Psychotherapeutic Injury: Reshaping the Implied Contract as an Alternative to Malpractice

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Despite the enormous number of Americans who seek psychiatric aid for their emotional problems, malpractice actions against psychiatrists are surprisingly rare. In this Article, Professors Feldman and Ward suggest that this state of affairs is caused not by the extraordinary competence of the psychiatric profession, but rather by the particularly severe legal obstacles that confront injured psychiatric patients. The elements of the traditional tort cause of action—especially causation—are not easily proved by plaintiffs claiming psychiatric injury. Moreover, recent cases show that courts are growing even more unsympathetic to those patients who suffer most grievously from unscrupulous psychiatrists. To remedy this problem, the authors reach to the historical origins of medical malpractice liability, and advocate the revival of an implied contract to treat with skill and care. By imposing a fiduciary obligation on the psychiatrist in the performance of this contract, the authors overcome the obstacles of proof that arise from traditional tort law. This alternative approach should bring a new balance to the law of psychiatric malpractice, in which aggrieved patients will be compensated for their injuries, but innovative practitioners will not be unduly deterred from medical experimentation.

I. Introduction

Psychotherapy is the only generally accepted healing art that can-
not be pre-tested. At present, no method is available for evaluating a "talking therapy" on nonhuman subjects. Therefore, the typical medical research model, which calls for careful testing of a substance or technique on animals prior to use on human beings, is not adaptable to psychotherapy. Moreover, the testing of treatment techniques on nonpatient human subjects is normally unproductive because these subjects do not suffer the emotional disability that an experimental therapy is designed to treat. The application of a psychotherapeutic technique to a volunteer subject who is not in the throes of a psychic disturbance will net the researcher very little. Thus, the administering of innovative psychotherapy to an actual patient for the first time is the ultimate test of whether it will work. Despite the limitations in the experimental methodology, it is generally agreed that there is need for research and discovery in order to develop and refine treatment techniques. Psychotherapy, in all its forms, is still an infant science with much to learn about itself. To advance the state of the art, the law must afford the sincere innovator some leeway when a treatment technique undertaken in good faith proves unsuccessful. Yet the law cannot leave the patient a defenseless guinea pig in the face of an overzealous, irresponsible, or self-serving practitioner. To serve these competing interests in the unique verbal context of psychotherapy, the law must find the delicate balance that will protect the patient population, and yet permit creativity and development in the healing art itself.

This article posits the existence of two serious problems in the
present law controlling the therapist-patient relationship. The first problem arises because most actions brought against therapists for injurious conduct are grounded in the tort of malpractice, which, due to several difficult problems of proof, unduly favors the doctor. Second, there is emerging in the cases on psychotherapeutic malpractice the curious, and to some extent successful, defense that certain injurious conduct is sufficiently nonprofessional to insulate the doctor from malpractice liability because he is no longer practicing. The most disturbing example of this “nonpractice” conduct occurs when a therapist takes advantage of his patient’s vulnerability in order to gain sexual intimacy or monetary advantage. In response to both problems this article advocates an even-handed solution that flows directly from a clarification of the true nature of the doctor-patient relationship. The solution is grounded historically and conceptually in a revitalized implied contract to treat with skill and care. Conceptually the implied contract should serve to broaden the doctor’s obligation to use skill and care. When this implied contract is appropriately invested with obligations in the nature of fiduciary duties running from the doctor to the patient, it becomes the basis for an independent cause of action whenever the therapist breaches his trust regardless of the patient’s failure to show a breach in the standard of care. Under this independent action, corollary rules that historically attend contractual obligations invested with fiduciary duties will, directly or by analogy, serve to distribute equitably the benefits and burdens between the patient and the doctor.


7. But see Saxe, Psychotherapeutic Treatment and Malpractice, 58 Ky. L.J. 467, 478-79 (1970) (author predicts increase in psychiatric malpractice suits and suggests caution in exposing the therapist to greater risk). Despite Professor Saxe’s concern, only two cases of psychotherapeutic malpractice have appeared in the appellate reports since his article was written in 1970—Anclote Manor Foundation v. Wilkinson, 263 So. 2d 256 (Fla. Dist. Ct. App. 1972), and Roy v. Hartogs, 85 Misc. 2d 891, 381 N.Y.S.2d 587 (App. Term 1976).

8. Blackstone informs us: “For it hath been solemnly resolved, that mala praxis is a great misdemeanor and offence at common law, whether it be for curiosity and experiment, or by neglect; because it breaks the trust which the party had placed in his physician, and tends to the patient’s destruction.” 3 W. Blackstone, Commentaries *122 (Sharwood ed. 1885) (footnote omitted). Authority for that statement is cited in note 8 to the text: “The law implies a contract on the part of a medical man, as well as those of other professions, to discharge their duty in a skillful and attentive manner . . . .” Id.


II. The Present Problem With the Law of Malpractice

Absent the screening function of state examination boards and licensing requirements,11 the only legal protection a patient has against a therapist who causes him psychic injury is a malpractice action for damages. This remedy is largely illusory.12 Problems of proof are immense. In order to establish a *prima facie* case of malpractice the plaintiff must adduce evidence on four basic allegations13 (although the first two are intertwined):

1. the standard of care to be applied, which is established by the profession for a practitioner of the healing art;
2. the breach by the defendant doctor of the standard;
3. the actual injury of the plaintiff;
4. the proximate causation of the injury by the breach.

It is the unique verbal character of psychotherapy which makes the proving of each one of these allegations problematical.

A. The Standard of Care and the Breach

To demonstrate that an act or omission of the therapist violated the standard of care that the law demands of a practitioner, the plaintiff must first establish the accepted level of professional skill existing in the medical community in which the doctor practices.14 This is done by the testimony of expert witnesses.15 Obtaining this expert testimony, however, presents a problem common to all malpractice suits. It is extremely difficult to get any professional to testify against his brethren.16 But assuming this testimony can be procured, the difficulties of establishing a clear standard of skill and care remain. Psychotherapy is a

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12. *In reviewing the difficulties inherent in a malpractice suit, Robert Strodel, an experienced plaintiff's attorney, states: “It is difficult enough to prove the merits of the claim when playing in the physicians' ball park. It is virtually impossible to prevail if the client is not saleable as an individual.”* Strodel, Medical Malpractice—A Primer for Attorneys, 1978 MED. TRIAL TECH. Q. 121, 123-24.
14. Annot., 99 A.L.R.2d 599, 606 (1965); *see McCoid, The Care Required of Medical Practitioners, 12 VAND. L. REV. 549, 558 (1959). But see Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974), in which the court held that the failure of an ophthalmologist to give a glaucoma test was negligence as a matter of law regardless of the standards of the ophthalmology profession.*
15. Comment, *supra* note 5, at 419.
16. *See Markus, Conspiracy of Silence, 14 CLEV.-MAR. L. REV. 520 (1965).*
young science with few principles that are universally accepted. If the allegedly breaching psychotherapist can show that his actions or modes of treatment are condoned by a respected minority of practitioners, he is virtually insulated from liability. Courts have recognized that in a changing science a physician is not liable for mistakes in judgment when a matter is more or less unsettled or when physicians might reasonably differ. In the field of psychotherapy, which accepts schools of thought ranging from Carl Rogers’ client-centered therapy to B.F. Skinner’s operant conditioning, there is a great deal of room for debate about proper modes or techniques of treatment. Thus, it is an enormous challenge to establish a standard against which to measure the asserted dereliction of the psychotherapist. An experienced trial lawyer in the malpractice field defined the general problem of establishing standard of care:

The legal aspects of medical negligence are relatively simple. It is the proof of medical care deviations in what is admittedly an inexact science that is the difficult aspect of such litigation. These observations are especially applicable to the infant science of psychotherapy.

B. Psychic Injury and Causation

Should the plaintiff, through expert testimony, establish the breach of a standard of care, or be excused from doing so due to the patently extreme acts of the therapist, the next hurdles are to prove actual

18. Rothblatt & Leroy, Avoiding Psychiatric Malpractice, 9 CALIF. W. L. REV. 260, 263 (1973); Comment, Injuries Precipitated by Psychotherapy: Liability Without Fault as a Basis for Recovery, 20 S.D. L. REV. 401, 407 (1975); Note, supra note 17, at 74-76; Comment, supra note 5, at 419. See also V. Nordby & C. Hall, supra note 4, which lists 42 respected psychologists and the schools of thought they engendered.
20. V. Nordby & C. Hall, supra note 4, at 147.
21. Id. at 156-59.
22. Strodle, supra note 11, at 131.
23. In a particularly bizarre case involving the actual beating of a patient by the therapist, the court held there was no need for expert testimony because “the very nature of the acts complained of bespeaks improper treatment and malpractice . . . .” Hammer v. Rosen, 7 N.Y.2d 376, 378, 165 N.E.2d 756, 757, 198 N.Y.S.2d 65, 67 (1960). For a full discussion of Hammer, see notes 122-129 and accompanying text infra. According to Hammer, the doctor must go forward with proof of compliance with an acceptable standard of care once plaintiff has shown evidence of apparently extreme or unusual treatment. 7 N.Y.2d at 378, 165 N.E.2d at 757, 198 N.Y.S.2d at 67. This evidentiary burden, however, is keyed exclusively to the issue of standard of care. The concept of a shifting burden of persuasion is similar to part of the proposed solution in this article, see notes 88-93 and accompanying text infra, but the issue about which it revolves differs, see notes 127-129 and accompanying text infra.
injury and proximate causation by the acts or omissions of the defendant. Both are formidable, but of these two the proof of actual psychic injury can be less burdensome because it can often be demonstrated by consequent physical symptoms.\textsuperscript{24} Case law now has a long history of allowing recovery for nonimpact torts that have caused physical discomfort through the infliction of fear or fright, whether intentionally or negligently occasioned.\textsuperscript{25} Absent physical consequences, however, the plaintiff’s task is difficult. While he is not precluded from testifying on his own behalf, or presenting lay witnesses who can accurately report his altered mental or emotional condition, such evidence, lacking palpable substantiation, will naturally be viewed more skeptically by a court or jury. Nevertheless, if the testimony is credited, the allegation of actual injury is proven.\textsuperscript{26}

