JOHN JARMIE *v.* FRANK TRONCALE ET AL.
(SC 18358)

Rogers, C. J., and Norcott, Palmer, Zarella, McLachlan, Eveleigh and Harper, Js.*

*Argued March 16—officially released September 17, 2012***

Steven D. Ecker, with whom, on the brief, was *Peter M. Haberlandt*, for the appellant (plaintiff).

Eugene A. Cooney, with whom, on the brief, was *Kay A. Williams*, for the appellees (defendants).

Opinion

ZARELLA, J. The principal issue in this appeal is whether a physician who fails to advise an unaware patient of the potential driving risks associated with her underlying medical condition breaches a duty to the victim of the patient's unsafe driving because of the failure to advise. The plaintiff, John Jarmie, appeals from the judgment of the trial court in favor of the defendants, Frank Troncale, a physician and gastroenterology specialist, and Gasteroenterology Center of Connecticut, P.C., Troncale's employer. Troncale diagnosed and treated his patient, Mary Ann Ambrogio, for various liver and kidney ailments, including hepatic encephalopathy, but failed to warn her of the latent driving impairment associated with her condition. After leaving Troncale's office, Ambrogio blacked out while operating her motor vehicle and struck the plaintiff. On appeal, the plaintiff claims that the trial court, in granting the defendants' motion to strike his complaint, improperly ruled that a third party is categorically barred from bringing an action against a physician for professional negligence and that Troncale owed no duty to the plaintiff to warn Ambrogio of the driving risks associated with her medical condition. The defendants argue that the trial court properly ruled that Troncale owed no duty to the plaintiff. As an alternative ground for affirmance of the trial court's decision, the defendants also argue that the plaintiff failed to plead the requisite causal connection between Troncale's alleged deviation from the standard of care and the plaintiff's claimed injury. We affirm the judgment of the trial court.

The following relevant facts and procedural history are set forth in the trial court's memorandum of decision. "On June 20, 2008, the plaintiff . . . filed a one count negligence complaint against the defendants . . . . The plaintiff also attached a good faith certificate, which, under General Statutes § 52-190a, is a prerequisite to filing a medical malpractice action.[1] . . .

"Troncale is a licensed Connecticut physician and specialist in gastroenterology and an agent or employee of Gastroenterology Center of Connecticut, P.C. On June 22, 2006, Troncale diagnosed and treated [Ambrogio] . . . for various liver and kidney ailments, including hepatic encephalopathy.

"It is generally known in Troncale's medical specialty that those suffering from hepatic encephalopathy are unable to safely operate a motor vehicle due to their impaired mental state. While operating a motor vehicle after leaving Troncale's offices on June 22, 2006, [Ambrogio] lost consciousness due to the hepatic encephalopathy and crashed into the plaintiff, causing him severe, permanent injuries. The [plaintiff alleged that his] injuries were caused by [Troncale's deviation from the accepted standard of care applicable to the

treatment of Ambrogio] in that [he] failed to . . . advise and warn [her] not to drive a vehicle.[2]

"On July 24, 2008, the defendants filed a motion to dismiss the plaintiff's complaint on the ground that the plaintiff failed to comply with General Statutes § 52-190a in that the written opinion supporting the good faith certificate [failed] to specify the specialty of its author, and there [was] no basis to conclude that the author is a similar health care provider to . . . Troncale and, therefore, qualified to determine whether there is evidence of medical negligence.

"On August 7, 2008, the plaintiff filed his first amended complaint, attaching a substitute copy of the good faith certificate. The plaintiff also filed an objection to the defendants' motion to dismiss in which he argued that the . . . motion . . . should be denied because the plaintiff over-redacted the specialty and board certification of the reviewer in the initial good faith certificate. On August 13, 2008, the defendants filed a claim for apportionment under General Statutes § 52-102b against [Ambrogio], claiming that she was the proximate cause of the plaintiff's alleged injuries and damages.

"On September 2, 2008, the defendants withdrew their motion to dismiss. On November 21, 2008, the defendants filed a motion to strike the plaintiff's second amended complaint on the ground that the plaintiff's medical malpractice claim [was] legally insufficient. On December 10, 2008, the plaintiff filed an objection to the defendants' motion."

On December 31, 2008, the trial court granted the motion to strike on the grounds that the plaintiff had failed to allege a physician-patient relationship, as required under Connecticut medical malpractice law, and that Connecticut authority indicates that physicians have no common-law duty to protect third parties from injuries caused by patients. The court thus found it unnecessary to address the defendants' argument that the plaintiff had failed to plead the required causal connection between Troncale's alleged deviation from the standard of care and the claimed injury. This appeal followed.[3]

"The standard of review in an appeal challenging a trial court's granting of a motion to strike is well established. A motion to strike challenges the legal sufficiency of a pleading, and, consequently, requires no factual findings by the trial court. As a result, our review of the court's ruling is plenary. . . . We take the facts to be those alleged in the [pleading] that has been stricken and we construe the [pleading] in the manner most favorable to sustaining its legal sufficiency." (Internal quotation marks omitted.) *Lestorti* v. *DeLeo*, 298 Conn. 466, 472, 4 A.3d 269 (2010).

PROCEDURAL ISSUES

The plaintiff first claims that the trial court improperly concluded that a third party who is not a patient is categorically barred from bringing a cause of action against a health care provider for professional negligence. The plaintiff specifically claims that this court's precedent establishes that a proper "duty" analysis requires a particularized examination of foreseeability and public policy under the relevant circumstances and that the plaintiff's attachment of a good faith certificate to the complaint does nothing to change that analysis. The defendants respond that the trial court correctly determined that the plaintiff's complaint sounded in medical malpractice and should be stricken because it failed to allege a physician-patient relationship, which is a necessary component of a medical malpractice complaint. We conclude, in light of the allegations in the plaintiff's complaint and the parties' arguments, that the trial court properly considered, as two separate issues, whether the plaintiff's complaint was legally insufficient under Connecticut's medical malpractice law and whether Troncale owed a duty to the plaintiff under common-law principles of negligence.

The following procedural background is relevant to our resolution of this claim. When the defendants filed their motion to strike the plaintiff's complaint, which they characterized as sounding in medical "malpractice," they argued that the plaintiff had failed to plead a physician-patient relationship and the required causal connection between Troncale's alleged deviation from the standard of care to the patient and the plaintiff's claimed injuries. The defendants also moved to strike the complaint on the ground that Troncale owed no duty to the plaintiff as a matter of law. The defendants thus discussed the "malpractice" and "duty" issues separately in the memorandum in support of their motion to strike.

In his memorandum in opposition to the motion, the plaintiff ignored the defendants' characterization of the complaint as sounding in medical malpractice and argued that Troncale owed him a legal duty, that the complaint properly alleged proximate cause and that there was no statutory authority prohibiting third parties from bringing an action in negligence against a health care provider. With respect to this last point, the plaintiff specifically argued that limiting medical malpractice claims against health care providers to their patients "turns the malpractice statute into a sword precluding negligence claims by third parties," a result that never was intended under the medical malpractice statutes.

In deciding the motion, the trial court rejected the plaintiff's contention that he had brought a common-law action in negligence. The court instead concluded

that the complaint sounded in medical malpractice and granted the motion to strike because the plaintiff had failed to allege a physician-patient relationship with Troncale. The court nonetheless addressed the defendants' argument that Troncale owed no duty to the plaintiff "because duty and the physician-patient relationship requirement in medical malpractice actions are intertwined . . . ."

The parties' arguments must be understood in light of this procedural history. The plaintiff maintains that the complaint is legally sufficient because it was brought under common-law principles of negligence, to which the good faith certificate was attached as a precautionary measure to "avoid . . . procedural wrangling," whereas the defendants contend that the complaint is legally insufficient because it sounds in medical malpractice. The complaint, however, does not purport to be grounded in either medical malpractice or common-law negligence. It merely describes the relevant facts and alleges that the plaintiff's injuries were caused by Troncale's "deviation from the accepted standard of care applicable to the treatment of the patient in that [he] failed to advise and warn the patient not to drive a vehicle," which was a substantial factor in causing the plaintiff's injuries. Although the plaintiff filed a good faith certificate with the complaint, and the complaint's reference to the accepted "standard of care" is consistent with the language ordinarily used in bringing a medical malpractice action, it was not until the defendants filed their motion to strike that the two sides began to characterize the complaint in different ways. Presented with this situation, the trial court decided the motion under both theories. The court initially rejected the plaintiff's position and concluded that the complaint sounded in medical malpractice, but subsequently considered the defendants' argument that Troncale owed no duty to the plaintiff because it described the notions of "duty" and "physician-patient relationship" as "intertwined" in medical malpractice actions.

