce a special relationship sufficient to support a cause of action against a physician.[79] Because of an intimate mother-child relationship, the Illinois Supreme Court had previously extended a physician's duty to include the protected rights of an injured newborn when the mother was negligently transfused with incompatible Rh blood[80]

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71. 390 N.W.2d 239 (Mich. Ct. App. 1986).

72. Duvall v. Goldin, 362 N.W.2d 275 (Mich. Ct. App. 1984) (failure to diagnose or properly treat an epileptic patient may create a risk of harm to third parties); *see also* Welke v. Kuzilla, 375 N.W.2d 403 (Mich. Ct. App. 1985) (cause of action against physician who injected patient with unknown substance and allowed patient to drive his [the physician's] car resulting in accident with plaintiff).

73. *Shepard*, 390 N.W.2d at 241.

74. *Id.* at 240.

75. *Id.*

76. *Id.*

77. *Id.* at 241.

78. *Id.*

79. Britton v. Soltes, 563 N.E.2d 910 (Ill. App. Ct. 1990).

80. When a Rh negative female is sensitized to Rh positive blood by transfusion or first pregnancy, a gradual immune response is produced by formation of antibodies against the positive Rh factor in red blood cells. When the sensitized female becomes pregnant with an Rh positive fetus, her body reacts by forming anti-Rh agglutinins which enter the fetal circulation through the placental membrane. The results are clumping and destruction of fetal red blood cells producing excess hemoglobin pigments. The effects are not seen while the fetus is in utero because the mother's system detoxifies the blood. However, after birth, the baby's system is too immature to rid its system of the excess hemoglobin. Possible results are jaundice, anemia, nerve tissue destruction and generalized tissue and brain damage. MILLER & KEANE, *supra* note 1, at 840.

13 years earlier.[81] Consistently, the same court did not extend physician liability to an injured auto passenger where the driver-patient took antipsychotic medication because no such intimate relationship existed.[82]

However, the Illinois court found another situation less clear cut. The 1990 decision of *Britton v. Soltes*[83] continued to limit liability when the appellate court sustained the lower court's partial summary judgement against the ex-wife and children of a man with tuberculosis.[84] The contagious father lived next door and visited the children frequently during the time that he was under the defendant's care but allegedly negligently undiagnosed.[85] The court held that a "duty will be extended only where the relationship between the patient and the third party is such that negligence to the patient necessarily results in injury to the third party."[86] The court did not find the relationship between the father and the family sufficiently special, such as the intimate mother/fetus relationship, because he was divorced and living separately therefore making the family's infection happenstance.[87] Additionally, the defendant had never treated the ex-wife and children, so he was unaware of their relationship with his patient.[88]

The Tenth Circuit Court of Appeals annunciated this reasoning more definitively in their interpretation of Colorado law by determining that the doctor has no duty to extend warning about contagious diseases to those unknown to him.[89] In *Gammill v. United States*, the court upheld the district court's decision adverse to the plaintiff's Federal Tort Claims Act action.[90] A civilian physician employed by the government treated a patient for hepatitis but did not

81. Renslow v. Mennonite Hospital, 367 N.E.2d 1250 (Ill. 1977).
82. Kirk v. Michael Reese Hospital & Medical Center, 513 N.E.2d 387 (Ill. 1987).
83. 563 N.E.2d 910 (Ill. App. Ct. 1990).
84. *Id.* at 911.
85. *Id.*
86. *Id.* at 912-13.
87. *Id.* at 913.
88. *Id.* at 911.
89. Gammill v. United States, 727 F.2d 950, 954 (10th Cir. 1984).
90. *Id.*

notify the local health department of the illness.[91] The plaintiffs voluntarily cared for the patient's children and contracted the disease from the then asymptomatic children.[92] The court squarely dispensed of any duty to warn the plaintiffs due to a special relationship because the doctor and the plaintiffs were not even acquainted.[93] The court then held "that at the bare minimum the physician must be aware of the specific risks to *specific persons* before a duty to warn exists."[94] (emphasis added)

Some very broad generalizations can be made from existing case law in predicting extension of physician liability. When a physician personally gives negligent advice to a third person, family member or not, concerning the risk of contamination from a patient, liability will most likely be extended to that contaminated party. This extension of liability is reasonable for it is founded on a "quasi" physician-patient relationship. The physician knows the exact person to whom he is giving advice and no intermediary exists that can cause the advice to be distorted.

Generally, the relationships found within a nuclear family may be sufficient to support a cause of action for physician negligence in treatment of communicable disease. However, if the family unit is not intact and living within the same household, the court may view the non-patient's infection as a happening of mere chance. Complexity of modern day relationships requires courts to carefully respond to the specific factual setting in determining the reasonable extent of physician liability.