Establishing the causal link between the psychotherapist’s breach and the injury is the most difficult burden of proof for the plaintiff.\textsuperscript{27} The historic lack of psychotherapeutic malpractice cases in the courts has been attributed to this problem.\textsuperscript{28} The initial obstacle for the patient is to show any cause at all. Almost nothing is known about the normal course of mental or emotional illness. While psychotherapists will presume to evaluate and categorize the nature and magnitude of a patient’s problem,\textsuperscript{29} none will predict the “normal course” the illness will take beyond speaking in general terms of optimism or pessimism. The ability to pinpoint the cause or causes for improvement or degeneration in a patient’s condition during treatment remains largely beyond the present knowledge in the field. A patient’s condition may sharply alter for better or worse without explanation. Set in this matrix of mystery, the plaintiff’s burden of showing the proximate causation of injury attributable to a particular act or omission of the therapist is

24. Dawidoff briefly lists “beating or compensation neuroses such as hives, acne, upset stomach.” \textit{D. DAWIDOFF, supra note 10, at 70. But the range of physical manifestations of mental or emotional illness is as varied as the individual patient.}

25. For a full history and review of the development of nonimpact tort recovery, see Lambert, \textit{Personal Injury (Tort) Law, 28 NACCA L.J. 33 (1961).}


27. Tarshis, \textit{Liability for Psychotherapy, 30 U. TORONTO FACULTY L. REV. 75, 96 (1972).}

28. Note, \textit{supra note 17, at 65.}

29. The accepted diagnostic guide, which establishes categories of mental illness, is the \textit{American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2d ed. 1968),} known in the mental health field simply as "DSM-2." See Note, \textit{supra note 3, at 700-02, for a discussion of the unreliability of diagnostic efforts. Failure of a state mental hospital to diagnose accurately has been held not to be a basis for holding the state liable when the patient killed someone while on convalescent leave. Milano v. State, 44 Misc. 2d 290, 253 N.Y.S.2d 662 (1964).}
Indeed heavy. Because psychic injury is by definition nonphysical, though physical consequences may sometimes exist, there is nothing like the neat causal clarity of a sponge left in an incision that might be available as proof to the surgical malpractice plaintiff.

After considering the problems of proof involved in establishing a prima facie case of psychotherapeutic malpractice (standard, breach, injury and causation), one can reasonably conclude that this form of protection for the patient and control of the doctor is not a very useful mechanism. Add to this a natural reluctance on the part of the patient to parade his illness before lawyers, judges and jurors, and the emotional difficulties that might attend a suit against a therapist who once held a deeply meaningful and trusted position in the plaintiff's life, and it is understandable that only seven cases of psychotherapeutic malpractice have appeared in appellate reports in the last 20 years. Of those seven cases, only two involved direct actions by patient against therapist. Of the others, one was brought by the guardian of the patient, two were brought by the husbands of the patient after the patient-wife had divorced the plaintiff or committed suicide, and two actions were against insurance companies that refused to appear and defend under the policy and later disclaimed malpractice liability coverage after the plaintiff recovered a judgment in the main action.

When estimates of the number of mentally ill in the United States range as high as twenty million and a major part of their treatment involves psychotherapy, one must agree with the commentator who said, "(1) either psychiatrists have reached near perfection in the conduct of therapy, or (2) something is amiss." If, in fact, something is amiss in the law of psychotherapeutic malpractice, one need only inspect the cited cases to find a line of reasoning that appears to be going...
even further in the direction of psychotherapeutic immunity from liability. Thus far we have discussed the problem only in terms of the enormous difficulty of making out a *prima facie* case of malpractice. A new problem seems to be emerging for the plaintiff who makes out too strong a case.

III. THE NEW PROBLEM WITH THE LAW OF MALPRACTICE

Should the therapist's dereliction be so clear as to leave no doubt that he is no longer engaged in therapeutic treatment of the patient, the plaintiff might conclude that his road to recovery has been made that much easier. This, however, is not necessarily the case. It now appears that the plaintiff is in distinct danger of proving himself out of his right to compensation by the very strength of his evidence. The clearest example of this phenomenon is *Nicholson v. Han.* In that case, Mr. and Mrs. Nicholson were receiving marital counseling from Dr. Han from 1960 through 1962. The effort failed and the couple was divorced in 1962. Unbeknownst to Mr. Nicholson, however, his wife and Dr. Han were having an affair for the latter half of that period. When Mr. Nicholson discovered this some years later, he filed an action against Dr. Han alleging breach of contract, malpractice, assault and battery, trespass on the case and fraud. The trial judge dismissed the plaintiff's suit for failing to state a claim upon which relief could be granted. The appellate court explained that "[t]he [trial] court believed the substance of the plaintiffs claim to be in the nature of an action for alienation of affections, charging criminal conversation and seduction of a person over the age of 18 or more years and therefore barred by statute." The appellate court then affirmed the dismissal by agreeing that the gist of the complaint, no matter how pleaded, was the tort of alienation of affections and, in truth, such a claim was "squarely within the abolished actions."

The *Nicholson* opinion establishes that the facts presented in that case do not make out a claim of malpractice because the wrongs alleged are beyond "practice" in any professional sense. The court's rationale appeared to be that Dr. Han could not have committed the tort of alienation of affections and have been *malpracticing* at the same time. The two were apparently mutually exclusive in the court's mind. While this result may seem curious, particularly in light of the modern

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39. *Id.* at 36, 162 N.W.2d at 314.
40. *Id.* at 40, 162 N.W.2d at 317.
day practice of permitting alternative and even inconsistent pleading, this case cannot be passed over as merely aberrant. In the same year that the Nicholson opinion was handed down in Michigan, the Supreme Court of Missouri echoed the identical rationale in Zipkin v. Freeman.

Mrs. Zipkin was treated for three years by the defendant psychiatrist. During that time, her symptoms of extreme nervousness were markedly improved and she suggested terminating the therapy. Dr. Freeman persuaded her to continue in his care, in the course of which Mrs. Zipkin became sexually intimate with him, divorced her husband at his suggestion, loaned him $14,000 to buy a farm, moved onto and worked the farm, stole suits of clothes from her former husband for defendant's benefit and sewed his labels in them, participated in nude swimming parties, perjured herself in frivolous lawsuits against her own relatives at his instigation and turned over to him child support that she was receiving from her former husband.

Once free of his influence, Mrs. Zipkin brought a malpractice suit against Dr. Freeman and recovered a verdict of $17,000. The doctor's insurance company, however, refused to defend and disclaimed coverage. The posture of the instant case was a garnishment proceeding in which the court treated the insurer as defendant. The Supreme Court, sitting en banc, upheld the garnishment by a six to one decision. Only three judges, however, were willing to characterize the defendant's actions as malpractice. The remaining three, in a concurring opinion, stated flatly that Dr. Freeman did not malpractice:

[M]any of the acts of Dr. Freeman did not constitute malpractice, nor did they have any true relationship with professional services performed or omitted . . . . this relationship (and the doctor's acts) passed the point at which anyone could logically believe that they had any reasonable connection with professional services, or that they were being performed in the course of any legitimate treatment. In other words, the 'treatment' ceased, and an ordinary, person to person, invasion of plaintiff's rights, civil or criminal or both, began.

To capsulize the point, it seems that if the acts or omissions of the therapist done under the guise of practice are sufficiently unrelated to professional services, as the court understands them, he is no longer

42. 436 S.W.2d 753 (Mo. Sup. Ct. 1968).
43. Id. at 764-65 (concurring opinion).
practicing therapy, and, therefore, cannot be malpracticing. The three concurring judges allowed the garnishment only because the manner of presentation of the evidence did not enable them to distinguish acts of possible malpractice from other torts or crimes perpetrated by the defendant. Again, the import is clear. If plaintiff alleges facts or presents evidence that proves malpractice, but in addition supports a wrong characterized by the court as something other than malpractice as well (Nicholson), or more than malpractice (Zipkin), then plaintiff is in danger of proving himself out of his basic claim of malpractice.