The issue is not merely one of semantics. How the complaint is characterized determines the standard under which it is reviewed. Unlike the trial court, we regard the two different approaches advocated by the parties as distinct, but, given the ambiguity in the language of the complaint and the nature of the arguments, the court properly considered whether the complaint should be stricken under both theories. Consequently, we first consider whether the trial court properly ruled that the complaint was barred under Connecticut's medical malpractice law. We then consider whether Troncale owed a duty to the plaintiff under common-law principles of negligence, there being nothing in the relevant statutory authority or the case law of this state that precludes the plaintiff from bringing an action against the defendants on negligence grounds. See, e.g.,

Murillo v. *Seymour Ambulance Assn., Inc.*, 264 Conn. 474, 476, 823 A.2d 1202 (2003) (considering whether health care provider owed duty to third party to prevent injuries caused by fainting while third party was observing medical procedure performed on her sister); *Fraser* v. *United States*, 236 Conn. 625, 626, 674 A.2d 811 (1996) (considering whether psychotherapist owed duty to third party harmed by patient to control and prevent patient from causing harm).

II

MEDICAL MALPRACTICE

Turning first to Connecticut's medical malpractice law, General Statutes § 52-190a provides in relevant part: "(a) No civil action or apportionment complaint shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after October 1, 1987, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action or apportionment complaint has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the *care or treatment of the claimant*. . . ."[4] (Emphasis added.)

Pursuant to this statute, which was enacted as part of the Tort Reform Act of 1986; see Public Acts 1986, No. 86-338, § 12; a cause of action alleging medical malpractice must be brought by a *patient* against a health care provider because the language of the statute specifically provides that the alleged negligence must have occurred "in the care or treatment of the claimant. . . ." General Statutes § 52-190a (a). As we explained in *Gold* v. *Greenwich Hospital Assn.*, 262 Conn. 248, 811 A.2d 1266 (2002), "[t]he classification of a negligence claim as either medical malpractice or ordinary negligence requires a court to review closely the circumstances under which the alleged negligence occurred. [P]rofessional negligence or malpractice . . . [is] defined as the failure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss, or damage to the *recipient* of those services. . . . Furthermore, malpractice presupposes some improper conduct in the treatment or operative skill [or] . . . the failure to exercise requisite medical skill . . . . From those definitions, we conclude that the relevant considerations in determining whether a claim sounds in medical malpractice are whether (1) the defendants are sued in their capacities as medical professionals, (2) *the alleged negligence* is of a specialized medical nature that *arises out of the medical professional-patient relationship*, and (3) *the alleged negligence is substantially related*

to medical diagnosis or treatment and involved the exercise of medical judgment. . . . [T]o prevail in a medical malpractice action, the plaintiff must prove (1) the requisite standard of care for treatment, (2) a deviation from that standard of care, and (3) a causal connection between the deviation and the claimed injury. . . . Generally, expert testimony is required to establish both the standard of care to which the defendant is held and the breach of that standard." (Citations omitted; emphasis added; internal quotation marks omitted.) Id., 254–55; accord *Trimel* v. *Lawrence & Memorial Hospital Rehabilitation Center*, 61 Conn. App. 353, 357–58, 764 A.2d 203, appeal dismissed, 258 Conn. 711, 784 A.2d 889 (2001); see also *Dias* v. *Grady*, 292 Conn. 350, 357, 972 A.2d 715 (2009) (describing requirement in § 52-190a that plaintiff in any medical malpractice action conduct reasonable inquiry to determine if there is good faith belief that grounds exist for action based on negligence in care or treatment of *plaintiff*).

Guided by these principles, we agree with the trial court that, insofar as the defendants characterize the plaintiff's complaint as sounding in medical malpractice, it is legally insufficient because it contains no allegations that the plaintiff and Troncale had a physician-patient relationship as required under Connecticut's medical malpractice law. Accordingly, we conclude that the trial court properly granted the defendants' motion to strike on that ground.

III

COMMON-LAW NEGLIGENCE

The plaintiff next claims that the trial court improperly granted the motion to strike on the ground that Troncale did not owe him a specific and limited common-law duty to inform Ambrogio of her potential inability to drive safely because of her impaired medical condition. The plaintiff claims that the duty to inform is already owed to the patient and that extending the duty to a third party victim is fully consistent with Connecticut law, is good public policy and has been adopted by other jurisdictions. The defendants respond that, under Connecticut law, physicians owe no duty to unidentifiable members of the public and that a duty analysis supports the conclusion that Troncale owed no duty to the plaintiff. We agree with the defendants.

"The essential elements of a cause of action in negligence are well established: duty; breach of that duty; causation; and actual injury. . . . Contained within the first element, duty, there are two distinct considerations. . . . First, it is necessary to determine the existence of a duty, and then, if one is found, it is necessary to evaluate the scope of that duty. . . . The existence of a duty is a question of law and only if such a duty is found to exist does the trier of fact then determine

whether the defendant violated that duty in the particular situation at hand. . . . If a court determines, as a matter of law, that a defendant owes no duty to a plaintiff, the plaintiff cannot recover in negligence from the defendant. . . .

"Duty is a legal conclusion about relationships between individuals, made after the fact, and imperative to a negligence cause of action. The nature of the duty, and the specific persons to whom it is owed, are determined by the circumstances surrounding the conduct of the individual. . . . Although it has been said that no universal test for [duty] ever has been formulated . . . our threshold inquiry has always been whether the specific harm alleged by the plaintiff was foreseeable to the defendant. The ultimate test of the existence of the duty to use care is found in the foreseeability that harm may result if it is not exercised. . . . By that is not meant that one charged with negligence must be found actually to have foreseen the probability of harm or that the particular injury which resulted was foreseeable, but the test is, would the ordinary [person] in the defendant's position, knowing what he knew or should have known, anticipate that harm of the general nature of that suffered was likely to result . . . .

"A simple conclusion that the harm to the plaintiff was foreseeable, however, cannot by itself mandate a determination that a legal duty exists. Many harms are quite literally foreseeable, yet for pragmatic reasons, no recovery is allowed. . . . A further inquiry must be made, for we recognize that duty is not sacrosanct in itself . . . but is only an expression of the sum total of those considerations of policy which lead the law to say that the plaintiff is entitled to protection. . . . The final step in the duty inquiry, then, is to make a determination of the fundamental policy of the law, as to whether the defendant's responsibility should extend to such results." (Citations omitted; internal quotation marks omitted.) *Pelletier* v. *Sordoni/Skanska Construction Co.*, 286 Conn. 563, 593–94, 945 A.2d 388 (2008).

We conclude as a matter of law that Troncale owed no duty to the plaintiff in this case because Connecticut precedent does not support it, the plaintiff was an unidentifiable victim, public policy considerations counsel against it, and there is no consensus among courts in other jurisdictions, which have considered the issue only rarely. We discuss each of these reasons in turn.