V. Analysis of *DiMarco v. Lynch Homes-Chester County, Inc.*

At first glance, the recent Pennsylvania Supreme Court's decision of *DiMarco v. Lynch Homes-Chester County, Inc.*[95] sends shivers of fear down the spines of physicians and joy to the hearts of plain-

91. *Id.* at 951.
92. *Id.* at 951-52.
93. *Id.* at 954.
94. *Id.*
95. 583 A.2d 422 (Pa. 1990) [hereinafter *DiMarco II*].

tiff's lawyers. In actuality, the decision says nothing new — only that a physician must treat his patient carefully and, from a litigation view, defensively. The decision appears to extend physician liability to all third persons infected with a communicable disease through sexual intimacy with a treated patient. Still, physicians who are aware of the facts and holding in this case will be better able to make daily decisions in the treatment of communicable diseases.

The close 4-3 decision may require explanation from the Pennsylvania Supreme Court in the future. The Pennsylvania Superior Court has subtly criticized the decision for going too far in announcing such a broad general rule. To understand the meaning and possible limitations of the decision, analysis will begin with the appeal[96] to the Pennsylvania Superior Court from the trial court's dismissal of the plaintiff's claim.[97] For simplicity and lack of clearer designation, the intermediate appeal to the Superior Court of Pennsylvania is designated *DiMarco I*, while appeal to the Supreme Court of Pennsylvania is designated *DiMarco II*.

A. Facts

A female phlebotomist (one who obtains blood specimens for laboratory testing) sustained a needle stick while drawing blood from a carrier of hepatitis.[98] She consulted the defendant osteopaths who advised her she would not have contracted hepatitis if she did not have symptoms within 6 weeks.[99] The defendants also advised her to abstain from sexual relations during this 6 week period.[100]

Remaining asymptomatic, she resumed sexual relations with the plaintiff after 8 weeks.[101] Ultimately, the phlebotomist and plaintiff

96. DiMarco v. Lynch Homes-Chester County, Inc., 559 A.2d 530 (Pa. Super. Ct. 1989) [hereinafter *DiMarco I*].

97. *Id.* at 530.

98. *Id.* at 531.

99. *Id.*

100. *Id.* Inconsistency is noted as the Supreme Court in Dimarco II states that no advice was given concerning sexual abstinence. *DiMarco II*, 583 A.2d at 423.

101. *DiMarco I*, 559 A.2d at 531.

were diagnosed with Hepatitis B[102] in 3 months and 6 months respectively.[103] The phlebotomist had separated from her husband.[104] She did not reside with the plaintiff but they had been sexual partners prior to the needlestick.[105] The trial court determined that the defendants knew both the phlebotomist and the plaintiff personally and "were aware or had reason to know [they] were intimate."[106] The trial court dismissed the plaintiff's complaint.[107]

B. *DiMarco I: Appeal to the Superior Court of Pennsylvania*

The superior court recognized the trial court's reasoning in not extending a physician's duty into the patient's private sexual conduct and the public policy concern of supporting family values.[108] However, the court found public policy did not outweigh the injury sustained by the plaintiff under these facts.[109]

The court recognized the general rule that, absent a physician-patient relationship, there can be no malpractice action.[110] Nevertheless, the court found a basis for duty in Section 324A of the Restatement (Second) of Torts,[111] if the plaintiff relied on the doc-

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102. Hepatitis B ("serum hepatitis") is a viral infection of the liver with an incubation period of 6 weeks to 6 months. It is usually transmitted by inoculation of infected blood, however, the antigen has been found in most body secretions and can be spread by oral or sexual contact. The clinical features of Hepatitis A ("infectious," or short-incubation period disease) and B are similar, but Hepatitis A has a 2-6 week incubation. C. Michael Knauer, M.D. & Sol Silverman, Jr., D.D.S., *Alimentary Tract & Liver*, in CURRENT MEDICAL DIAGNOSIS & TREATMENT 433-434 (Steven A. Schroeder et al. eds., 1990).

103. *DiMarco I*, 559 A.2d at 531.

104. Caveat: It is of note that the headnote printed for this case erroneously states that the plaintiff is the woman's husband. Two authorities have followed this information; 70 C.J.S. *Physicians and Surgeons* § 87 (Supp. 1991); Heigert v. Riedel, 565 N.E.2d 60, 63 (Ill. App. Ct. 1990).

105. *DiMarco I*, 559 A.2d at 531.

106. *Id.*

107. *Id.* at 530.

108. *Id.* at 531.

109. *Id.* at 532.