Can it be argued that the rationale of the Zipkin concurrence is applicable only to questions of insurance coverage, and, therefore, would not pose a danger to the injured patient in his suit directly against the therapist? (This would require us to disregard Nicholson, but for the sake of argument and analysis we will do so.) The answer may reside in two recent cases involving a New York psychiatrist named Dr. Hartogs. The first suit, Roy v. Hartogs, was a malpractice claim by the patient against the doctor in which the doctor's insurer refused to defend and disclaimed coverage. The second, Hartogs v. Employers Mutual Liability Insurance Co., was a suit by the doctor to recover the costs of having to defend the claim of Ms. Roy due to the insurance company's refusal to do so.

Ms. Roy was in treatment to work out problems of lesbianism. Under the guise of therapy, Dr. Hartogs became sexually intimate with her. The affair and therapy continued for approximately thirteen months when both were terminated. Ms. Roy then brought her malpractice suit and was awarded $150,000 in damages. On appeal, the judgment was conditionally affirmed by a two to one decision. The dissenting judge, however, again raised the curious danger of proving too much:

[In my view this did not constitute malpractice . . . . I neither condone the defendant's reprehensible conduct, nor maintain that it was not violative of his professional ethics . . . . But let him not be convicted of his acts of misfeasance and malfeasance by virtue of an action in malpractice.]

He then went on briefly to explain that the wrong done to Ms. Roy was

44. Id. at 765 (concurring opinion).
46. 89 Misc. 2d 468, 391 N.Y.S.2d 962 (Sup. Ct. 1977).
47. The Appellate Court invoked remittitur and reversed and remanded the case for trial on the issue of compensatory damages only, unless plaintiff agreed to a reduced judgment of $25,000. 85 Misc. 2d at 893, 381 N.Y.S.2d at 589.
48. Id. at 894-95, 381 N.Y.S.2d at 591-92 (dissenting opinion).
essentially a seduction, and because that cause of action was barred by
state statute, the complaint should have been dismissed, citing the 
Nicholson case. While this opinion is merely a dissent, it is nonetheless
significant because there was no question of insurance before this court.
The issue of coverage vel non was not guiding this judge's decision, and
the adoption of Nicholson was on the merits.

The question of malpractice insurance coverage was, of course,
squarely presented when Dr. Hartogs filed suit against his insurer. The
trial court granted a motion for summary judgment in favor of the de-
fendant insurance company, holding no coverage.49 Here, Dr. Hartogs
argued that he must be covered by the insurance contract because a
jury had already found him liable for malpractice in the Roy suit. The
insurance company countered with the argument of the Roy dissent
that Dr. Hartogs' actions did not constitute the practice of psychother-
apy, and therefore were not malpractice. The trial court said:

They are both correct. A distinction should be drawn in a factual
situation such as this between medical malpractice in the mind of the
patient and medical malpractice in the mind of the doctor. Plainly
when the patient submitted she believed that appropriate medical
therapy was being administered . . . . On the other hand, the doctor
administering the "treatment" at all times knew . . . . that what he was
doing was in no way pursuant to the doctor-patient relationship.50

This neat solution suggests that a patient may claim malpractice
against the doctor if she is injured when she believes she is being
"treated," but that belief is not binding on the insurance company in a
claim by the doctor for indemnification. The insurance company may
legitimately disclaim coverage if the doctor knows his actions are not a
part of the treatment. The Hartogs court supported its distinction with
an ethical policy statement: "To hold otherwise would be to indemnify
immorality and to pay the expenses of prurience."51 This dicta is itself
seductive but turns out to be perfectly circular. The court evidently
realized that, despite its nice distinction allowing liability to turn on the
subjective state of mind of either the patient or the doctor, depending
upon who is the plaintiff, the reality was that the patient, in all likeli-
hood, would go uncompensated if there were no insurance coverage of
the doctor. It therefore suggests a direct cause of action for the patient
against the insurance company. The court's clear implication is that in

1977).
50. Id. at 470, 391 N.Y.S.2d at 964.
51. Id. at 471, 391 N.Y.S.2d at 965.
such a suit the patient's state of mind controls. Herein lies the beginning of the circle. The patient will thus be able to reach the insurance funds even though the doctor cannot because he knew he was not practicing. The court explained its policy in this fashion: "No longer is it the law in this state 'that the liability policy existed solely for the benefit of insured.' The courts recognize that the injured person also is to be protected." Under the court's view of the insurance law of New York an injured party was allowed a direct action against the insurer even though the insurer had properly disclaimed coverage against its own insured. This extension of the limited direct action authorized by section 167 of the New York Insurance Law finds little support in the language of the statute itself. This dicta is even more troublesome

52. Id. at 470, 391 N.Y.S.2d at 964 (citations omitted).
53. Section 167(1)(b) of the New York Insurance Law provides that personal injury liability insurance policies issued or delivered in New York must contain:

   (b) A provision that in case judgment against the insured or his personal representative in an action brought to recover damages for injury sustained or loss or damage occasioned during the life of the policy or contract, shall remain unsatisfied at the expiration of thirty days from the serving of notice of entry of judgment upon the attorney for the insured, or upon the insured, and upon the insurer, then an action may, except during a stay or limited stay of execution against the insured on such judgment, be maintained against the insurer under the terms of the policy or contract for the amount of such judgment not exceeding the amount of the applicable limit of coverage under such policy or contract.

N.Y. INSURANCE LAW § 167(1)(b) (McKinney 1966). It is further provided in subsection (1)(d) that the policy must contain a provision to the effect that a claim made by the insured or any other claimant, including the injured party under subsection (1)(b), shall not be invalidated for failure to give the notice required under the policy if it is shown that notice within the contractual limits was not reasonably possible and thereafter was given as soon as reasonably possible. Id. § 167(1)(d). Liability policies without these mandated provisions will be construed as though they did conform under § 143 of the New York Insurance Law. Together these sections are designed to prevent the insurer from benefitting from a windfall defense against the injured party whenever the insured is delinquent in giving notice to his insurer. The statute simply mandates a provision forgiving the claimant when notice is given outside the policy limits but as soon as possible in a situation where noncompliance is understandable. The claimant may be the injured party if he falls within subsection (1)(b). The statute contains no hint that the legislature intended to provide an injured party under subsection (1)(b) with a ground for recovery against the insurer when the injury is outside the scope of the coverage contracted for by the insured.

For its expansive reading of § 167 Hartogs draws language and support from Lauritano v. American Fidelity Fire Ins. Co., 3 A.D.2d 564, 162 N.Y.S.2d 553 (1957), aff'd mem., 4 N.Y.S.2d 1028, 152 N.E.2d 546, 177 N.Y.S.2d 530 (1958). Lauritano is merely an application of § 167(1)(b) to the case of an injured passenger who recovered a judgment against the insured and upon failing to satisfy the judgment sued the insurer. The insurer's motion to dismiss was granted at the trial because the required notice had not been given under the policy. 3 A.D.2d at 567, 162 N.Y.S.2d at 555-56. The Appellate Division reversed, relying on § 167(1)(d) and finding that notice by the injured party could not have been reasonably expected within the policy limits and was given as soon as reasonably possible. Id. at 568, 162 N.Y.S.2d at 557-58. In referring to subsection (1)(d) the Lauritano court uses the following language: "Today the injured party is no longer wholly dependent upon the diligence and conscientiousness of the person who caused him injury." Id. at 567, 162 N.Y.S.2d at 556. This language is expanded beyond the confines of § 167(1)(d) by the dicta in Hartogs. Lauritano had only the specific notice-forgiving provision in mind when this language was written. In fact, part of the holding in Lauritano expressly contradicts the Hartogs
because it brings the court full circle from the point of view of the insurer. The company apparently need not pay its insured doctor if he knew he was not treating the patient, but, according to the court's construction of section 167 of the New York Insurance Law, it must pay the patient who is unsuccessful in satisfying a judgment against the doctor if she thought she was being treated by him. Surely, the insurance company cares very little whether its check is made out to the patient or the doctor. Even though the insurer's liability may not be triggered until the injured party fails to obtain satisfaction against the insured doctor, the court's suggestion does considerable violence to the reasoning supporting the holding in *Hartogs*, because when the dust settles the insurer winds up having to "indemnify immorality and pay the expenses of prurience." The court has simply cut out the middle man.

The discussion above is based on the *Hartogs* court's implication that it is the patient's state of mind that is controlling in a direct action against the insurer. If, however, we posit the alternative that it is the doctor's state of mind that is controlling in the patient's direct action against the insurer, the result is even worse. It bars the plaintiff's recovery as completely as it barred the doctor's recovery in *Hartogs*. It is, in fact, the *Nicholson/Zipkin* result. If we assume that the injured patient's rights are controlled by the same definition of malpractice that is applied when the doctor sues his insurer, then the narrow holding in *Hartogs* of noncoverage might be extended to reach the *Nicholson/Zipkin* result. But the *Hartogs* court avoids this extension by bottoming the injured patient's claim on her own state of mind rather than that of the doctor.