A

Connecticut Precedent

It is useful to view Connecticut common-law rules defining the duty of health care providers in conjunction with § 52-190a, the medical malpractice statute, because all of the relevant case law followed enactment of that provision. The statute had several purposes,

including: "(1) to put some measure of control on what was perceived as a crisis in medical malpractice insurance rates; (2) to discourage frivolous or baseless medical malpractice actions; (3) to reduce the incentive to health care providers to practice unnecessary and costly defensive medicine because of the fear of such actions; (4) to reduce the emotional, reputational and professional toll imposed on health care providers who are made the targets of baseless medical malpractice actions; and (5) the replacement of proportional liability for the preexisting system of joint and several liability as a central part of [tort reform], so as to remove the health care provider as an unduly attractive deep pocket for the collection of all of the plaintiff's damages. See Conn. Joint Standing Committee Hearings, Judiciary, Pt. 1, 1986 Sess., pp. 212–26, 268–83, 320–21; Conn. Joint Standing Committee Hearings, Judiciary, Pt. 6, 1986 Sess., pp. 1968–93; Conn. Joint Standing Committee Hearings, Judiciary, Pt. 7, 1986 Sess., pp. 2319–27; Insurance and Real Estate Committee Report on Health Care Liability Insurance in Compliance with Special Act 85-85, concerning Substitute House Bill No. 5110, entitled 'An Act Establishing a Task Force on Health Care Liability Insurance.' " *Lostritto* v. *Community Action Agency of New Haven, Inc.*, 269 Conn. 10, 47, 848 A.2d 418 (2004) (*Borden, J.*, concurring and dissenting). Thus, a principal goal of § 52-190a, and of tort reform generally, was to limit the potential liability of health care providers. See 1 D. Louiselle & H. Williams, Medical Malpractice § 8.01 [3] [b] (2012) ("The tort reform movement of the 1980s led some states to attempt to codify much of the law of malpractice in a way that limited the potential liability of a health care provider. These efforts . . . resulted in laws that addressed areas historically developed by the courts even in code states.").

The common law, reflecting the goals of the tort reform movement and the legislature's purpose in enacting § 52-190a, likewise disfavors the imposition of liability on health care providers. The established rule is that, "absent a special relationship of custody or control, there is no duty to protect a third person from the conduct of another." *Kaminski* v. *Fairfield*, 216 Conn. 29, 33, 578 A.2d 1048 (1990); accord *Fraser* v. *United States*, supra, 236 Conn. 632; see 2 Restatement (Second), Torts § 315, p. 122 (1965). Thus, physicians owe an ordinary duty to their patients not to harm them through negligent conduct and an affirmative duty to help them by providing appropriate care. 1 Restatement (Third), Torts, Liability for Physical Harm § 41 (h), p. 790 (Proposed Final Draft No. 1, 2005). There is no well established common-law rule that a physician owes a duty to warn or advise a patient for the benefit of another person. See id., pp. 790–91.

Consistent with the purpose of the medical malpractice statute and the limited duty of health care providers under the common law, this court has exercised

restraint when presented with opportunities to extend the duty of health care providers to persons who are not their patients. As a consequence, we have held that a nurse and an emergency medical technician owed no duty of care to a patient's sister, who fainted while observing a medical procedure performed on the patient; *Murillo* v. *Seymour Ambulance Assn., Inc.*, supra, 264 Conn. 477–78; a psychiatrist owed no duty to a patient's former spouse for any direct injury to the marriage caused by the allegedly negligent treatment of the patient for marital difficulties; see *Jacoby* v. *Brinckerhoff*, 250 Conn. 86, 88, 95–98, 735 A.2d 347 (1999); a psychiatrist who evaluated children for possible sexual abuse owed no duty of reasonable care to protect the children's father, the suspected abuser, from false accusations of abuse arising out of the performance of the evaluations; *Zamstein* v. *Marvasti*, 240 Conn. 549, 550–51, 559–61, 692 A.2d 781 (1997); and a physician owed no duty of care to his patient's daughter, who suffered emotional distress as a result of observing the patient's health deteriorate because of the physician's malpractice. *Maloney* v. *Conroy*, 208 Conn. 392, 393, 403, 545 A.2d 1059 (1988). The only time that we have even *contemplated* enlarging the duty of a health care provider to include a person who is not a patient was when we considered whether a psychotherapist owed a duty to a third party to control an outpatient, who was not known to have been dangerous. See *Fraser* v. *United States*, supra, 236 Conn. 627–30. In that case, we determined that no duty existed "in the absence of a showing that the victim was either individually identifiable or, possibly, was either a member of a class of identifiable victims or within the zone of risk to an identifiable victim." Id., 634. Accordingly, although there is no directly comparable Connecticut case law on which to rely, our precedent, in general, does not support extending the duty of care in the present case because, with one limited exception that does not apply; see part III B of this opinion; we repeatedly have declined, in a variety of situations, to extend the duty of health care providers to persons who are not their patients.[5]

B

Foreseeability

We next consider whether the duty of care should be extended under a classic duty analysis. This requires us first to determine whether the alleged harm was foreseeable. See, e.g., *Pelletier* v. *Sordoni/Skanska Construction Co.*, supra, 286 Conn. 593–94.

The plaintiff claims that the complaint sufficiently alleges that the harm he suffered was foreseeable. The complaint specifically alleges that Troncale diagnosed Ambrogio with a medical condition that he knew, or should have known, judged by the standards of his professional specialty, would render her unable to drive safely but that he improperly failed to advise or warn

her not to continue driving. In other words, a prudent physician in Troncale's position would have foreseen that a motor vehicle accident would be likely to occur if Ambrogio continued to drive in her impaired condition. The defendants claim that foreseeability in an abstract sense is insufficient to impose a duty. They argue that the alleged injury to the plaintiff in this case was not foreseeable because the plaintiff does not allege that Ambrogio's ability to drive was impaired due to an affirmative act by her physician, that Ambrogio previously had suffered a blackout or experienced any problems while driving or that she had exhibited signs or symptoms of an impending blackout while in her physician's presence. We conclude, on the basis of past cases in which this court has limited foreseeable victims of a health care provider's negligence to identifiable persons, that the plaintiff's allegations are insufficient to support a finding that his injuries were a reasonably foreseeable consequence of Troncale's failure to warn Ambrogio.

As a general matter, this court has stated: "It is impractical, if not impossible, to separate the question of duty from an analysis of the cause of the harm when the duty is asserted against one who is not the direct cause of the harm. In defining the limits of duty, we have recognized that [w]hat is relevant . . . is the . . . attenuation between [the defendant's] conduct, on the one hand, and the consequences to and the identity of the plaintiff, on the other hand. . . . Articulated another way, the attenuation between the plaintiffs' harm and the [defendant's] conduct is nothing more than a determination of whether the harm was a reasonably foreseeable consequence of the [defendant's] conduct. It is a well established tenet of our tort jurisprudence that [d]ue care does not require that one guard against eventualities which at best are too remote to be reasonably foreseeable. . . . Due care is always predicated on the existing circumstances." (Citations omitted; internal quotation marks omitted.) *Lodge* v. *Arett Sales Corp.*, 246 Conn. 563, 574–75, 717 A.2d 215 (1998).

Most Connecticut negligence cases in which we have considered the duty of health care providers have involved identifiable victims. See, e.g., *Murillo* v. *Seymour Ambulance Assn., Inc.*, supra, 264 Conn. 479; *Maloney* v. *Conroy*, supra, 208 Conn. 397, 400. In *Fraser* v. *United States*, supra, 236 Conn. 625, however, in which the victim was not identifiable; id., 633; we concluded that a psychotherapist owed no duty to the victim because "our decisions defining negligence do not impose a duty to those who are not identifiable victims" and "in related areas of our common law we have concluded that there is no duty except to identifiable persons . . . ." Id., 632. We specifically noted that, in *Kaminski* v. *Fairfield*, supra, 216 Conn. 29, the only previous case in which we had considered the type of

relationships that "might trigger a special duty of care to protect third parties from personal harm," our determination that "the injured third party had not established a duty to protect him from physical harm rested in part on the fact that he . . . was not a specifically identifiable victim." (Internal quotation marks omitted.) *Fraser* v. *United States*, supra, 633. We further noted that our holding in *Kaminski* had been based on the rule of law articulated in *Tarasoff* v. *Regents of the University of California*, 17 Cal. 3d 425, 431, 551 P.2d 334, 131 Cal. Rptr. 14 (1976). See *Fraser* v. *United States*, supra, 633. In *Tarasoff*, the California Supreme Court concluded that a psychotherapist owed a duty to warn a foreseeable victim of the patient's potential for violent and bizarre behavior because the psychotherapist knew of the patient's specific threat against a specific victim, whom the patient subsequently killed. See *Tarasoff* v. *Regents of the University of California*, supra, 430–31, 438–39. But cf. *Thompson* v. *Alameda*, 27 Cal. 3d 741, 746, 752–58, 614 P.2d 728, 167 Cal. Rptr. 70 (1980) (declining to impose liability on defendant for failing to warn parents of murdered child, parents of other neighborhood children, police or parolee's mother, into whose care parolee had been released, of parolee's threat to take life of random child in neighborhood following his release from prison).