110. *Id.*

111. RESTATEMENT (SECOND) OF TORTS § 324A (1965) reads:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of a third person or his things, is subject to liability to the third person for the physical harm resulting from his failure to exercise reasonable care to protect his undertaking, if (a) his failure to exercise reasonable care increases the risk of such harm, or (b) he has undertaken to perform a duty owed by the other to the third person, or (c) the harm is suffered because of reliance of the other or the third person upon the undertaking.

tors' advice in consenting to sexual relations. The court also distinguished this case from mandatory precedent[112] denying a cause of action because of lack of a direct physician-patient relationship for two reasons. First, a physician-patient relationship existed between the phlebotomist and the defendants.[113] Secondly, communicable diseases require prevention and control to protect the public at large.[114] In its analysis, the court looked to the *Hofmann* and *Shepard* decisions holding that actions were available for children who had contracted communicable diseases from their parents.[115]

DiMarco I was "limited to the facts of the case before us"[116] where the plaintiff claimed knowledge and reliance on erroneous medical advice in interacting with the patient.[117] For emphasis, the court quoted the cautioning words of the Pennsylvania Supreme Court in *Kaczkowski v. Bolubasz,*[118]: "We refrain 'from attempting to fashion broad general rules as a panacea. The obviously wiser choice is to resolve disputes on a case-by-case basis until we develop, through experiences in [an] area, a sound basis for developing overall principles.'"[119] By reversing and remanding in favor of the plaintiff, the court held the "physicians had a duty to act reasonably in advising [the patient] regarding her ability to transmit the communicable disease."[120] Unfortunately, these limitations on the holding appear in a footnote instead of being prominently placed in the body of the opinion.

C. DiMarco II: Appeal to the Supreme Court of Pennsylvania

The defendants' appeal to the Supreme Court of Pennsylvania resulted in a 4-3 affirmation of the superior court's decision.[121] The

112. Ervin v. American Guardian Life Assurance Co., 545 A.2d 354 (Pa. Super. Ct.1988) (life insurance company medical director owed no duty to applicant in reading EKG or advising of results), Craddock v. Gross, 504 A.2d 1300 (Pa. Super. Ct. 1986) (doctor employed strictly by workmen's compensation carrier owed no duty to employee for examination of work related injury).

113. *DiMarco I*, 559 A.2d at 533.

114. *Id.*

115. *Id.* at 534.

116. *Id.* at 535 n.3.

117. *Id.* at 535.

118. 421 A.2d 1027, 1036 n.21 (Pa. 1980).

119. *DiMarco I*, 559 A.2d at 535 n.3.

120. *Id.*

121. *DiMarco II*, 583 A.2d 422 (Pa. 1990).

supreme court explained the Restatement (Second) of Torts Section 324A in terms of a requirement of foreseeability.[122] The court followed their own reasoning as set forth in *Cantwell v. Allegheny County*.[123] *Cantwell* established that to state a cause of action based on the Restatement of Torts Section 324A, there must be facts to establish the defendant has undertaken "to render services to another which he should recognize as necessary for the protection of a third person."[124]

The court reasoned that a physician's advice to the patient concerning proper sanitary procedures during the communicable period was not for the protection of the patient, whose health has already been compromised, but to protect the health of others "within the foreseeable orbit of risk of harm."[125] A duty to protect third persons exists within the Pennsylvania reporting regulations requiring physicians to notify the local board of health of Hepatitis B cases.[126] Therefore, the court concluded that erroneous advice to a patient with a communicable disease would allow a cause of action against the doctor by anyone likely to and who does contract the disease.[127]

In addition to finding a cause of action for the plaintiff, the court further held "that the class of persons whose health is likely to be threatened by the patient includes *any* one who is physically intimate with the patient."[128] Adding an awakening slap on the trial court's face, the court noted the societal reality of extramarital relationships over the wishful thinking of moralists[129] thereby requiring protection of all persons in intimate relationships.

Until the decision of *DiMarco II*, the majority of courts addressing communicable disease cases, providing only a grey line of

122. *Id.* at 424.

123. 483 A.2d 1350 (Pa. 1984). This case centered on the issue of whether the county crime lab owed a duty to an incarcerated rape suspect in the performance of laboratory tests for the police department for investigative purposes. The court found that the suspect failed to state a cause of action.

124. *DiMarco II*, 583 A.2d at 424.

125. *Id.*

126. *Id.* at 425. The court cites 28 Pa. Code § 27.115 requiring physicians to report cases of Hepatitis B.

127. *Id.* at 424-25.

128. *Id.* at 425.

129. *Id.*

predictability for physician liability, has been most sympathetic to plaintiffs related by blood or marriage. The broad language of the *DiMarco II* holding appears to open the door for claims against physicians by any plaintiff who becomes sexually intimate with the communicable patient, providing there exists sufficient proof of causation. If a patient has multiple sexual partners, the monetary liability could increase exponentially.

However, the court did not address the important question of whether the injured third party must have actual knowledge of the specific advice given to the patient. Additionally, the advice the patient relates to the third party may be in a substantially different form than when originally communicated from the doctor to the patient. In essence, the majority's broad holding creates more questions than it answers. Courts should view the breadth of the *DiMarco II* decision with caution. Hasty adoption of such a broad rule extending physician liability would be unwise in an untested area of law.