Our Hobson's choice, then, is between one result that is totally circular and inconsistent with the policy that spawned it (as well as based on a tenuous construction of the applicable insurance law), and another—leaving the plaintiff without recovery—that the court itself finds unacceptable. Thus, there is no clear answer in *Hartogs* to the question whether the definition of malpractice in a suit by the patient is governed by an insurance contract or by tort law. In other words, the theoretical question posed above of whether it is only an insurance issue when the patient proves too much, or whether the patient's suit against

dicta. There were two original insured defendants in *Lauritano*. Plaintiff was a judgment creditor as to both before he sued their insurers. The Appellate Division affirmed the trial court's dismissal as to one insurer because the injury was outside the scope of the policy issued to the insured. *Id.* at 566, 162 N.Y.S.2d at 555.
the doctor is also jeopardized, is still an open one. But as a pragmatic dollars and cents matter of recovery, according to all jurisdictions outside of New York, the question allows of a definitive answer. If the insurer is entitled to claim noncoverage because the doctor's acts or omissions are essentially in the realm of the bizarre, the injured patient will go uncompensated. If a theoretically permissible malpractice suit directly against the doctor does remain in the extreme fact situation cases, the patient who proves too much will be holding a judgment that is unenforceable against the insurance company.

Thus, the unique verbal nature of psychotherapy, the peculiarly difficult problems of proof involved in the traditional malpractice claim against a therapist, and the emerging theoretical and practical impediments to recovery in the extreme cases, all suggest that the defendant doctor is unfairly protected from liability. This conclusion is justified because, on the one hand, it is extremely hard to make out a prima facie case of malpractice, and, on the other hand, if the case is made too spectacularly, the injured plaintiff may wind up equally empty-handed. This twin problem calls for a remedy that is tailored to solve both problems at once. We suggest that such a theory presently exists and only waits to be properly applied.

IV. A PROPOSED SOLUTION—THE IMPLIED CONTRACT TO TREAT FAITHFULLY

The solution consists of three parts: (a) retain the traditional action of malpractice as Count I of any claim when it is appropriate; (b) resurrect the original concept of an implied contract to treat with skill and care as Count II of the claim; and (c) recognize that the true contractual relationship of the doctor/promisor to the patient/promisee is

54. The argument that most medical doctors are wealthy enough to pay a malpractice judgment is too shallow. There are two reasons why this is not a sufficient argument: (1) most doctors protect their wealth from personal liability through corporate or marital arrangements; and (2) the basic assumption is not valid when dealing with Ph.D. psychologists who have not reached the income levels of most medical doctors. Moreover, the facts of these two cases reveal that Dr. Freeman was unable to pay, and Dr. Hartogs declared bankruptcy.

55. The retention of the malpractice cause of action will not be discussed further. The claim is founded in the common law, and is theoretically valid for the plaintiff who manages to prove the necessary elements without proving himself out of recovery. It will also allow a tort measure of damage, which the proposed Count II will not, and there may be cases in which the tort remedy is the more equitable. Allowing this tort recovery to the injured patient does not harm the operation or validity of Count II.

56. To avoid confusion at the outset, this is not the concept of express contracts to cure. For cases dealing with that problem, see Annot., 43 A.L.R.3d 1221, 1238-44 (1972) and the discussion accompanying notes 103-112 infra.
a special relationship with fiduciary obligations running from doctor to patient. This recognition would infuse the contract to treat with skill and care with the obligation to treat faithfully and honestly.

The failure of the plaintiff's bar to emphasize the fiduciary nature of the doctor-patient relationship, and the concomitant failure of the bench to apply rigorously the principles of fiduciary obligations, has permitted many of the problems of recovery that now beset many injured patients. Both the "old" and "new" problems can be solved by the full implementation of the fiduciary duties inherent in the implied contract solution. The legal consequences that automatically flow from the conceptual framework of Count II will enhance the patient's position without unduly diminishing that of the doctor. The parties will be on a fairer footing when they come to controversy over treatment.

V. THE COUNT II RECOMMENDATION APPLIED TO THE NEW PROBLEM

The idea of basing a malpractice claim on the breach of an implied contract to treat with skill and care is not a new one. Indeed, the separate tort of negligence has only been recognized for about a century and a half. In the older cases "malpractice was regarded simply as a form of breach of implied contract." Yet, because early practitioners usually pleaded contract and tort in the alternative (or even in one paragraph, alleging the defendant "negligently" breached his contract), malpractice has been recognized as "a somewhat blurred area of contract and tort law." Today the majority view sees malpractice as a negligent tort, albeit a tort that is "inextricably bound up with the idea of breach of implied contract." The growth of the case law suggests a steady movement away from contract towards tort as the latter appears to be a more inclusive concept. The tort theory of recovery permits greater damage awards, and the tort statute of limitation is gen-

58. 1 D. Louisell & H. Williams, supra note 13, at § 8.01 (1977).
59. Miller, supra note 9, at 413.
60. D. Harney, supra note 6, § 1.2 at 8. Other commentators agree: "This problem historically has caused and continues to cause considerable confusion." 1 D. Louisell & H. Williams, supra note 13, § 8.03 at 194 (1977).
61. D. Harney, supra note 6, at 248.
63. See Miller, supra note 9, at 413-16, for a brief history of this transformation.
erally regarded as more appropriate for these suits. While there is no evil in casting a malpractice suit in tort or implied contract at the option of the pleader (provided he understands the problems of differing periods of limitations and measures of damages), the danger of proving too much, discussed above, arises only when malpractice is seen as a cause of action exclusively in tort.

The paradox of the doctor not malpracticing because he was no longer practicing at all can only occur when the law woodenly insists on defining his breach as negligence in his supposed function. The rationale we have reviewed is that the therapist cannot be negligently practicing therapy if he is not, in fact, practicing therapy on the occasion of the injury. This rationale is in error because it forgets that the roots of the practitioner's liability for malpractice are grounded in the implied contract to treat with skill and care. The obligations of the practitioner in either tort or contract should be identical. But today they are not. Legal forgetfulness has allowed the nominal distinction to become significant. Courts now often assume that there is a smaller ambit to the duty of care when the claim sounds in tort rather than contract. It should be observed that in this instance the tort theory has become rigid because it grew in ignorance of its history. Because of this error we have seen the "new" danger of proving too much, as reflected in Nicholson and Hartogs, the concurrence in Ziokin, and the dissent in Roy. If those opinions had harkened back to the genesis of malpractice as a breach of implied contract they would have reached the correct conclusion that the therapist had breached his contractual duty to treat with skill and care, whatever the nature of the acts of omission or commission and whatever the characterization of his professional function. He could not be excused for simply having gone too far from any conceivable therapeutic treatment. The tort analysis that there is no liability because defendant was not "practicing" is exactly the opposite result reached by the contract analysis, which finds defendant liable because he was not practicing.

By adding part (c) of the proposed solution we can demonstrate

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64. See I D. LOUISELL & H. WILLIAMS, supra note 13, §§ 13.02-.03, for a general discussion and listing of all applicable statutes by jurisdiction.
65. Id. § 8.03.
66. Professor Gilmore has suggested that the absorption of contract doctrine into the more flexible tort doctrine is the prevalent theoretical pattern. G. GILMORE, THE DEATH OF CONTRACT 87-88 (1974). While psychotherapeutic malpractice is a deviation from this norm, its modern development illustrates the error in forgetting that, historically, tort and contract occupy common theoretical grounds.
that the Count II recommendation not only solves the "new" problem, but relieves the "old" problem as well. Part (c) recognizes that the special consensual relationship of patient and doctor includes the fiduciary obligations that flow from doctor to patient.

VI. The Count II Recommendation Applied to the Old Problem

We earlier identified the difficult burden of proof the plaintiff must bear on each element of his prima facie case in the traditional malpractice suit. By recognizing and clarifying the fiduciary principles that inhere in the doctor-patient relationship, and functionally implementing the fiduciary obligations that flow from doctor to patient in this contractual context, much of this burden will shift to the defendant by the operation of the law that attends fiduciary duties. A therapist, however, is not a true, legally defined fiduciary of his patient, and the confusion that surrounds the term may be the reason full application of fiduciary principles has been forestalled. While some commentators and cases state flatly that a true fiduciary relationship exists, this characterization must be discounted as loose language. More careful writers speak in terms of a "fiduciary matrix," or a "relationship . . . within an embryo of confidence," or simply a "confidential relation." The reason for these more careful characterizations is that a therapist may find that the absolute candor and complete disclosure requirements of a fiduciary are therapeutically contraindicated by the condition of the patient. For this reason, he may need to take what is sometimes called the therapeutic privilege, and not disclose his diagnosis or proposed treatment. The best example of this necessity is the therapist's use of the basic psychoanalytic tool of transference. A pa-

67. See notes 11-37 and accompanying text supra.
69. Dawidoff, supra note 10, at 702-03.
70. D. Dawidoff, supra note 10, at 17.
71. A. Scott, 1 THE LAW OF TRUSTS § 2.5 (3d ed. 1967).
72. Id.
74. This phenomenon is explained in two footnotes to Zipkin v. Freeman, 436 S.W.2d 753, 755 n.1, 756 n.2 (Mo. Sup. Ct. 1968), as follows:

1. "What is perhaps regarded as the most significant concept in psychoanalytical therapy, and one of the most important discoveries of Freud, is the emotional reaction of the patient toward the analyst known as the transference..." Modern Clinical Psychiatry, Noyes & Kolb, 6th Ed., 1963, p. 505.
tient could hardly require the doctor to disclose completely the dynamics of transference because a full and candid discussion of that process would impede the operation of the transference itself, and thus impede the therapy. With this clarification, we will continue to refer to fiduciary "duties" or "obligations" with the understanding that the doctor is not a true fiduciary by legal definition, at least with respect to full disclosure requirements.