Although many harms, in hindsight, may be foreseeable; see *RK Constructors, Inc.* v. *Fusco Corp.*, 231 Conn. 381, 386, 650 A.2d 153 (1994); the foreseeability test as applied by this court in the context of health care providers has, until now, required an identifiable victim because we have deemed the effect of a physician's conduct on third parties as too attenuated to extend liability beyond the patient. No Connecticut case since *Fraser* has changed that analysis. See *Jacoby* v. *Brinckerhoff*, supra, 250 Conn. 96 (recognizing conclusion in *Fraser* that scope of psychotherapist's duty does not extend beyond therapeutic relationship when there is no imminent risk of serious personal injury and no identifiable victim); *Zamstein* v. *Marvasti*, supra, 240 Conn. 562 (recognizing conclusion in *Fraser* that liability should not be imposed on health care providers for harm "to unidentifiable victims or unidentifiable classes of victims" when patient has "no history of dangerous conduct or articulated threats of dangerous behavior" [internal quotation marks omitted]).

"Related areas of Connecticut negligence law [also] provide support for the proposition that proof that the victim was an identifiable target is ordinarily an essential element of an action in negligence. [Thus] [a]s a common law matter, to impose liability on a municipal employee who presumptively enjoys immunity in the performance of discretionary governmental acts, a plaintiff must show the existence of circumstances that make it apparent to the public officer that his or her failure to act would be likely to subject an identifiable

person to imminent harm . . . . *Mulligan* v. *Rioux*, 229 Conn. 716, 728, 643 A.2d 1226 (1994) . . . *Burns* v. *Board of Education*, 228 Conn. 640, 645, 638 A.2d 1 (1994); *Sestito* v. *Groton*, 178 Conn. 520, 528, 423 A.2d 165 (1979)." (Citation omitted; internal quotation marks omitted.) *Fraser* v. *United States*, supra, 236 Conn. 634.

In the present case, we conclude that, even if it was foreseeable that Ambrogio might have caused a motor vehicle accident due to her impaired condition, the plaintiff was not an identifiable victim, nor does he belong to an identifiable class of victims, because the potential victims of Troncale's alleged negligence included any random pedestrian, driver, vehicular passenger or other person who happened to come in close proximity to a motor vehicle operated by Ambrogio following her diagnosis. Moreover, "any" person cannot be construed to mean an "identifiable" victim or "class" of identifiable victims, as this court has used those terms in prior cases involving health care providers, because it would be impossible to know who such persons might be *before* an accident occurs. Accordingly, if we decide to abandon this court's former approach and to extend a health care provider's duty to possibly foreseeable victims who are not identifiable, we must do so for reasons of public policy.[6] See *Pelletier* v. *Sordoni/Skanska Construction Co.*, supra, 286 Conn. 594.

C

Public Policy Considerations

The plaintiff argues that several key policy considerations favor imposing on health care providers a limited duty to third persons to warn an unaware patient of a potential driving impairment. These include that it would reduce the harm caused by medically impaired drivers, would be highly efficient because a physician is the best cost-avoider and already has a duty to warn the patient, and would have the positive effect of eliminating inconsistent outcomes. The plaintiff further argues that the proposed duty would not implicate the policy concerns raised by more expansive third party duties such as the duty to protect, control or warn third persons because it would not impinge on the physician-patient relationship or on a physician's professional obligation to exercise independent medical judgment in treating a patient. The defendants respond that public policy considerations disfavor imposing such a duty because physicians do not expect to be held accountable to members of the general public for decisions regarding patient treatment, optimal treatment of patients is frustrated by extending a physician's liability to unidentifiable third persons and extending liability would lead to increased litigation and higher health care costs. We agree with the defendants.

We first emphasize that, "[w]hile it may seem that

there should be a remedy for every wrong, this is an ideal limited perforce by the realities of this world. Every injury has ramifying consequences, like the rippling of the waters, without end. The problem for the law is to limit the legal consequences of wrongs to a controllable degree. . . . [Accordingly] [t]he final step in the duty inquiry . . . is to make a determination of the fundamental policy of the law, as to whether the defendant's responsibility should extend to such results." (Citation omitted; internal quotation marks omitted.) *Jaworski* v. *Kiernan*, 241 Conn. 399, 406, 696 A.2d 332 (1997); see also *Maloney* v. *Conroy*, supra, 208 Conn. 400–404 (looking beyond foreseeability and determining that public policy dictates that no duty of care was owed by defendant).

1

Purposes of Tort Compensation

"[T]he fundamental policy purposes of the tort compensation system [are] compensation of innocent parties, shifting the loss to responsible parties or distributing it among appropriate entities, and deterrence of wrongful conduct . . . . It is sometimes said that compensation for losses is the primary function of tort law . . . [but it] is perhaps more accurate to describe the primary function as one of determining when compensation [is] required. W. Prosser & W. Keeton, Torts (5th Ed. 1984) § 4, p. 20. An equally compelling function of the tort system is the prophylactic factor of preventing future harm . . . . The courts are concerned not only with compensation of the victim, but with admonition of the wrongdoer. Id., p. 25. [I]mposing liability for consequential damages often creates significant risks of affecting conduct in ways that are undesirable as a matter of policy. Before imposing such liability, it is incumbent upon us to consider those risks." (Citation omitted; internal quotation marks omitted.) *Lodge* v. *Arett Sales Corp.*, supra, 246 Conn. 578–79.

With respect to the compensation of innocent parties, the present situation is not one in which an injured party necessarily receives no compensation, as the plaintiff suggests. Injured parties may be covered by their own motor vehicle and health insurance policies. Moreover, accidents caused by persons with latent driving impairments may not always be due to the driver's medical condition but, rather, may be due to other factors indicative of negligence, such as speeding or driving while intoxicated. In such cases, injured parties may bring an action against the driver and seek compensation through the driver's insurance policy. We also disagree with the plaintiff that a failure to extend the duty to injured persons would lead to inconsistent outcomes merely because a patient could file a lawsuit against a negligent health care provider and receive a potentially greater recovery than an injured victim who could not file a similar lawsuit. Any conclusion regarding incon-

sistent outcomes must involve a comparison between two parties that stand in the *same* relationship to another party, and patients and injured third persons do not stand in the same relationship to health care providers. We thus conclude that, to the extent an injured party may not be covered by a motor vehicle or health insurance policy, the financial cost to victims resulting from such accidents does not necessarily outweigh the impact of the proposed duty on thousands of physician-patient relationships across the state and the potentially high costs associated with increased litigation, even if, in some exceptional cases, a single victim may not be "adequately compensated through [his] motor vehicle and health insurance" policies, as the dissent maintains. See part III C 2 a and b of this opinion.

Turning next to the issue of distributing loss, we agree with the plaintiff that, if a physician warns a patient before an accident occurs, the proposed duty would serve the goal of shifting the injured party's loss to the driver, who is the most responsible party, because patients who continue to drive unsafely after being warned may be deemed legally negligent if they subsequently cause an accident. A physician who does not warn a patient before an accident occurs, however, could be unfairly subject to liability. The plaintiff assumes that a patient who has been warned will discontinue driving without recognizing that not all patients will necessarily follow their physician's advice. Accordingly, because all health care providers cannot be presumed to control their patient's lifestyle decisions, such as whether or not to drive, it would not be fair to hold an allegedly negligent health care provider responsible for injuries caused by a patient's unsafe driving without knowing whether the patient would have heeded a prior warning.

