

Law notes

Diplomas, half-doctors and fraud

There is a strong and natural public tendency to believe that any individual with a medical diploma and title is not only a qualified doctor but that throughout his life any involvement which he has in health matters will reflect his professional expertise and sense of duty. That is, unfortunately, not always the case. Some packaged medicines and even cosmetics and foodstuffs carry the medical title of their inventor – a pre-1914 custom which is still tolerated for products dating from that era. Some physicians entering the health industry continue to use their medical titles even after assuming purely commercial roles. Even more unfortunately, some medical men (and women?) also engage in dubious and unprofessional practices, enriching themselves improperly with the aid of the aura which their title endows upon them.

In 1997, a haematologist and a veterinary surgeon practising in private in Britain were reported to be selling a £10,000 “cure” for AIDS and cancer. Their so-called “adoptive immunotherapy”, stated to have been developed at an academic hospital, involved injecting patients with lymphokine stimulated killer T-cells; the agent had not completed safety studies, and experts had described the approach as worthless, “scientifically unfounded” and potentially capable of accelerating the disease. Patients appeared to have been prescribed the treatment after a cursory interview and without undergoing physical examination. The term “indefinite survival” was mentioned and patients were advised to stop their existing treatment for AIDS. An editorial in the *British Medical Journal* discussed the case as an example of “the selling of quack cures by doctors” [1].

Physicians who engage in charlatanism, making available for profit medicines or other forms of treatment which they should reasonably know are worthless, can be regarded as perpetrating fraud, and in most legal systems this is likely to provide a sufficient basis for bringing disciplinary, criminal and civil charges.

Fraud and the practising physician

Even the practising physician may in certain cases be charged in law with civil or criminal fraud, but the courts have been loath to admit such charges. An action will lie in fraud only if the injury to the patient can be traced back to material misrepresentation by the physician. Fraud is an intentional tort consisting not only of such misrepresentation by the defendant, but also of his knowledge of its falsity, intent to defraud, justifiable reliance of the plaintiff on the statements made by the defendant, and resultant injury. One problem is that of proof. The events giving rise to such a charge may have commenced with a private talk between physician and patient, and if the two differ in their account of the event it may be entirely impossible to determine what actually happened and against what background.

Mere silence or non-disclosure by the physician does not comprise fraud; there are some situations in which a physician may justifiably withhold some information to avoid upsetting a patient, and others in which the physician may unintentionally omit to disclose some matter about which the patient may consider that he should have been informed. That may constitute medical negligence but nothing more.

A fraud charge may, however, lie if the physician has deliberately and falsely misrepresented the nature, outcome or prognosis of a completed procedure or falsely reassured the patient by wilfully concealing negligence or disease [2]. It is also possible for a patient to consent to a particular form of treatment on the basis of facts which have been misrepresented to him or incompletely disclosed¹ and if the treatment proves injurious there may be a clear basis for an action in fraud. In one American case heard as long ago as 1985, a patient was awarded damages against a doctor who was held to have knowingly and intentionally misrepresented the risks of silicone injections for breast supplementation as having “absolutely no side effects” and intentionally represented that he could safely administer it, without informing the patient that it could only be administered subject to controls and restrictions imposed by state and federal authority [2, p. 145].

Hospital emergency rooms: non-delegable duties

On 24th January 1994, Mr. McBride was brought to the emergency room of a regional Medical Centre in South Carolina after sustaining injuries while riding a motorized bicycle. His daughter signed an admission form for her father on which it was explicitly stated that the emergency room was staffed by “independent physicians” and that these were not employees of the Centre. The patient was treated for contusions and released; he returned the following day when he was found to have a subdural haematoma from which he subsequently died at another hospital. In an action brought against the Medical Centre, the daughter charged that the emergency room physicians had failed to diagnose and treat his condition adequately when he was first seen. In its defence, the Centre claimed that it was not liable because its emergency room physicians were independent contractors, pointing to a contract with the physicians in question according to which the Centre exercised no “control over the means, manner or methods” by which the physicians carried out their task. The Court of first instance allowed this defence and summarily dismissed the claim.

The daughter turned successfully to the Court of Appeals for South Carolina which on 2nd February 1998 accepted her argument that the work in the emergency room was a “non-delegable duty” of the hospital. It advanced three grounds for this view. *Firstly*, the reliance placed by the public upon emergency rooms creates a non-delegable duty owed by the hospital to patients using these services, which have become vital to public safety. As the Court noted, patients in need of emergency services clearly could not be expected to check out first all the local hospitals in order to find one where the emergency room was staffed by the institution’s own employees. *Secondly*, the public had come to regard a hospital as a single entity providing multifaceted medical services, and to view all the physicians practising there as “instrumentalities” of the hospital; hospitals actually advertised their ability to provide multiple services thus fostering this perception. *Thirdly*, a specific South Carolina ordinance on “minimum standards” for hospital licensing created an obligation on any hospital, unless specifically exempted, to maintain an open emergency room; inherent in this provision was the view that the hospital itself must ensure the maintenance of proper standards in the emergency room, irrespective of the exact contractual relationship with physicians involved.

The Appeal Court rejected a defence by the Medical Centre that South Carolina had never imposed corporate liability on hospitals; such a defence could be relevant as regards direct liability of the hospital for its own negligence, but direct corporate negligence was not at issue. In the present case the hospital was vicariously liable for the acts and omissions for the physicians working in its emergency room.

¹“...if information is withheld in bad faith, the consent will be vitiated by fraud.” See [3].

The principal arguments of the Court of Appeal in this case are striking in their reliance on considerations of public need and essential public policy rather than on specific rules or on the principles of tort law [4].

References

- [1] R. Smith, Doctors, unethical treatments, and turning a blind eye, *Brit. Med. J.* **298** (1989), 1125–1126.
- [2] R.M. Wettstein, Legal aspects of neuroleptic-induced movement disorders, in: *Legal Medicine*, C.H. Wecht, ed., Praeger Special Studies, New York and Philadelphia, 1985, p. 144.
- [3] J. Bristow, *Chatterton v. Gerson* (1981) 1, All E.R., pp. 257, 265.
- [4] *Simmons v. Tuomey Regional Medical Center*, No. 2788, 1988, WL 57450 (S.C. Ct. App. Feb. 2, 1998).