In the pure tort approach to malpractice the plaintiff must adduce evidence on standard of care, breach, injury and causation in order to get to the jury. In the contract approach the plaintiff need only show the existence of the contract, the breach of the fiduciary duty infused in the contract, and the injury. Establishing the contract should create no serious problem. The plaintiff either is or is not a patient in treatment. Although the inventive mind might hypothesize a quasi-treatment arrangement that could raise doubts about the existence of the necessary relationship, the proof of the doctor-patient contract normally would not hamper the plaintiff. Proving the breach would, of course, be a more difficult task. Here the plaintiff must have evidence of some act or omission that violates the contractual duty to treat with skill and care. But because the doctor's duty is founded upon and is in the nature of a fiduciary obligation to use the utmost good faith in the application of skill and care, the basic requirements of a true fiduciary

"Inappropriate emotions, both hostile and loving, directed toward the physician are recognized by the psychiatrist as constituting a special aspect of the patient's neurosis—the transference. The psychiatrist looks for manifestations of the transference, and is prepared to handle it as it develops." Melvin S. Heller, M.D., Some Comments to Lawyers on the Practice of Psychiatry, 30 Temple University Law Quarterly, 401, 402.

"[T]ransference * * * In psychiatry, the shifting of an affect from one person to another * * * especially the transfer by the patient to the analyst of emotional tones, either of affection or of hostility * * *." Dorland's Illustrated Medical Dictionary, 23rd Ed., 1957, p. 1454.

"* * * Transference may be positive, when the feelings and reactions are affectionate, friendly, or loving. * * * Understanding of transference forms a basic part of the psychoanalytic technique." Blakiston's New Gould Medical Dictionary, 2nd Ed., 1956, p. 1260.

2. In A Primer for Psychotherapists, Kenneth Colby, M.D. (1951) says, pp. 113-14, "Once a transference is recognized, the therapist makes use of it in two ways. First by evaluating what transference role the patient is forming, the therapist gains understanding of what is being relived and re-experienced rather than being remembered * * *." * * *

"The second use made by the therapist of a transference is in regulating the future course of therapy * * *" (Emphasis supplied.)

75. A doctor-patient relationship is consensual. Tvedt v. Haugen, 70 N.D. 338, 294 N.W. 183 (1940). A private physician is free to refuse service, but the duty of performance in the physician-patient relationship exists even if the services are performed gratuitously. D. Harney, supra note 6, at 2, 9.

76. Nontraditional modes of therapy might blur the line between treatment and other relationships. See Note, supra note 17.
may be properly invoked. Thus, the high standards mandated of a trustee can be imposed, requiring the doctor to act with a fidelity above the standards of the marketplace and with "a punctilio of honor the most sensitive." He must avoid all professional conflicts and situations tending to interfere with the discharge of his duties, or situations in which honesty may be a strain on him, and he must never take selfish advantage of his trust. Under this standard the evidentiary burden the plaintiff must bear is far easier in contract than in tort. The question becomes not whether the doctor negligently failed to meet a professional standard of care—with both aspects having to be proved by the plaintiff—but whether the doctor breached his fiduciary duty of good faith treatment. Examples of likely liability on the contract which would be problematical in tort are: the doctor who is attempting to gather a number of patients for group therapy and includes the plaintiff in order to reach, in his opinion, an optimal number of participants in the group without considering the particular need of the plaintiff; the doctor who is researching an innovative therapy technique and applies it to a patient in the interest of research rather than the interest of the patient; the doctor who maintains an extended supportive relationship without informing the patient that the dynamics of the applied technique have run their course; or, of course, the doctor who becomes personally involved with his patient claiming he was no longer acting as therapist in that regard.

The difficulty the patient might have as a plaintiff in the traditional tort malpractice suit is that group therapy, responsible research and supportive therapy are all accepted behavior in the professional community. The defendant would not lack for expert witnesses who could validate his actions, at least facially, as well within the guidelines of the profession. In other words, evidence of his breach of a standard of care would be extremely elusive. Similarly, the therapist who claimed his acts were unrelated to therapy would escape liability under the "new" problem rationale. It is not suggested that the defendant has an ironclad defense, but rather that the likelihood of plaintiff's proving his case in tort is unfairly small. If the action were cast in contract, however, the evidence needed would be only that the therapist

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78. Wootten v. Wootten, 151 F.2d 147, 149 (10th Cir. 1945).
80. Galbraith v. Tracy, 153 Ill. 54, 63, 38 N.E. 937, 940 (1894).
breached his fiduciary duty of failing to serve the best interest of the individual patient, that he put his own research interest ahead of the patient, that he failed to disclose readily disclosable and nonharmful information to the patient, or that he was simply no longer practicing under the terms and conditions to which his implied contract bound him. The availability of this evidence to the patient is much easier than the marshalling of reluctant and expensive experts necessary to prove the tort elements of standard of care and breach by defendant. The contract-theory plaintiff may offer his own testimony, and because it relates primarily to the relationship in which he participated, he is competent to relate it as a lay witness.\(^2\) The discovery process is also available to obtain from the doctor and his records\(^3\) the motivations for his acts or omissions.

To complete his case in contract the plaintiff now must show actual injury. As to this element, there is no difference in burden of proof under either the contract or tort theory. Psychic injury was evaluated earlier as the less burdensome item of proof because it often can be demonstrated by physical symptoms.\(^4\) Nonphysical injury or symptomatology, however, is no bar.\(^5\) Lay witness testimony in the form of opinion or inference is admissible to show altered emotional or mental condition if the opinion or inference is "rationally based on the perception of the witness and ... helpful to ... the determination of a fact in issue."\(^6\) Evidence of nonphysical injury, however, should be carefully weighed and scrutinized by the jury. Psychotherapy is volatile; a patient may well have sharp swings in attitude, outlook and condition in the course of a successful therapy. Should the timing of the claim coincide with a negative phase of the patient's condition, he may appear injured when, in fact, the dynamic process of amelioration is well under way.\(^7\) For this reason, the trier of fact must pay close attention to the defense testimony as it has a much larger role to play under the Count II structure we have been describing.

\(^{22}\) \textit{FED. R. EVID.} 601, 602.

\(^{23}\) \textit{Id.} 803(3), (6). The patient/plaintiff may also have a limited right to discover information from other patient files to establish the doctor's motivation. \textit{See} Lora v. Board of Education, 74 F.R.D. 565 (E.D.N.Y. 1977), in which the court granted plaintiff's motion for an order compelling production of 50 randomly selected, anonymous diagnostic files, and stated that "[t]hese [psychiatrist-patient privilege] rights are not absolute. They must be balanced against other important rights and needs. In the special circumstances here presented ... the limited right or privilege to protect therapist-patient interchanges must yield." \textit{Id.} at 567.

\(^{24}\) \textit{See} text accompanying notes 24 & 25 \textit{supra}.

\(^{25}\) \textit{See} text accompanying note 26 \textit{supra}.

\(^{26}\) \textit{FED. R. EVID.} 701.

\(^{27}\) Saxe, \textit{supra} note 7, at 479.
VII. THE SHIFTING BURDEN OF PERSUASION

Once the plaintiff has produced evidence of the existence of the contract, the breach of fiduciary duty and the injury, he has satisfied the elements of a *prima facie* case. Significantly, the element of causation has been deleted. It now becomes the defendant's burden to persuade the jury of noncausation and to present any rebuttal evidence that might be directed at plaintiff's *prima facie* case. This shift of the burden of persuasion is well grounded in the law of fiduciary obligations. Pomeroy tells us that it is a natural concomitant of being a fiduciary:

> The doctrine to be examined arises from the very conception and existence of a fiduciary relation. . . . [B]ecause every fiduciary relation implies a condition of superiority held by one of the parties over the other, in every transaction between them by which the superior party obtains a possible benefit, equity raises a presumption against its validity, and casts upon that party the burden of proving affirmatively its compliance with equitable requisites, and of thereby overcoming the presumption.

Thus, it becomes the burden of the therapist, once the patient has demonstrated injury and breach of contract, to show that he has not breached his fiduciary duty, or, if he did, that the breach did not cause the injury suffered by the plaintiff. His fiduciary status requires him to take the witness stand to justify his actions as those of a responsible, good-faith practitioner. Lest there be any doubt that the law imposes this fiduciary burden on a therapist, Pomeroy further informs us:

> Courts of equity have carefully refrained from defining the particular instances of fiduciary relations in such a manner that other and perhaps new cases might be excluded. It is settled by an overwhelming weight of authority that the principle extends to every possible case in which a fiduciary relation exists as a fact, in which there is confidence reposed on one side, and the resulting superiority and influence on the other. The relation and the duties involved in it need not be legal; it may be moral, social, domestic, or merely personal.

Therefore, clarifying the true nature of the doctor-patient relationship—

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88. This includes (a) no doctor-patient contract, (b) no breach of fiduciary obligation or (c) no injury. Success on any one of these defenses will free the doctor from liability.