With respect to the deterrence of wrongful conduct, the proximate cause of a driving accident is the conduct of the driver. If, as the plaintiff argues, the proposed duty is the same duty owed by health care providers to their patients, then expanding the liability of health care providers would not reduce the potential for harm because health care providers would be required to do no more than they already must do to fulfill their duty to patients. In addition, as previously explained, extending a physician's duty to third persons does not mean that a patient with a latent driving impairment would be more likely to discontinue driving. Even if Troncale had advised Ambrogio at the time of her diagnosis that she should no longer drive, she might have continued driving and caused an accident regardless of the warning.

Finally, expanding the duty of health care providers would create a significant risk of affecting conduct in ways that are undesirable because it would interfere

with the physician-patient relationship and give rise to increased litigation, with all of its attendant costs. See part III C 2 a and b of this opinion. The proposed duty also would conflict with the public policy implicit in General Statutes § 14-46 of shielding health care providers from liability to members of the general public by providing that health care providers "may" report any persons diagnosed with "any chronic health problem which in [the physician's] judgment *will significantly affect the person's ability to safely operate a motor vehicle* . . . for the information of the commissioner [of motor vehicles] in enforcing state motor vehicle laws . . . [and] for the purpose of determining the eligibility of any person to operate a motor vehicle on the highways of this state."[7] Accordingly, we conclude that extending the duty of health care providers to injured victims would not advance the fundamental purposes of tort compensation and would be contrary to the legislative intent expressed in § 14-46.

2

Specific Factors

We have articulated four specific factors to be considered in determining the extent of a legal duty as a matter of public policy. These are: "(1) the normal expectations of the participants in the activity under review; (2) the public policy of encouraging participation in the activity, while weighing the safety of the participants; (3) the avoidance of increased litigation; and (4) the decisions of other jurisdictions." *Murillo* v. *Seymour Ambulance Assn., Inc.*, supra, 264 Conn. 480; accord *Perodeau* v. *Hartford*, 259 Conn. 729, 756–57, 792 A.2d 752 (2002); *Jaworski* v. *Kiernan*, supra, 241 Conn. 407. We conclude, upon consideration of these factors, that extending the duty of health care providers to unidentifiable third persons in the present context would be contrary to sound public policy.

a

Starting with the expectations of the parties, long established common-law principles hold that physicians owe a duty to their patients because of their special relationship, not to third persons with whom they have no relationship. Furthermore, there is no state statute or regulation that imposes a duty on health care providers to warn a patient for the benefit of the public. As previously discussed, § 14-46[8] provides that a health care provider "may" report to the department of motor vehicles the name, age and address of any person diagnosed with any chronic health problem that would significantly affect the person's ability to safely operate a motor vehicle. The statute is notable, however, for the fact that it is permissive rather than mandatory, reflecting the legislature's judgment that physicians owe no duty to the public to report even serious health problems that could affect a patient's driving ability.

Accordingly, the defendants would not have expected their liability to extend to the plaintiff in this case because of Troncale's failure to warn Ambrogio on the day of her diagnosis of the latent driving impairment associated with her medical condition.

Correspondingly, although a person injured in a motor vehicle accident would not expect to recover from a nonnegligent driver,[9] an injured person might expect compensation under his or her own motor vehicle or health insurance policy. Even without this coverage, however, it is unlikely that a person injured in a motor vehicle accident caused by another driver would expect to be compensated by the driver's health care provider, given the privileged status of the physician-patient relationship, the common-law protections granted to health care providers, and the legislature's implicit decision in § 14-46 to shield health care providers from liability for failing to report their patients. The normal expectations of the parties thus weigh heavily against extending the duty of health care providers to victims of their patients' unsafe driving.

b

We next consider whether the proposed duty would impermissibly interfere with the physician-patient relationship and discourage patients from seeking treatment and care from their health care providers. We conclude that, when the accepted standard of care requires a health care provider to advise or warn a patient of the risks of driving due to the patient's underlying medical condition, imposing an additional duty on the health care provider to the victim of the patient's unsafe driving would be problematic, at best, because it would be inconsistent with the physician's duty of loyalty to the patient, would threaten the inherent confidentiality of the physician-patient relationship and would impermissibly intrude on the physician's professional judgment regarding treatment and care of the patient.

We begin with the premise that, "[u]nlike most duties, the physician's duty to the patient is explicitly relational: physicians owe a duty of care to *patients*." (Emphasis in original.) 1 Restatement (Third), supra, § 41 (h), p. 790. Mindful of this principle, we have recognized on more than one occasion the physician's duty of "undivided loyalty" to the patient; *Jacoby* v. *Brinckerhoff*, supra, 250 Conn. 97; accord *Mack* v. *Saars*, 150 Conn. 290, 312, 188 A.2d 863 (1963) (*Shea*, *J.*, dissenting); *Lieberman* v. *Board of Examiners in Optometry*, 130 Conn. 344, 350, 34 A.2d 213 (1943); and the patient's corresponding loyalty, trust and dependence on the professional opinions and advice of the physician. *Blanchette* v. *Barrett*, 229 Conn. 256, 266, 640 A.2d 74 (1994), overruled on other grounds by *Grey* v. *Stamford Health System, Inc.*, 282 Conn. 745, 924 A.2d 831 (2007). "Undivided loyalty" means that the patient's

well-being must be of paramount importance in the mind of the physician. Indeed, this is the foundation for the patient's reciprocal loyalty, trust and dependence on the physician's medical treatment and advice. Consistent with this view, we have stated that, "[*a*]*s a matter of public policy . . . the law should encourage medical care providers . . . to devote their efforts to their patients . . . and not be obligated to divert their attention to the possible consequences to* [*third parties*] *of medical treatment of the patient*." (Emphasis added.) *Murillo* v. *Seymour Ambulance Assn., Inc.*, supra, 264 Conn. 481. "It is . . . the consequences to the patient, and not to other persons, of deviations from the appropriate standard of medical care that should be the central concern of medical practitioners." *Maloney* v. *Conroy*, supra, 208 Conn. 403. Accordingly, the duty urged by the plaintiff would undeniably interfere with a physician's duty of loyalty to the patient because, in deciding when and how to advise the patient, the physician would be required to consider a second, possibly conflicting duty to persons who are not their patients.

Extending a health care provider's duty also would threaten the confidentiality inherent in the physician-patient relationship because lawsuits alleging a breach of the duty would compel the use of confidential patient records by defending physicians. The principle of confidentiality lies at the heart of the physician-patient relationship and has been recognized by our legislature. General Statutes § 52-146o was enacted in 1990; see Public Acts 1990, No. 90-177; to address the need "to protect the confidentiality of communications in order to foster the free exchange of information from patient to physician . . . ."[10] *Edelstein* v. *Dept. of Public Health & Addiction Services*, 240 Conn. 658, 666, 692 A.2d 803 (1997). The statute provides that a health care provider shall not disclose patient information in their files without the patient's explicit consent. See General Statutes § 52-146o (a). Thus, when a patient decides to bring a claim against a health care provider, the patient makes a purposeful decision to waive confidentiality. See General Statutes § 52-146o (b) (2); cf. *Coombes* v. *Florio*, 450 Mass. 182, 213, 877 N.E.2d 567 (2007) (Cordy, J., dissenting) (patient's decision to bring medical malpractice action against patient's physician "implies a waiver of . . . confidentiality for purposes of [that action]"). Subsection (b) (2) of § 52-146o, however, contains an exception whereby patient consent is not required for the disclosure of communications or records by a health care provider against whom a claim has been made. Consequently, if a person injured in a motor vehicle accident files an action against the health care provider of the driver causing the accident, records containing the patient's medical history will very likely be disclosed in court and subjected to public scrutiny. The effect of expanding the duty of a health care pro-

vider in this fashion cannot be underestimated. Physician-patient confidentiality is described as a "privilege . . . ." *Edelstein* v. *Dept. of Public Health & Addiction Services*, supra, 666. When that confidentiality is diminished to any degree, it necessarily affects the ability of the parties to communicate, which in turn affects the ability of the physician to render proper medical care and advice. Accordingly, it is not in the public interest to extend the duty of health care providers to third persons in the present context because doing so would jeopardize the confidentiality of the physician-patient relationship. See, e.g., *Jacoby* v. *Brinckerhoff*, supra, 250 Conn. 96.