D. The Dissent

In a hearty dissent, Justice Flaherty argues that the majority misstates the Pennsylvania rule concerning professional liability under Restatement Section 324A by relying on the non-professional situation in *Cantwell*.[130] By looking to precedent concerning professional duty to third persons, the minority finds that absent privity or a specific undertaking for the benefit of the third person, there exists no duty and therefore no liability.[131] In addition to opening up physician liability to situations beyond their control and knowledge, the minority foresees doctors limiting their inquiries into patient's private lives to avoid potential suits, thereby hampering the patient's treatment.[132]

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130. *Id.*

131. Guy v. Leiderbach, 459 A.2d 744, 746 (Pa. 1983) (supreme court specifically retains an attorney-client relationship or a specific undertaking by the attorney as necessary to maintain a negligence action). *See* Lawall v. Groman, 37 A. 98 (Pa. 1897) (in dicta, an attorney has duty to exercise reasonable care to third parties if 1) undertook specific service to third party, 2) third party relied 3) attorney aware of reliance).

132. *DiMarco II*, 583 A.2d at 426, 427 n.4.

The dissent presents two arguments. First, the minority argues that Pennsylvania law requires a professional relationship or a specific undertaking for the third party to maintain a malpractice action.[133] This argument's flaw becomes apparent since the injuries sustained in precedents were economic and not physical. A strong argument can be made that the precedents can not be analogous and, therefore, do not bar actions outside a physician-patient relationship.[134]

Secondly, the more valid argument asserts that a physician may be forced to practice so defensively that the health of the patient, third persons and the public in general will be compromised.[135] The minority might have been willing to agree with the majority if the holding would have been more factually limited and did not announce the rule in such general terms.

E. After DiMarco II: Possible Limitations

Courts have decided two cases concerning a physician's duty to third persons since *DiMarco II*, but these cases revolve around distinguishable facts,[136] lending little aid in predicting the extent of *DiMarco II*. But importantly in these opinions, the superior court makes clear that the intention of their decision in *DiMarco I* was limited to those specific circumstances involved: where a physician gives advice to a contagious patient that a non-patient claims to be aware of and specifically relies on in interaction with the patient.[137] Because of these complaints from the superior court, it would be possible that the Pennsylvania Supreme Court may clarify its holding

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133. *Id.* at 426.

134. *Id.* at 425 n.1.

135. *See id.* at 427 n.4.

136. Crosby v. Sultz, 592 A.2d 1337 (Pa. Super. Ct. 1991) (no cause of action allowed against physician when diabetic patient lost consciousness while driving resulting in injury to plaintiffs); Dunkle v. Food Service East, Inc., 582 A.2d 1342 (Pa. Super. Ct. 1990) (psychiatrist owes no duty to warn non-patient of patient's dangerous propensities or to protect non-patient where patient has not threatened harm to a particular individual).

137. *Crosby*, 592 A.2d at 1343 n.9 ("In fact, the Pennsylvania Supreme Court's evaluation and ultimate decision in DiMarco far extended the narrow holding that this Court explicitly intended when it decided the case originally."); *Dunkle*, 582 A.2d at 1348 ("In addition, this Court was clear in its directive that *DiMarco* be confined to the circumstances of that case.").

in *DiMarco II*,[138] when faced with another similar case in the future.

Courts should approach claims of non-patients with caution. Close attention must be paid to the facts and proof of causation. A prosaic following of the holding in *DiMarco II* could require courts to modify the rule in later cases. The better approach allows an evolution of law arising from a case by case analysis. The *DiMarco II* decision does little to change the physician's everyday treatment of patients with communicable diseases. Appropriate laboratory tests must be administered and while awaiting results, conservative advice should be given concerning the behaviors to avoid for protection of others. This advice should be clearly documented in the patient's record. The patient may be given specific written instructions including information about the disease and how it can be transmitted.[139] The patient can then show these written instructions to those in close contact with him, ensuring the physician's instructions remain intact when delivered to non-patients. A copy of the written instructions should be retained in the patient's record as evidence of the actual instructions given.[140]

VI. Effects of Reporting Statutes

Communicable disease reporting statutes have not been particularly helpful to plaintiffs in bringing claims against physicians, nor has compliance been of great advantage in protecting physicians against liability. Many state statutes require physicians to report communicable and infectious diseases to local health officers, the failure of which is a misdemeanor.[141] The failure to report does not produce liability to those contracting the disease unless the failure to report can be shown as the proximate cause of the injury.[142]

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138. Phone interview with Susan M. Weber, R.N., J.D. of the Pennsylvania Medical Society (Aug. 14, 1991). The Society is closely watching further developments in the wake of *DiMarco*. There is the possibility of the Society entering in as amicus to the court should *Dunkle* or *Crosby* be appealed.

139. Commercially prepared information sheets are available. The information sheets could then be personalized to the specific patient by hand written instruction.

140. These recommendations are given by the author from 13 years experience as a Registered Nurse, 7 of which were in a family practice setting. The author credits development of her views to Dr. LeMoyne Coffield of New Martinsville, WV and the late Dr. Terrell Coffield for their close attention to quality patient care, patient teaching and careful documentation.