89. 3 J. POMEROY, A TREATISE ON EQUITY JURISPRUDENCE § 956 (5th ed. 1941) (emphasis added).

The shifting of the burden of persuasion on the issue of causation is not unique to the law of fiduciaries. A bailee must bear the same burden upon a *prima facie* showing by the bailor of a contract of bailment, delivery and failure or refusal to return the bailed property. See generally 8 AM. JUR. 2d Bailments §§ 313, 314, 316, 317, 321 (1963).

90. 3 J. POMEROY, supra note 89, § 956(a) (emphasis in original).
ship, recognizing the functioning of the law that historically inheres in this relationship, and permitting its natural application to the parties is the very heart of the Count II recommendation. The normal operation of the law itself now more equitably distributes the burdens of proof and persuasion upon the patient and the doctor. Clearly the patient's burden is lightened and the doctor's increased. The well-qualified and responsible doctor, however, assumes no greater risk of liability than he faced under the tort formulation. He can now avoid liability by either justifying his actions as having been in “compliance with equitable requisites” in that he did not breach his fiduciary contract to render treatment in good faith or by showing that, regardless of their nature, his actions were not the proximate cause of the patient's injury. The able doctor, even when employing an innovative therapy, is in a strong position to discharge either of these burdens. As to the first, he need only explain what he did in the course of treatment, how he did it and why it was in the best interest of his patient. If his testimony is clear and cogent it will most likely serve, of itself, to vindicate him. Success or failure of the experimental technique will be irrelevant because that is never a proper test of liability in any medical malpractice suit absent an express contract to cure.91 As to his second defense of no proximate causation, his strength is in his own expertise as a psychotherapeutic expert. He is qualified to give his opinion regarding the cause of the injury, and he may testify that the injury was caused by extra-treatment events, or simply by the unavoidable progression of the illness. While this testimony is obviously self-serving and its credibility is lessened thereby, the doctor will be able to buttress his explanation with his own expert witnesses. If he cannot find colleagues to support his explanation, then the jury, in the exercise of common sense, might properly find against him.

A beneficial effect of this reallocation of burdens will be to strengthen the field of psychotherapy itself. The able, thorough, responsible therapist will continue to experiment, innovate and advance the discipline with little risk of enlarged liability. His protection is founded on his own ability, rigor and judgment. He is the very practitioner that the profession would want to encourage in his investigation of the outer boundaries of the field. Once he understands what the law requires of him, the responsible therapist will be little intimidated by it because it obligates him to no higher standard than he would have imposed upon himself. The good therapist, without knowing the legal

91. See notes 104-112 and accompanying text infra.
language, knows that the fiduciary role—the reposing of ultimate trust and confidence—is the essence of effective therapy, and he would never knowingly violate that trust. On the other hand, this high standard might do much to deter the dilettante or the irresponsible practitioner from experimenting beyond his own capability. Once this lesser therapist understands what the law requires, he will either attempt to abide by its strictures or abandon the effort to go beyond the safe, well-known and well-accepted modes of therapy. Both these results are salutary. The law is thus employed to encourage the more talented practitioner to expand his knowledge and abilities, and enhance the art, while the journeyman is well advised to remain within the standard procedures of established therapeutic techniques.

VIII. DAMAGES UNDER COUNT II—RESTITUTION EXPANDED

A. Traditional Measures of Recovery Under Count I—Tort and Contract

When the plaintiff can prove the elements necessary to show that the therapist departed from the appropriate standard of professional care, he is entitled to those items of compensatory damages that he can prove. Compensatory damages available under a negligence or malpractice theory usually include: (1) impairment of future earning capacity, (2) loss of accumulated earnings due to injury, (3) pain and suffering, (4) curative medical expenses made necessary by the negligence of the therapist and (5) the cost of the therapy itself to the extent that it did not, as a result of the negligence, independently benefit the plaintiff.

As previously noted, the historical antecedent to negligent malpractice was the action in assumpsit for breach of an implied contract to treat with skill and care. Since the separate tort of negligence has received distinct judicial recognition, it has all but supplanted the con-
tractual cause of action grounded on the physician’s failure to exercise appropriate skill and care. Today both theories of recovery stand for the identical duty of due care. Minor differences in the quantum of damages, however, still appear in the cases. For example, nominal damages are recoverable in contract but not under a negligence theory. Thus, plaintiff might get the question of liability before a jury under contract theory irrespective of the deficiencies in the proof on actual damages. This distinction has little practical significance, however, inasmuch as there is no collateral incentive for any action in malpractice that does not yield substantial damages. Despite this kind of minor variation and the more common attempts to avoid a shorter tort statute of limitations by sounding a malpractice action in contract, courts generally regard negligence as the essential theory of malpractice for damages purposes regardless of the pleadings.

Contract theory has more than token significance for damage purposes when plaintiff alleges an express contract to cure. The express contract is difficult to prove however. Courts are understandably skeptical about the express contract to cure or effect a specific result. Doctors will seldom in good faith promise specific results and some patients are prone to read into the optimistic small talk of the doctor firm commitments never intended. When clear proof of such a commitment exists, however, recovery may be premised on the express contract. When commitment is proved more attention is paid to the precepts of a contract theory of recovery than is evident under the implied contract to treat with skill and care—the harbinger of negligent malpractice. In theory, the successful plaintiff in an action based on an express contract is entitled to “expectancy damages,” or that amount necessary to put him in the position he would have occupied had the contract been fully performed. Alternatively, contract theory provides an opportunity to elect “restitution damages,” the sum equal to the total benefit conferred by plaintiff upon the defendant in the performance of a contract that

100. I D. LOUISELL & H. WILLIAMS, supra note 13, § 8.03, and cases cited therein.
101. Id. at 198.
104. Sullivan v. O'Connor, 363 Mass. 579, 296 N.E.2d 183 (1973). See also Annot., 43 A.L.R.3d 1221 (1972). Unless these actions are permitted when consent is clearly shown the patient public might fall victim to charlatans whose enticements are rooted in a routine commitment to cure. See Miller, supra note 9, at 416-23.
was materially breached.\textsuperscript{105} 

Although some cases of contracts to cure have turned on a benefit of the bargain rationale, the trend is toward other more flexible contract remedies.\textsuperscript{106} In the leading Massachusetts case, \textit{Sullivan v. O'Connor},\textsuperscript{107} the supreme court rejected expectancy damages under an express contract to correct and beautify plaintiff's nose. The \textit{Sullivan} court concluded that, unlike those for most commercial agreements, expectancy damages for breach of such a contract would usually be excessive when measured against the consideration paid by the patient, and that valuation of the expected resultant condition "may sometimes put an exceptional strain on the imagination of the fact finder."\textsuperscript{108} Restitution was also an alternative mentioned and rejected in \textit{Sullivan}. Recovery in restitution is traditionally measured by the value of the benefit conferred on the defendant. In \textit{Sullivan}, benefit was seen as equal to the fee paid defendant, a recovery "plainly too meager" in the eyes of the court.\textsuperscript{109} The court opted instead for reliance as the measure of recovery. Once thought of as a noncontractual form of recovery, reliance damages have blossomed within the last generation as estoppel begins to replace consideration as the cornerstone of promissory

\textsuperscript{105} Restatement of Contracts § 329 and Comment a (1932). Contract recovery under an express contract theory does not traditionally embrace pain and suffering. Frechette v. Ravn, 145 Wis. 589, 130 N.W. 453 (1911); 1 D. Louisell & H. Williams, supra note 13, § 8.10; Restatement of Contracts § 341 (1932). Notwithstanding this traditional prohibition, at least one case in which liability turned on express contract recognized that strict adherence to contract recovery is unrealistic when the essential harm is manifested in physical or mental injury. See Sullivan v. O'Connor, 363 Mass. 579, 296 N.E.2d 183 (1973). It might be convenient in such a case to reason that pain and suffering is within the contemplation of the parties when the contract is made and thus recoverable as consequential damages. In any case, when the pain and suffering is connected with subsequent medical treatments that are necessitated by the unsuccessful medical procedures under contract, damages for that injury should be recoverable as consequential damages. See id. at 588-89, 296 N.E.2d at 186-87. Because the contract theory is dedicated to giving plaintiff the value of his expected cure and not just to restoring him to his pre-injury condition in a given case, the theory may yield a more comprehensive recovery than tort damages.

\textsuperscript{106} In the famous case of Hawkins v. McGee, 84 N.H. 114, 146 A. 641 (1929), the defendant physician contracted to make plaintiff's burned and disfigured hand "one hundred percent good." Because the operation produced only a more "hideous hand," the physician was held to have breached a contract, and the damage award was based on plaintiff's expectation of a "one hundred percent good" hand. \textit{Id.} at 118, 146 A. at 644. Hawkins has received considerable attention from commentators and casebook editors over the years. See L. Fuller & M. Eisenberg, Basic Contract Law 1-4 (3d ed. 1972); F. Kessel & G. Gilmore, Contracts: Cases and Materials 111-13 (2d ed. 1970). See also Note, Civil Liability of a Physician for Non-willful Malpractice, 29 Colum. L. Rev. 985 (1929); Note, 5 U. Chi. L. Rev. 156 (1937). Despite this notoriety, even when an express contract to cure can be found, courts generally have been hesitant to protect the expectancy interest in the same manner as if they were dealing with a commercial agreement. See Robins v. Finestone, 308 N.Y. 543, 127 N.E.2d 330 (1955).