Finally, extending a health care provider's duty to third persons would affect the decisions of treating physicians and, in some cases, allow strangers in their capacity as jurors and medical experts to substitute their judgment for that of physicians and patients, who are empowered to bring their own lawsuits, if deemed necessary, to determine whether a patient should have been warned. We can think of no more egregious interference with the physician-patient relationship than this.

Contrary to what the plaintiff and the dissent apparently believe, the proposed duty is not the same as a physician's existing duty to warn a patient of a latent driving impairment. A "duty to act" has been defined as "[a] duty to take some action to prevent harm to another . . . ." Black's Law Dictionary (9th Ed. 2009).[11] "Duty" thus consists, first, of an underlying obligation to prevent possible harm to another person, and, second, of the action required to satisfy this obligation. In the present context, the action required to satisfy a physician's obligation to patients and potential victims of the patient's unsafe driving would be the same, namely, warning the patient regarding the risks of driving. The physician's underlying obligation to patients and potential victims, however, would not be the same. This is because there is a fundamental difference between a physician's relationship to patients and to potential victims that would pull the physician in different directions in deciding when to issue the warning. See *Coombes* v. *Florio*, supra, 450 Mass. 211–13 (Cordy, J., dissenting).

The reasons for this tug of war are not hard to understand and relate to the difficulty in determining exactly when a patient's medical condition requires a warning and the inherent ambiguity in the standard of care. With respect to medical conditions or diseases that may create driving risks, most diseases do not appear suddenly, in full blown form, nor is a diagnosis necessarily possible on the basis of a single early symptom. Diseases naturally progress over a period of time, and, as they do, more symptoms appear that may cause various types and degrees of incapacitation. The stan-

dard of care described in the plaintiff's complaint and the medical expert's report, however, merely requires that a physician advise and warn the patient of the risks of driving when there is a latent driving impairment. There is nothing in this standard that mandates when the patient must be advised or warned. The ambiguity in the standard of care and the slow evolution of most diseases, which may be barely detectable in their early stages, are why a physician's differing obligations to patients and potential victims may require that the warning be issued at different times.

Because a physician's only obligation to potential victims would be to warn the patient, the public would expect and demand that the physician issue the warning at the earliest possible time, such as when the disease is initially diagnosed or, at the very least, before an accident occurs. In contrast, a physician's obligation to the patient is not limited to the warning but is accompanied by a second, overarching obligation to ensure the patient's general well-being. See 1 Restatement (Third), supra, § 41 (h), p. 790 (physician's duty to patient encompasses ordinary duty not to harm patient through negligent conduct and affirmative duty to use appropriate care to help patient). In deciding how to satisfy these dual obligations, the physician must consider other aspects of the patient's physical and mental condition, the patient's personality and lifestyle, and how far the disease has progressed.

For example, a health care provider may decide that a patient is not psychologically or emotionally prepared for a complete explanation and discussion of a disease and its potential effects at the time of the initial diagnosis, preferring instead to schedule a separate appointment when more time is available to answer questions and allay the patient's concerns. There also may be occasions when a patient with a progressive and potentially disabling disease, such as high blood pressure, multiple sclerosis, Parkinson's disease, mental illness or cancer, has not experienced and reported symptoms such as blackouts or severe physical or mental impairments that would render driving unsafe. In these circumstances, the health care provider, in his professional judgment, might not deem it necessary to warn the patient regarding the risks of driving. When physicians conclude for such reasons that patients should not be warned at the time of the diagnosis or before an accident occurs, their obligations to patients and potential victims necessarily will conflict.[12]

The consequences of this conflict for decisions regarding patient care are not insignificant. A physician whose attention is diverted from the patient to the effects of his advice on unknown persons who could be harmed by the patient's future conduct "may, understandably, become less concerned about the particular requirements of any given patient, and more concerned

with protecting himself or herself from lawsuits by the potentially vast number of person[s] who will interact with and may fall victim to that patient's conduct outside of the treatment setting." *Coombes* v. *Florio*, supra, 450 Mass. 211 (Cordy, J., dissenting). In other words, a physician's desire to avoid potential lawsuits may result in far more restrictive advice than necessary for the patient's well-being. In a worst case scenario, the patient simply would ignore or reject an early warning regarding potential driving risks as inapplicable and untimely. We therefore conclude that it cannot be considered good public policy to encourage health care providers to cast aside their preeminent duty of undivided loyalty to the patient and to render advice that would unnecessarily restrict or eliminate a life activity that contributes to the patient's well-being.

Furthermore, health care providers who owe a duty to potential victims of a patient's unsafe driving would be required to weigh and balance many new and unfamiliar factors in deciding how and when to advise their patients. Thus, some health care providers might find themselves in the uncomfortable position of wondering whether the disclosure to a patient of a potential driving impairment, accompanied by advice that the patient need not stop driving because the condition is not yet disabling, would be deemed inadequate in a court of law. The purpose of a warning also might be diluted if a health care provider should determine that the only cost-effective way to achieve sufficient protection from potential lawsuits is to seek the patient's signature on a generic consent form containing all of the possible effects of a disease instead of advising the patient based on a more considered judgment as to what the patient needs to know in light of the patient's actual condition. See id., 211–12 (Cordy, J., dissenting). In sum, expanding the duty of a health care provider to an unforeseen victim of a patient's unsafe driving could interfere significantly with a health care provider's discretion to treat and counsel patients in accordance with an assessment of the patient's individual needs. Indeed, it is for this reason that we repeatedly have rejected past requests to expand the duty of physicians to include nonpatients on the basis of an alleged deviation from the standard of care. See, e.g., *Murillo* v. *Seymour Ambulance Assn., Inc.*, supra, 264 Conn. 479–84; *Jacoby* v. *Brinckerhoff*, supra, 250 Conn. 96–100; *Zamstein* v. *Marvasti*, supra, 240 Conn. 559–61.

By far the most egregious interference with the physician-patient relationship, however, would be in the form of lawsuits brought against health care providers for breach of the duty that the plaintiff urges in this case. The question of whether a physician reasonably failed to warn a patient would then be placed in the hands of jurors and medical experts who have no knowledge of the physician, the patient or their ongoing relationship. Moreover, an action brought by a third party dif-

fers from an action brought by a patient because the patient *voluntarily* exposes the relationship to public scrutiny based on a belief, founded on a complete understanding of the relationship, that the physician has deviated from the standard of care. In contrast, a third party who brings an action without the patient's permission has no knowledge of the physician-patient relationship. Interference of this kind, which would open private communications between physicians and patients to potentially endless investigation and lead to interminable arguments regarding the patient's symptoms and the physician's treatment decisions, is simply not compatible with the privilege granted to physician-patient relationships by the legislature and the common-law duties of loyalty and confidentiality owed to patients by their health care providers.

We have reached the same conclusion when third parties have attempted to expand the duty of other professionals beyond the privileged relationship. In *Krawczyk* v. *Stingle*, 208 Conn. 239, 246–47, 543 A.2d 733 (1988), we disallowed a claim by the beneficiaries of a decedent against the decedent's attorney for the attorney's failure to arrange for the timely execution of certain estate planning documents before the decedent died. We explained that the "[i]mposition of liability would create an incentive for an attorney to exert pressure on a client to complete and execute estate planning documents summarily. Fear of liability to potential third party beneficiaries would contravene the attorney's primary responsibility to ensure that the proposed estate plan effectuates the client's wishes and that the client understands the available options and the legal and practical implications of whatever course of action is ultimately chosen." Id. For similar reasons, extending the duty of physicians, as the plaintiff suggests, would impermissibly interfere with the physician-patient relationship.

c

The proposed duty also would result in increased litigation because it would open the door to an entirely new category of claims against health care providers, not only in the present context, but in the context of other treatment decisions that might indirectly cause injury to third parties, thereby greatly expanding the liability of health care providers and creating an additional burden on the courts. This would have the effect of driving up health care costs because the additional expenses incurred in defending against lawsuits very likely would be passed on to patients. As a dissenting justice explained when the Massachusetts Supreme Judicial Court concluded that a physician owed a duty of care to everyone foreseeably put at risk by the physician's failure to warn of the side effects of a patient's treatment, "[o]ne need not be clairvoyant to understand the inevitable result of today's enlargement of liability:

a significant increase in third party litigation against doctors and an attendant increase in expenses at a time when our health care system is already overwhelmed with collateral costs. . . . [Imposing such a duty] impedes not only the work of doctors. It impedes the work of [the] courts." *Coombes* v. *Florio*, supra, 450 Mass. 205–206 (Marshall, C. J., dissenting). The same concern applies in the present case.