141. 61 Am. Jur. 2d *Physician, Surgeons, Etc.* § 245 (1981).

142. *Id.*

The individual states possess the power and duty to protect the citizenry against communicable diseases and have been vested with broad discretion in promulgation of legislation to effect this end.[143] The specific language of the statute and associated regulations by the state's health department must be read carefully to determine when the duty to report arises, either when the disease is suspected or when it becomes definitively diagnosed. By way of example, the court in *Sorgente v. Richmond Memorial Hospital*[144] read the New York law on tuberculosis, specifically addressing protection of a patient's household,[145] to impose a duty on a physician only upon actual discovery of the tuberculosis.[146] The patient's son contracted tuberculosis shortly after the doctor diagnosed the father as having the disease. However, the father had been under the doctor's care for some time without a definitive diagnosis.[147] The court dismissed the son's claim against the doctor for negligent diagnosis of his father because duty by statute to protect the household members did not arise until definitive diagnosis.[148] Apparently no cases have turned strictly on reporting statutes to state a claim but have used non-reporting as a theory of duty to enhance physician liability found in case law.[149]

A. West Virginia Communicable Disease Reporting Statutes

The West Virginia Legislature has placed a duty upon physicians to report communicable disease to local health officers upon diagnosis by stating:

> It shall be the duty of every practicing physician to report to the municipal or county health officer, where there is such official, immediately on diagnosis, those diseases or conditions for which a report is required by the state board of health and in the manner specified by the state health director which may arise or come under the physician's treatment. Any health officer receiving such reports shall

143. 39A C.J.S. *Health & Environment* § 18 (1976).
144. 539 N.Y.S.2d 269 (N.Y. Sup. Ct. 1989).
145. *Id.* at 270.
146. *Id.*
147. *Id.*
148. *Id.* at 271.
149. *Id.*; *See also* Skillings v. Allen, 173 N.W. 663 (Minn. 1919); Gammill v. United States, 727 F.2d 950 (10th Cir. 1984).

> make to the state director of health a weekly report in a manner specified by the director of health.[150]

However, by the empowerment of the Division of Health[151] with the determination of which diseases will be reported[152] and subsequent promulgation of rules and regulations,[153] the physician's duty arises "upon suspecting a case of a reportable disease to follow a method of control as specified by the state health director."[154] The physician is "to follow a protocol as specified by the state health director for reporting to the county health department."[155] Physicians who fail to report those diseases specified are guilty of a misdemeanor and,

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150. W. VA. CODE § 16-2A-5 (1991).

151. *See generally* W. VA. CODE § 5F-2-1(d)(4) (1990) (redesignation of the Department of Health as Division of Health, within the Department of Health and Human Resources).

152. Telephone Interview with Loretta Haddy, Director of Surveillance and Disease Control, West Virginia Department of Health (Aug. 5, 1991) (there are no federal statutes for determination of what diseases are reportable but recommendations from the Counsel of State and Territorial Epidemiologists are used in deciding which diseases will be reportable in West Virginia); *See also* 64 W. VA. C.S.R. 7 § 5 (1991) (W. Va. Legislative Rules of the Board of Health, *Reportable Diseases* sets forth 4 categories of reportable diseases) (Table 64-7A lists specific reporting requirements and diseases applicable to physicians): 64 W. VA. C.S.R. 7 § 5.1 (1991) (*Category I* Diseases or conditions to be reported immediately by telephone to the county health department, including case name, address, age and sex. Call within 24 hours to report: botulism, cholera, diphtheria, foodborne diseases, gonococcal disease, . . . meningitis, . . . plague, poliomyelitis, smallpox, syphilis, . . . waterborne disease, yellow fever. . .); 64 W. VA. C.S.R. 7 § 5.2 (1991) (*Category II* Diseases or conditions reported weekly by name, address, age and sex to the county health department: amebiasis, anthrax, brucellosis, campylobacteriosis, chancroid, chlamydia trachomatis, conjunctivitis in the newborn, other than gonococcal, encephalitis . . ., giardiasis, gonorrhea . . ., hepatitis . . ., herpes simplex virus (Type 2), leptospirosis, lyme disease, malaria, meningitis . . ., mumps, pertussis, psittacosis, rabies in Animals and in Man, rheumatic fever, rubella. . ., rubeola, salmonellosis. . ., shigellosis, syphilis (late latent), tetanus, trichinosis, tuberculosis (All Forms), tularemia, typhoid fever, typhus fever . . .); 64 W. VA. C.S.R. 7 § 5.3 (1991) (*Category III* Diseases to be reported weekly by numerical totals to the county health department: chickenpox, influenza-like illness); 64 W. VA. C.S.R. 7 § 5.4 (1991) (*Category IV* Illnesses of unusual prevalence or clusters of unexplained health occurrences to be reported by name, age, sex, and specific disease information to the state health department according to protocols specified by the director of the department: Symptomatic infection with the Human Immunodeficiency Virus (HIV), including person with AIDS and with other illnesses falling in Groups I, III and IV of the CDC HIV infection classification, birth defects, cancer, dengue, hemophilia, lead poisoning, occupational-related illnesses, unusual or ill-defined conditions); W. VA. CODE § 16-3C-8(b) (1991) ("The department shall promulgate rules . . . to provide for a reporting and monitoring system for reporting to the department all positive HIV tests results."); W. VA. CODE § 26-5A-4 (1986) (requiring physician to report to the health department within 48 hours every tuberculosis diagnosis by name, age, sex, race and address).