\textsuperscript{108} \textit{Id.} at 586, 296 N.E.2d at 188.

\textsuperscript{109} \textit{Id.} at 585, 296 N.E.2d at 187.
liability. The concept of "reliance damages" is a flexible one that takes on different definitional shades depending on the circumstances surrounding the promisor's undertaking. In the context of the noncommercial contract in *Sullivan*, reliance damages begin to resemble compensatory tort damages. The elements of the damage award upheld in *Sullivan* included plaintiff's expenditures and other detriment incurred in reliance on the promise breached. The "other detriment" in *Sullivan* included the amount attributable to the worsening of her condition and pain and suffering incurred in a corrective operation. In dicta the court went so far as to suggest that further pain and suffering related to the operations contracted for might have been compensable under a reliance formulation because the pain and suffering endured was "wasted" when the operation failed. The issue was avoided, however, because plaintiff had waived any claim to pain and suffering for the first two contracted for operations in the event that defendant's objections on appeal were overruled.

*Sullivan*’s irregular application of contract doctrine serves the instinct that an injured patient should be compensated regardless of the theory of liability. It should not be surprising that the most significant examples of this patchwork assimilation of tort and contract "reliance" damages are occurring in the noncommercial context. This expansion of reliance damage is fair, given the likelihood of jury confusion when they attempt to apply a commercial contract theory of damages to an apparent injury case that is presented as a suit on a private contract.

B. The Measure of Recovery Under Count II—Restitution

Unlike the "express contract" in *Sullivan*, the Count II contract outlined above is not a contract to cure but only a contract to treat faithfully and professionally. As such it may not be conceptually valid or wise to follow the *Sullivan* track, which starts in contractual liability and ends in a "contorts" vision of reliance damages. Reliance damages that approach tort compensatory damages, as they did in *Sullivan*, seem unwarranted when no cure was promised and no showing of negligence is required. In addition, expectancy damages, which were rejected in

110. See G. Gilmore, supra note 66, at 87-89. The trial judge whose instructions were upheld in *Sullivan* on a reliance theory had no notion that the "reliance interest" was involved in the case. His charge was not conceptualized around reliance at all. See R. Danzig, The Capability Problem in Contract Law: Further Readings on Well-Known Cases 20 (1978).

111. 363 Mass. at 588-89, 296 N.E.2d at 189-90.

Sullivan as speculative and disproportionate in relation to the exchange, would be even more speculative under Count II because no cure is promised—only honest, faithful effort, the putative effect of which is incalculable.

Restitution, on the other hand, should be available when the therapist breaches the Count II contract. In the narrow sense in which restitution was viewed in Sullivan the patient would only be entitled to recover fees paid to the therapist, in keeping with the traditional measure of restitution as the value of the benefit conferred on the defendant. Restitutionary damages, however, are not as meager as Sullivan suggests.

The Restatement of Restitution defines benefit conferred to include the performance of a service “beneficial to or at the request of the [defendant].” Any actions of the patient that involve direct expense or that involve costs in their performance might be fictionalized as “benefit” if the therapist specifically requested that the acts be performed. Under this definition, of course, benefit is a fiction and the real basis approaches restoration for detrimental reliance. This expansive view of restitution does not, however, include reliance damages to the extent permitted by Sullivan. Sullivan would authorize disability damages and pain and suffering as it stretches towards complete tort compensation. By sticking to restitution and broadening the benefit concept to cover the cost of performing acts requested or recommended by the therapist, Count II is clearly not an easy route to an expansive malpractice verdict. While the cost of activities and extra correlative services recommended by the breaching therapist would be recoverable under Count II along with the full cost of the therapy, items of compensa-

115. Somewhat analogous to the Count II contract to treat in good faith is the developing doctrine on contracts to bargain in good faith in the commercial area. Professors Kessler and Fine first suggested that there was such an obligation “instinct” in the cases although the existence of a “contract to bargain” was denied and is still not overtly recognized. See Kessler & Fine, “Culpa in Contrahendo,” Bargaining in Good Faith and Freedom of Contract: A Comparative Study, 77 Harv. L. Rev. 401 (1964). Professor Knapp’s formulation is set out in Knapp, Enforcing the Contract to Bargain, 44 N.Y.U.L. Rev. 673 (1969). The contractual duty to bargain in good faith does not yield a certain standard for expectancy damages on breach. For that reason, Professor Knapp rejects an expectancy measure in most cases. Id. at 723-24. He does conclude, however, that reliance damages should be generally available. Id. at 723. Reliance in the commercial context involves out-of-pocket costs or even lost opportunity costs, but not compensatory damages, which might be brought within the scope of “reliance” in a noncommercial case involving injury, such as Sullivan. To qualify under Count II and its corollary restitution principle, out-of-pocket expenses would have to be recommended or requested by the therapist.
tory damage associated with reliance in the express contract to cure cases like *Sullivan* would not be recoverable. Pain and suffering and disability, for example, would not fit within the restitutionary award in Count II, although they could be recovered as compensatory damages if plaintiff proved his malpractice claim under Count I.\(^{116}\)

The link between a restitutionary theory of recovery and liability premised on the bad faith of the therapist finds some support in the Florida case of *Anclote Manor Foundation v. Wilkinson.*\(^ {117}\) The plaintiff in *Anclote*, John Wilkinson, committed his wife to the care of defendant hospital for psychiatric and medical treatment. The treating psychiatrist was a full-time member of defendant’s staff and had direct supervision over Mrs. Wilkinson during her entire stay. In the course of therapy, the doctor told Mrs. Wilkinson that he was going to divorce his own wife and marry her. While there is no report of the doctor’s eventual marital status, the plaintiff, Mr. Wilkinson, obtained a divorce from his wife shortly after she was discharged from defendant hospital. Within a year, Mrs. Wilkinson committed suicide. Plaintiff husband sued alleging breach of contract to render psychiatric services and malpractice. He prevailed on both counts, recovering damages in virtually the exact amount he had paid defendant for its services. The trial judge ruled that defendant’s employee had malpracticed as a matter of law, and the jury found breach of contract. Both findings were affirmed on appeal. With respect to the contract count, the court focused on the doctor’s failure to treat in good faith, thus destroying “the possibility of any benefit.”\(^ {118}\) Having found the record sufficient to support the jury’s finding of breach, the court went on to affirm as an appropriate recovery a sum equal to “all [the] expenses incurred by him in the entire course of treatment.”\(^ {119}\) Neither the appropriateness nor proper extent of restitution damages was discussed. Plaintiff’s demand was apparently limited to “full reimbursement for monies paid under the contract.”\(^ {120}\) Because the plaintiff was not the patient but the patient’s husband who paid the hospital bills, perhaps the plaintiff himself did not think beyond reimbursement under the contract. Under Count II, however, the plaintiff patient ought to be able to recover, in addition to the cost of the therapy, any further direct or indirect expenses occa-

\(^{116}\) “Reliance” damages for pain and suffering and disability might also be recoverable under the *Sullivan* rationale if an express contract to cure were found.


\(^{118}\) *Id.* at 257.

\(^{119}\) *Id.*

\(^{120}\) *Id.*
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sioned by conduct of the patient undertaken at the recommendation of the therapist.121

IX. TESTING THE COUNT II RECOMMENDATION

The final test of the Count II recommendation is to apply it to the seven cases that represent the existing appellate case history of psychotherapeutic malpractice to determine (a) if a different result would obtain, and (b) if the altered result is a better one.

1. *Hammer v. Rosen.*122 Defendant was a psychiatrist with a reputation for an unusual and highly controversial treatment for schizophrenics. His method was called "direct analysis," which involved an attempt to treat the patient by locating her in the realm of her infancy and bringing her up over again.123 It also allegedly involved beating the patient, for which acts, occurring over a period of seven years, this malpractice suit was filed. The trial court dismissed the malpractice claim at the close of plaintiff's case, but allowed a second claim of breach of express contract to cure to go to the jury, resulting in a defense verdict. The New York Court of Appeals ultimately affirmed the jury verdict, but reversed the malpractice ruling, remanding for a new trial on that issue. Both the trial judge and the appellate division had decided, in dismissing the malpractice claim, that the plaintiff failed to make out a *prima facie* case.124 According to the appellate division she presented no expert evidence to show "that the treatment given by the defendant was not consistent with good standards of professional judgment addressed to [plaintiff's] psychiatric problem."125 In reversing, the court of appeals stated succinctly that evidence of beatings presented by three lay witnesses, absent a credible explanation, was sufficient to show malpractice even without expert testimony.126

Under the Count II recommendation, the ultimate result of allowing the plaintiff to get to the jury would be the same, but two ap-