In addition, health care providers would be forced to spend valuable time away from their patients so that they could respond to interrogatories, attend depositions and testify at trial. Litigiously inclined victims of motor vehicle accidents also could use their newly granted power to conduct time-consuming fishing expeditions for the purpose of discovering medical information that could be used in bringing claims against health care providers to supplement the coverage provided under their own insurance policies. The prospect of increased litigation and its attendant costs in terms of time and money thus militates against expanding the duty of health care providers in the present circumstances.

d

We finally consider the law of other jurisdictions. The plaintiff claims that, of the states that have decided the issue, a clear majority supports the proposed duty. The defendants respond that an analysis of foreign authority does not support the proposed duty. We agree with the defendants.

To the extent the plaintiff argues that "a clear majority of [the] decisions support the rule" that a health care provider owes a duty to the victim of a patient's unsafe driving to warn the patient when "a patient's medical condition *or medication* renders [the patient] unable to drive safely"; (emphasis added); he mischaracterizes the proposed rule and relies on inapposite law. The issue before this court is whether health care providers owe a duty to third parties arising from a latent driving impairment caused by the patient's *underlying medical condition*,[13] not by prescribed medication or treatment, an issue on which we express no opinion. We further note that, of the sixteen cases on which the plaintiff principally relies, all but two are factually distinguishable because they involve the court's finding of a duty when the health care provider failed to warn the patient not to drive after prescribing medication or otherwise treating the patient, or failed to warn the patient that he or she either had a communicable disease or had been exposed to one. See *Hoehn* v. *United States*, 217 F. Sup. 2d 39, 41–42, 48–49 (D.D.C. 2002) (claim that medical center owed duty to unidentified third parties to warn heavily medicated patient of dangers of driving following chemotherapy treatment was deemed viable but not subject to review due to sparse record); *McKenzie* v. *Hawaii Permanente Medi-*

cal Group, Inc., 98 Haw. 296, 308–309, 47 P.3d 1209 (2002) (physician owed duty to third parties injured in automobile accident caused by patient's adverse reaction to prescribed medication when physician negligently failed to warn patient that medication might impair driving ability and circumstances were such that reasonable patient could not have been expected to be aware of risk without such warning); *Cram* v. *Howell*, 680 N.E.2d 1096, 1097–98 (Ind. 1997) (physician owed duty of care to take reasonable precautions in monitoring, releasing, and warning patient in order to protect unknown third persons potentially jeopardized by patient's driving upon patient's departure from physician's office following immunizations and vaccinations that caused patient to lose consciousness two times before leaving office); *Joy* v. *Eastern Maine Medical Center*, 529 A.2d 1364, 1365–66 (Me. 1987) (permitting cause of action against health care providers for injuries to third party caused by their alleged negligence in failing to warn motorcyclist not to drive after placing eye patch over one eye); *Wilschinsky* v. *Medina*, 108 N.M. 511, 512–16, 775 P.2d 713 (1989) (physician owed duty to persons injured by patient driving automobile from physician's office when patient had been injected with drugs known to affect judgment and driving ability); *Hardee* v. *Bio-Medical Applications of South Carolina, Inc.*, 370 S.C. 511, 516, 636 S.E.2d 629 (2006) (medical provider who provided dialysis treatment that it knew might detrimentally affect patient's ability to drive owed duty to warn patient of risks of driving before administering treatment in order to prevent harm to patient and to third parties who were injured in motor vehicle accident); *Burroughs* v. *Magee*, 118 S.W.3d 323, 331–33 (Tenn. 2003) (physician owed duty of care to patient and third party to warn patient of possible adverse effect of two prescribed drugs on patient's ability to operate motor vehicle safely); *Kaiser* v. *Suburban Transportation System*, 65 Wn. 2d 461, 462, 469, 398 P.2d 14 (1965) (physician owed duty to passenger on bus to warn patient, who was driver, of potential side effect of drowsiness caused by prescribed medication); see also *Reisner* v. *Regents of the University of California*, 31 Cal. App. 4th 1195, 1197, 1199, 37 Cal. Rptr. 2d 518 (1995) (health care provider owed duty to third person to warn patient with positive human immunodeficiency virus [HIV] test of risks involved in certain conduct), review denied, California Supreme Court, Docket No. S045274 (May 18, 1995); *Coombes* v. *Florio*, supra, 450 Mass. 195–96 (Greaney, J., concurring in part and dissenting in part) (agreeing with conclusion of plurality of court that physician who had knowledge of danger posed to others from patient's decision to operate motor vehicle while under influence of prescribed medication but who did not warn patient of risks could be held liable for injuries to others caused by failure to warn); *C.W. ex rel. J.W.* v. *Cooper Health System*, 388 N.J. Super. 42, 47–48, 62, 906 A.2d 440 (App. Div.

2006) (health care provider who ordered HIV test for patient owed duty to third party to take reasonable measures to notify patient of results of test); *Estate of Amos* v. *Vanderbilt University*, 62 S.W.3d 133, 138 (Tenn. 2001) (health care provider owed duty to third parties to warn patient of potential exposure to HIV so that patient could take appropriate measures to protect third parties); *Bradshaw* v. *Daniel*, 854 S.W.2d 865, 866, 872 (Tenn. 1993) (physician owed duty to third party to warn patient, who was third party's spouse, of risk of exposure to source of patient's noncontagious disease).

The plaintiff's reliance on case law developed in an entirely different context is unpersuasive. The plaintiff asks that a duty be imposed, not because of an affirmative act on the part of the health care provider, as requested by the plaintiffs in the overwhelming majority of cases on which he relies, but because of the health care provider's failure to warn a patient of a latent driving impairment based solely on his knowledge of the patient's medical condition. Thus, if we agreed with the plaintiff, the simple act of accepting a person as a patient with a preexisting medical condition could form the basis for imposing a duty on health care providers to an unlimited number of persons with whom they have no relationship, with the attendant liability for harm caused by no act of the provider but by the effects of the medical condition alone. See *Medina* v. *Pillemer*, Massachusetts Superior Court, Docket No. 2004-00290H (July 29, 2011).

The only two cases cited by the plaintiff with any possible relevance in the present context are *Duvall* v. *Goldin*, 139 Mich. App. 342, 345–46, 352, 362 N.W.2d 275 (1984) (physician owed duty to person injured in motor vehicle accident to instruct epileptic patient not to operate motor vehicle after physician withdrew prescription for antiepileptic medication), and *Myers* v. *Quesenberry*, 144 Cal. App. 3d 888, 890, 894, 193 Cal. Rptr. 733 (1983) (physicians owed duty to person injured in motor vehicle accident to warn patient of driving impairment arising from gestational diabetic condition). In each of those cases, however, the court limited the physician's duty to the narrow facts before it.

As the court in *Duvall* explained, "[g]iven the nature of the condition involved . . . epileptic seizures, and assuming as we must the truth of [the] plaintiffs' allegations, we are of the opinion that it is foreseeable that a doctor's failure to diagnose or properly treat an epileptic condition may create a risk of harm to a third party. . . . Here, one of the alleged breaches of duty involves the defendant's failure to inform his patient not to operate a motor vehicle. The likelihood of injury to a third party due to an automobile accident arising from that breach is not so rare or unusual an occurrence as to be considered unforeseeable. . . .

"However, our decision in this regard is limited to

the narrow facts set forth in [the] case. We decline to find a duty in every instance involving a physician, his patient and an unidentifiable third party. We do not intend to make physicians highway accident insurers." *Duvall* v. *Goldin*, supra, 139 Mich. App. 352.