153. W. VA. CODE § 16-1-7 (1991).

154. 64 W. VA. C.S.R. 7 § 8 (1991).

155. *Id.* at § 7.

upon conviction, will be fined no more than two hundred dollars or imprisoned for no more than thirty days.[156]

Duty to report does not arise if the patient becomes hospitalized or placed in a nursing home.[157] In those cases, the duty to report rests with the admitting institution.[158] Additionally, statutes require private and public laboratories to immediately report certain positive laboratory tests to either the county health department or to the State Department of Health.[159]

Additional reporting statutes for tuberculosis[160] and venereal diseases[161] are scattered throughout the West Virginia Code. Inconsistency becomes apparent when one compares these statutory requirements imposed upon physicians to the rules promulgated by the Board of Health.[162] Fortunately, the AIDS-Related Medical Testing and Records Confidentiality Act[163] is placed logically within the Code in close proximity to the general communicable disease statutes. The Act provides that the Department of Health shall promulgate rules for reporting to the Department all positive HIV test results.[164] The Act permits, within strict confidentiality requirements, the use of HIV test results to inform individuals who may be at risk of having acquired the HIV infection from a serologic positive person.[165] Additionally, the legislature has limited physician duty by stating:

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156. *Id.* at § 24.

157. *Id.* at § 7.

158. *Id.* at § 6.

159. *Id.* at § 6 (public and private laboratories have a duty to report immediately positive results of tests in Categories I,II and III to the county health department and Category IV to the state department of health).

160. W. VA. CODE § 26-5A-4 (1986) (Tuberculosis Control statute requires written report of tuberculosis cases within 48 hours after diagnosis to the department of health); W. VA. CODE § 16-25-3 (1991) (diagnosed tuberculosis cases shall be reported within 72 hours, excluding Sundays and holidays, to the state department of health whose misdemeanor violation will incur a fine of not less than twenty dollars nor more than one hundred dollars).

161. W. VA. CODE § 16-4-6 (1991) (requiring written reports to both the local municipal or county health officer and to the director of health of the State within 48 hours).

162. 64 W. VA. C.S.R. 7 § 5.2 (1991) (tuberculosis cases to be reported weekly by name, address, age and sex to the county health department); 64 W. VA. C.S.R. 7 § 5.1 (1991) (requiring cases of gonorrhea and syphilis to be reported immediately to the county health department by telephone within 24 hours).

163. W. VA. CODE § 16-3C-1 to -9 (1991).

164. W. VA. CODE § 16-3C-8(b) (1991).

165. W. VA. CODE § 16-3C-3(d) (1991).

> There is no duty on the part of the physician or health care provider to notify the spouse or other sexual partner of, or persons who have shared needles with, an infected individual of their HIV infection and a cause of action will not arise from any failure to make such notification. However, if contact is not made, the department will be so notified.[166]

Legislative reform is necessary in communicable disease statutes to provide physicians with consistent, easily accessible and readily obtainable information concerning their duty to report. This reform could be obtained by repeal of outdated and misplaced statutes, and replaced by a general statute defining when a physician's duty to report arises. Clear centralization of authority, subject to legislative approval, should be placed with the Department of Health for dealing with communicable diseases.

Until such centralization becomes a reality, the aforementioned statutes and rules will promote confusion in determining whether a physician's duty to report arises on suspicion or confirmation of diagnosis. If the patient presents for treatment in the office setting, the physician suspecting a case of reportable communicable disease should consult the information contained in the *West Virginia Reportable Disease Protocol Manual*.[167] This manual should be a readily accessible tool for reference in all physicians' offices.

The *Protocol Manual* also includes examples of some reporting forms[168] that provide a section to request assistance in contact follow-up.[169] The state provides a contact tracing program to follow up communicable disease cases for the notification of persons pos-

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166. W. VA. CODE § 16-3C-3(e) (1991).

167. STATE OF WEST VIRGINIA DEPARTMENT OF HEALTH REPORTABLE DISEASES PROTOCOL MANUAL (1988) [hereinafter *Protocol Manual*]. This first edition manual is published by the West Virginia Department of Health and is available through local health departments. It was developed as a reference guide for dealing with diseases required to be reported by the Board of Health. In addition to general information such as phone numbers for immediate reporting of certain diseases, each reportable disease is separately indexed with reporting protocol for medical care providers. The protocol varies with the disease, ranging from required reporting upon suspicion of disease to others requiring reporting only upon definitive diagnosis by laboratory test.