121. *See note 114 and accompanying text supra.*
124. 7 A.D.2d at 216, 181 N.Y.S.2d at 805-06.
125. *Id.* at 216-217, 181 N.Y.S.2d at 806.
peals would not have been necessary to establish the effectiveness of lay testimony to show violation of a standard of care. Under Count II, of course, full compensatory damages would not have been available.\footnote{127} The claim based on the revitalized implied contract to treat faithfully would overcome a trial motion to dismiss because plaintiff clearly had established the \textit{prima facie} elements of the action:

\begin{itemize}
  \item the contract is easily shown by the seven years of treatment;
  \item the breach is shown by the testimony of witnesses to the beatings; and
  \item the injury is shown by virtue of plaintiff's evidence in support of the court's finding of "regression rather than stabilization of her [plaintiff's] condition."\footnote{128}
\end{itemize}

At this point, under the Count II formulation, Dr. Rosen would have the burden of showing either that the beatings were not a breach of his fiduciary duty, but rather an innovative, albeit extreme, technique of treatment designed for the severe illness of the patient, or that the beatings were not the cause of her regression. Persuading the jury of either of these propositions would free the doctor from liability. The court of appeals actually stated part of this formulation even though it was speaking in tort-malpractice terms:

\[\text{The evidence . . . indicating that the defendant had beaten Alice on a number of occasions, made a \textit{prima facie} case of malpractice which, if uncontradicted and \textit{unexplained and credited by the jury}, would require a verdict for the plaintiff.}\footnote{129}\]

The court would thus have allowed the defendant to explain his actions and avoid malpractice (in the court's terms) or breach of contract (in our terms). In summary, the case was ultimately rightly decided in letting plaintiff get to the jury. The Count II contract would have gone to the jury without having to raise the puzzling problem of when the case is established without expert testimony. In the next case, however, the tort theory and the contract theory part company and produce opposite results.

\textbf{2. \textit{Landau v. Werner}.}\footnote{130} Plaintiff in this English case believed,
after a fairly short time in therapy, that she was in love with her therapist, Dr. Werner. The doctor diagnosed this behavior as a function of the transference phenomenon and reassured her that these intense feelings would pass. They did not, and the parties agreed to terminate therapy, but maintain social contact to ease the separation. They had a series of visits outside the office, discussed vacations together, and once visited together in plaintiff’s sitting room. Her condition deteriorated, and she attempted suicide. Formal treatment was resumed, but to no avail. The plaintiff sued and prevailed on a malpractice claim. The trial judge absolved the doctor of any professional misconduct but found:

[W]ith the best intentions in the world he had made a tragic mistake. The departure from the recognised standard has resulted in gross deterioration in the [plaintiff’s] health, and on the evidence it would also amount to negligence in treatment.\[131\]

The appellate court affirmed stating:

If his novel or exceptional treatment had failed disastrously he could not complain if it was held that he went beyond the bounds of due care as recognised generally. *Success was the best justification for unusual and unestablished treatment*.\[132\]

Though the appellate court noted that the trial judge “absolved the doctor from all charges of professional misconduct,”\[133\] it upheld the recovery. The case is wrongly decided and internally inconsistent. If the doctor is “absolved of all professional misconduct,” upon what is the liability based? According to the court, liability is based on the doctor’s negligence. If he is negligent, it can only be as a therapist, which amounts to professional misconduct.\[134\] Worse still is the message the appellate court is sending to the field of psychotherapy—“Success [is] the best justification for unusual and unestablished treatment,” and failure is equivalent to liability. It puts one in mind of the grade B movie scenario in which the modern doctor in the heart of a remote jungle must treat the stricken chief of a head-hunting tribe. If he fails, he dies. This is hardly a policy that aids experimentation in an infant science.

Under the Count II recommendation, Dr. Werner would have been absolved of all liability on these facts because he never breached his contract to treat with skill and care. He did his utmost to meet his

\[131\] *Id.* at 258.
\[133\] *Id.*
\[134\] See text accompanying notes 57-65 *supra.*
obligation. If he failed, even if his failure caused the injury, he is not liable. It is the policy of Count II to allow for good faith mistakes in judgment. If Count II protects Dr. Werner simply because of absolute good faith, when does that protection end? In other words, is any good faith attempt at treatment protected no matter how horribly bungled? The answer is yes under Count II, but no under Count I. Our formulation contemplates the retention of the traditional tort claim of malpractice whenever warranted. Under Count I, plaintiff may still recover for negligent acts of a therapist, regardless of whether the acts were in good faith. In Landau, for example, the plaintiff recovered on the ground of negligence irrespective of the doctor's good faith. The next case, however, demonstrates one of the failings of the tort approach.

3. Nicholson v. Han.135 The facts and holding of Nicholson have already been described.136 Dr. Han prevailed on summary judgment. After having seduced plaintiff's wife while both were in marital counseling with him, defendant never even had to take the witness stand. The court ruled that plaintiff failed to state a claim upon which relief could be granted because the gist of the wrong was seduction or alienation of affections, both of which were abolished by statute. The Count II recommendation would reverse the result. Clearly, defendant breached his contract to treat with skill and care. The resultant divorce could be claimed as the element of injury because the Nicholsons remained in counseling for another year after the covert liaison began. Of course, Dr. Han could argue no causation in that the marriage may have been inexorably headed for divorce, but he would scarcely be able to avoid the proof of actual psychic injury to plaintiff by the incredible deception. The contract theory at least would have allowed plaintiff to get to the jury, and, most likely, prevail. Its application to this case would not only have brought about a more just result, but also would not have spawned the rationale that appeared in Zipkin v. Freeman, Roy v. Hartogs and Hartogs v. Employers Mutual. It is these cases, along with Nicholson, that define the "new" problem previously discussed.137 The Count II recommendation has already been applied to these cases,138 and there is little to add. Under the Count II recommendation, the Hartogs holding, and all of the cases that found the therapist not to be practicing and, therefore, not to be malpracticing, become

136. See text accompanying notes 38-41 supra.
137. See text accompanying notes 38-54 supra.
138. See text accompanying notes 57-65 supra.
irrelevant and their conclusions are reversed. According to the contract
theory, not practicing under a contract to do so faithfully is precisely
the breach that comprises the actionable wrong.

There is one case that not only proceeds, in part, on the implied
contract to treat faithfully, but invokes restitution as the measure of
recovery.

4. Anclote Manor Foundation v. Wilkinson.\textsuperscript{139} The facts of An-
clote are discussed above.\textsuperscript{140} Anclote might appear to be the perfect
two-count template that we have urged throughout this article. There
are four reasons why it is not: (1) the plaintiff was not the mistreated
patient; (2) his claim in malpractice was in a representative capacity; (3)
he had no contractual relationship with the treating psychiatrist; (4) his
contract with the defendant hospital was not invested with fiduciary
obligations running to him. Therefore, Mr. Wilkinson's claim could
not have been bottomed on the type of implied contract to treat with
skill and care posited above.

Even though not direct authority for the conceptual framework of
recovery in Count II, Anclote stands as an interesting and informative
analogy. The doctor's breach in Anclote was not a failure to exercise
due care but rather conduct that "destroy[ed] the possibility of any ben-
efit" which could have been anticipated.\textsuperscript{141} It was the doctor's orientation
toward the "acting out" of his feelings and away from patient
treatment as a primary concern that "destroyed the possibility of bene-
fit" and constituted the breach. The doctor's contractual obligations to
the plaintiff/husband in Anclote were not direct nor were they vested
with the same fiduciary standards as the doctor-patient contract envi-
visioned in Count II. If anything, however, the standard of good faith
treatment should be higher when the plaintiff is a patient.

In Anclote plaintiff was reimbursed for money paid under the con-
tract.\textsuperscript{142} Although the concept of restitution is more broadly stated in
the Count II recommendation, Anclote is also direct authority for the
damage theory recommended as a balance to the broader bases of lia-
ibility posited in Count II.\textsuperscript{143}

\textsuperscript{139} 263 So. 2d 256 (Fla. Dist. Ct. App. 1972).
\textsuperscript{140} See text accompanying notes 117-120 supra.
\textsuperscript{141} 263 So. 2d at 257 (emphasis added).
\textsuperscript{142} Id.
\textsuperscript{143} See text accompanying notes 113-121 supra.
X. Conclusion

No dramatic innovation is suggested in the foregoing discussion. While some may view the recommendation to revitalize the implied contract in the context of good faith treatment as a major alteration in malpractice theory, and even applicable beyond the realm of psychotherapy, the authors make no such claim. What is attempted instead is an identification and clarification of the true nature of the therapist-patient relationship and the legal consequences that naturally attend that relationship. The patient/plaintiff is granted easier access to recovery through a contract theory, but damages in case of breach are appropriately confined to restitution, albeit restitution in its broadest sense. The responsible and conscientious therapist will be encouraged to experiment and innovate in order to bring about the desired advances in the psychological disciplines. He need not be concerned about the enlarged rights of the plaintiff as long as he does not break faith with his patient and violate his fiduciary obligations. On the other hand, the dilettante, the incompetent and the irresponsible will have second thoughts before applying outlandish or faddish procedures to an unsuspecting patient because they will no longer enjoy the overprotection that present malpractice law affords. This result should be welcomed by the more talented scientist/practitioners who will take the lead in discovery and development while the less able will be better advised to remain within recognized and accepted modes of procedure.