168. *Id.* The report forms are only samples for informational purposes. Actual reporting forms must be requested from the West Virginia Department of Health and Human Resources, Office of Epidemiology and Health Promotion, Division of Surveillance and Disease Control, 1422 Washington Street, East, Charleston, WV 25305 or by calling 1-800-423-1271.

169. *Id.* (Exhibit 9 re: Syphilis. Form No.VD-15-11/86 West Virginia State Department of Health).

sibly infected and to limit the spread of disease.[170] The extent of tracing depends upon the specific disease. For example, the Department of Health will trace hepatitis to the initial contact and household members, while the Department follows sexually transmitted diseases, such as AIDS or syphilis, until contact information is exhausted.[171] This policy seems inconsistent in that Hepatitis B can also be sexually transmitted.[172]

An estimate purports that only 10% of communicable disease reports contain a request for state assistance in contact follow-up.[173] Also, theoretically, a physician who did not choose to participate in the State's tracing program could then be liable to infected persons.[174] Therefore, routine request for state follow-up in communicable disease cases promotes the best interest of both the nonpatient and the physician. Request for routine State contact follow-up could effectuate reduction in the spread of disease. Also, by requesting assistance, the physician shows action on his part not only to comply with statutory duty but to control disease dissemination.

Additionally, the physician has a statutory duty in reportable diseases to:

> advise other members of the household regarding the precautions to be taken to prevent further spread of the disease, (using caution where venereal disease is involved) and shall cooperate with the county health officer in seeing that the methods of the state director of health concerning the control of such reportable diseases are carried out by the patient and other members of the household.[175]

This legislative rule is explicit in limiting the physician's duty to advise of the patient's disease only to those who live as part of the patient's household.

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170. Telephone Interview with Loretta E. Haddy, Director of Surveillance and Disease Control for the West Virginia Department of Public Health (July 18, 1991).

171. *Id.*

172. "Hepatitis B is a viral infection of the liver usually transmitted by inoculation of infected blood or blood products. However, the antigen has been found in most body secretions, and it is known that the disease can be spread by oral or sexual contact." C. Michael Knauer, M.D. & Sol Silverman, Jr., D.D.S., *Alimentary Tract & Liver*, in CURRENT MEDICAL DIAGNOSIS & TREATMENT 433 (Steven A. Schroeder et al. eds., 1990).

173. Telephone Interview with Loretta Haddy, *supra* note 170.

174. *Id.*

175. 64 W. VA. C.S.R. 7 § 8 (1991).

However, a person injured by violation of a West Virginia statute may recover in a civil action, unless the penalty imposed is expressly mentioned to be in lieu of such damages.[176] Apparently, the reporting statutes make no mention of such limitations. Additionally, compliance with a statute constitutes competent proof of due care but will not be conclusive.[177] Therefore, compliance with the reporting statutes will not insulate the physician from a civil suit, but only aid in showing that the physician complied with the minimum standards imposed for the protection of non-patients.

VII. Recent West Virginia Malpractice Cases

Research of West Virginia case law reveals no authority in regard to the direct transmission of communicable disease nor physician duty to third persons who have contracted communicable diseases. However, decisions involving third party plaintiffs show a reluctance to extend the liability of a professional.

First, the court in *First National Bank of Bluefield v. Crawford*[178] adopted the majority and Restatement[179] view that liability of professional accountants is limited. An accountant, in absence of privity of contract, becomes liable for negligence only to those who he knows will receive and rely on his report.[180] This case, of course, concerns economic losses and is thus difficult to analogize to the physical injury suffered by a third party contracting a communicable disease. However, the theory of reasonable knowledge of the injured person and his reliance on the information may be useful in limiting the slippery slope effect possible in the wake of the broad general rule annunciated in *DiMarco II*.

Secondly, the requirement of a professional relationship to bring a medical malpractice claim remains the law in West Virginia, as pronounced by the supreme court in *Weaver v. Union Carbide Cor-*

176. W. Va. Code § 55-7-9 (1981).
177. *See* Miller v. Warren, 390 S.E.2d 207 (W. Va. 1990).
178. 386 S.E.2d 310 (W. Va. 1989).
179. Restatement (Second) of Torts § 552 (1985).
180. *Crawford*, 386 S.E.2d at 313.

poration.[181] In *Weaver*, the court answered in the negative a certified question[182] of first impression[183] as to whether a non-patient wife could maintain a malpractice suit against a marriage counselor. While in treatment, the counselor and husband-patient engaged in sexual relations leading to the dissolution of the marriage.[184] Because of the breach of a trust relationship with the plaintiff, the court distinguished persuasive authority[185] allowing a malpractice claim when spouses are jointly counseled.[186] Therefore, the court foreclosed the malpractice action because no professional relationship existed between the counselor and the uncounseled spouse.[187]

The court reiterated the holding of *Weaver* as a basis for affirming summary judgment against the plaintiff's malpractice claim in *Sisson v. Seneca Mental Health/Mental Retardation Counsel, Inc.*[188] The female patient met with the defendant, an on call crisis counselor, while her regular counselor vacationed.[189] She resumed her regular counseling sessions when he returned, but became sexually involved with the on call crisis counselor.[190] Although recognizing from *Weaver* the potential validity of a malpractice claim where a counselor engages in sexual intimacy with a patient during therapy,[191] the court found no therapeutic or trust relationship sufficient to sustain such an action.[192] Apparently, the court is prepared to allow malpractice action only where there is an identifiable professional relationship.

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181. 378 S.E.2d 105 (W. Va. 1989). *See also* Rand v. Miller, 408 S.E.2d 655 (W. Va. 1991) (a physician who inaccurately evaluates a prospective employee's medical records for the employer, which results in non-hiring, will not support a malpractice action because of lack of sufficient professional relationship).

182. *Weaver*, 378 S.E.2d at 105.

183. *Id.* at 106.

184. *Id.* at 109.

185. Horak v. Biris, 474 N.E.2d 13 (Ill. App. Ct. 1985) (a marriage counselor may be liable to a spouse for loss of consortium resulting from sexual intimacy with the other when both husband and wife are jointly counseled).

186. *Weaver*, 378 S.E.2d at 107.

187. *Id.* at 109.

188. 404 S.E.2d 425 (W. Va. 1991).

189. *Id.* at 426.

190. *Id.* at 427.

191. *Id.* at 429.

192. *Id.* at 429-30.

Most recently in *Rand v. Miller*,[193] the court succinctly stated that "[t]he essence of a medical malpractice action is a physician-patient relationship," using for support the *Weaver* and *Sisson* decisions.[194] The *Rand* case involved a physician hired by an employer to evaluate the medical records submitted by the applicant's personal physician.[195] In reviewing the plaintiff's records, the defendant detected a personality disorder that prevented the plaintiff from being hired.[196] The defendant appealed, asserting that the trial court erred in allowing a medical malpractice claim.[197] The court agreed, finding the lack of a sufficient professional relationship between the physician and the applicant to support a malpractice action because the physician's duty ran to the employer, not to the applicant.[198] Additionally, the defendant had not physically examined the plaintiff, thus making the relationship tenuous at best.[199] A defamation action for reporting of false information would have been possible but became barred by the statute of limitations.[200]

However, the court's recognition of the Pennsylvania Superior Court decision of *Ervin v. American Guardian Life Assurance Co.* is of interest.[201] The *Ervin* court held that the Restatement (Second) of Torts Section 324A[202] did not apply to a third party claim when an insurance company physician advised the company concerning the applicant's test results. The *DiMarco I* court distinguished *Ervin* when applying Section 324A to the *DiMarco* facts because there existed a physician-patient relationship between the doctors and the phlebotomist, and communicable diseases, such as hepatitis B, must be controlled.[203] The *DiMarco II* court made no mention of *Ervin*.

Conceivably, West Virginia courts could follow the conservative lead in *DiMarco I* or adopt the broad rule of *DiMarco II*, when

193. 408 S.E.2d 655 (W. Va. 1991).
194. *Id.* at 656-57.
195. *Id.* at 656.
196. *Id.*
197. *Id.*
198. *Id* at 658.
199. *Id.*
200. *Id.* at 659.
201. Ervin v. American Guardian Life Assurance Co., 545 A.2d 354 (Pa. 1988).
202. § 324A, *supra* note 111.
203. *DiMarco I*, 559 A.2d at 533.

faced with a similar third party non-patient claim. The preferred approach would be the moderate path of the *DiMarco I* court, utilizing close attendance to facts and relationships and limitation of the decision to specific facts. The advantage to this approach would be the prevention of necessary judicial backtracking should the rule in *DiMarco II* prove too expansive in extending physician liability disproportionately.

VIII. Conclusion

Non-patient's malpractice claims against physicians for infection with communicable diseases revolve around specific facts, producing an unsettled area of law. The recent Pennsylvania Supreme Court decision in *DiMarco II* appears to open third party malpractice claims to anyone who becomes sexually intimate with an infectious patient and claims knowledge and reliance on physician advice.

Courts should approach similar situations with moderation, not blindly adopting the broad language of *DiMarco II*. An evolution of law under varying factual settings will more likely produce fairness for the third party and physician alike. Physicians should provide the communicable patient with thorough teaching, including written precautionary instructions. Careful documentation and routine Department of Health notification should be the physician's standard procedure. Expansion of the Department of Health's contact tracing program would enhance control of communicable disease.

Legislative reform is needed in regard to the various communicable disease statutes sprinkled throughout the West Virginia Code. Legislation providing centralization with and clarification by the Department of Health, along with a clear definition of when a physician's duty to report communicable diseases arises, would provide consistency and predictability in an unsettled area of law.

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