The court in *Myers* likewise limited its holding to the specific facts in question. In that case, two physicians began treating the patient for gestational diabetes several months before the accident. See *Myers* v. *Quesenberry*, supra, 144 Cal. App. 3d 890. The physicians knew that the patient's condition had seriously affected her previous pregnancies. Id. Approximately three months later, after they had discharged her from the hospital with her diabetes "unstabilized," they examined her during a scheduled appointment and, "[h]earing no fetal heart tones," asked her to return in one week for further examination. Id. Upon her return, the physicians determined that the fetus had died. Id. The patient became emotionally upset, and the physicians advised her to drive immediately to the hospital for laboratory tests. Id. During the drive, the patient lost control of her vehicle due to a diabetic attack and struck the plaintiff as he was standing by the side of the road. Id., 890–91. On these facts, the court held that the plaintiff had stated a cause of action against the physicians for negligently failing to warn the patient against driving in an uncontrolled diabetic condition that was complicated by emotional trauma. Id., 890.

The defendants also rely on two cases in which medication was not a factor in causing a patient to lose control of a motor vehicle. In those cases, however, one of which also involved a patient with a seizure disorder, the court reached a different conclusion. In *Schmidt* v. *Mahoney*, 659 N.W.2d 552, 553–54 (Iowa 2003), a patient had a seizure while driving, which caused her to lose control of her motor vehicle and to injure the plaintiff. Although her treating physician knew that she had suffered from a seizure disorder since early infancy and had lost control of her motor vehicle on other occasions because of oncoming seizures, he advised her that it would be safe to drive. Id., 553. Nevertheless, the Iowa Supreme Court declined to recognize a duty by the physician to the injured plaintiff for policy reasons, explaining that "it is highly likely that a consequence of recognizing liability to members of the general public on the facts of this case will be that physicians treating patients with seizure disorders will become reluctant to allow them to drive or engage in any other activity in which a seizure could possibly harm a third party. In order to curtail liability, physicians may become prone to make overly restrictive recommendations concerning the activities of their patients and will exercise their role as reporters to the department of transportation in an inflexible manner not in their patient's best interest. We are unable to distinguish, on public-policy grounds, the potential for

disrupting the physician-patient relationship that would arise from recognizing liability in [this] case from the potential for damaging that relationship acknowledged in [prior cases recognizing the duty of medical providers]." Id., 555.

Similarly, in *Flynn* v. *Houston Emergicare, Inc.*, 869 S.W.2d 403, 404 (Tex. App. 1993), a patient who had gone to a hospital emergency department for treatment of chest pain several hours after using cocaine was discharged without a warning from the physician not to drive. On the way home, the patient had a seizure that was related to his cocaine use and crashed into the back of the plaintiff's vehicle. See id., 404, 406. The court concluded that, because there was no allegation or evidence that the physician did anything to create the impairment that ultimately led to the accident and resulted in the plaintiff's injury, he did not owe the plaintiff a duty to warn the patient not to drive. Id., 406. The court determined that it was the ingestion of cocaine that had caused the impairment that led to the accident and not any affirmative act of the physician. Id. Accordingly, the physician owed no duty to the public to warn the patient not to drive following the patient's ingestion of cocaine. See id.

As the foregoing cases suggest, there is no clear trend in the law of other jurisdictions. We thus find no convincing support from our sister states for either party's view and return for guidance to statutory authority and well established common-law principles developed in our own jurisdiction.

In view of all of the relevant factors, we decline to expand the duty of health care providers to unidentifiable third persons for reasons of public policy. We also decline to expand the duty because, given its potential impact on the physician-patient relationship, we deem the legislature rather than the courts the proper forum for resolving this issue, as it has done in similar situations.

We are particularly mindful of the legislature's deliberate expansion of the common-law liability of purveyors of alcoholic beverages in the Dram Shop Act (act), General Statutes § 30-102, which authorizes a private cause of action against the seller of alcohol to an intoxicated person who causes injury to another person due to his or her intoxication. *Craig* v. *Driscoll*, 262 Conn. 312, 314, 813 A.2d 1003 (2003). The common-law general rule was that "no tort cause of action lay against one who furnished, whether by sale or gift, intoxicating liquor to a person who thereby voluntarily became intoxicated and in consequence of his intoxication injured the person or property either of himself or of another. The reason generally given for the rule was that the proximate cause of the intoxication was not the furnishing of the liquor . . . but the consumption of it by the purchaser or donee. The rule was based on

the obvious fact that one could not become intoxicated by reason of liquor furnished him if he did not drink it. . . . Common-law tort claims against purveyors routinely failed, therefore, because the consumption of the liquor was viewed as an intervening act breaking the chain of causation between the purveyor and the ensuing injury caused by the intoxication. . . .

"In Connecticut, as far back as 1872, it came to be felt that the foregoing common-law rule was to some extent overly harsh and should be modified by statute. Such statutes, which were enacted in numerous other states, came to be known as civil damage or dram shop acts. . . . Connecticut's first such statute is found in § 8 of chapter 99 of the Public Acts of 1872, and its enactment indicated a knowledge, by the General Assembly, of the foregoing common-law rule. The 1872 act gave a cause of action against a seller who sold intoxicating liquor to a person who thereby became intoxicated for any damage or injury to any other person, or to the property of another done by the intoxicated person in consequence of his intoxication. Thus, this act, in situations [in which] it was applicable, displaced the common-law rule that the proximate cause of intoxication was not the furnishing of the liquor but its consumption. . . . In subsequent amendments to the act, the legislature expanded liability by including sales by the purveyor's agents and by eliminating the requirement of proof of a causal connection between the selling of the alcoholic liquor and the intoxication that caused the injury." (Citations omitted; internal quotation marks omitted.) Id., 322–23. "The act, therefore, modified the common-law rule." Id., 323.

The legislature expanded the liability of the purveyors of alcoholic beverages because of the inability of the common-law rule to address a matter of general public concern, namely, the consequences to persons and property flowing from the objectionable behavior of intoxicated customers to whom liquor had been sold.[14] In contrast, the plaintiff and the defendants in the present case agree that motor vehicle accidents caused by drivers whose health care providers have failed to advise or warn them of a latent driving impairment are rare. Accordingly, such accidents do not raise public concerns even remotely comparable in significance to the concerns that gave rise to dram shop laws. In addition, the relationship between a purveyor of alcoholic beverages and a customer is unlike the physician-patient relationship because it is not privileged or protected by statutory authority. Lastly, a cause of action under the dram shop laws rests on an affirmative act of the purveyor, namely, the sale of alcohol to an intoxicated person, whereas the proposed cause of action in the present case is premised on the failure of a physician to advise or warn a patient not to drive because of an underlying medical condition that the physician did nothing to create. Accordingly, expanding the liability

of health care providers involves considerations that differ from those that caused the legislature to expand the liability of purveyors of alcoholic beverages.

Although we have recognized that a common-law rule may be "subject to both legislative and judicial modification"; (internal quotation marks omitted) id., 323; we deem the reluctance in the common law to extend the duty of health care providers to nonpatients, the legislative policy evinced in § 14-46 of shielding health care providers from liability to the general public for injuries caused by the effect of serious, chronic health conditions on a patient's driving ability, and the purpose of § 52-190a and tort reform of limiting the potential liability and medical malpractice insurance rates of health care providers as strong reasons for leaving the issue of extending a health care provider's duty to legislative rather than judicial modification. Accordingly, we decline to adopt the rule that the plaintiff proposes and conclude that the trial court properly granted the defendants' motion to strike on the ground that Troncale owed no duty to the plaintiff to advise or warn Ambrogio of the latent driving impairment associated with her medical condition.[15]

The judgment is affirmed.

In this opinion ROGERS, C. J., and NORCOTT, PALMER and McLACHLAN, Js., concurred.

* The listing of justices reflects their seniority status on this court as of the date of oral argument.

** September 17, 2012, the date that this decision was released as a slip opinion, is the operative date for all substantive and procedural purposes.

[1] The good faith certificate was accompanied by a "medical expert report" in which the medical expert, a physician, described Ambrogio's medical records and concluded that Troncale "fell below the standard of care in his treatment of . . . Ambrogio by failing to warn Ambrogio about the risks of driving with impaired mental functioning, resulting in whole or part, from hepatic insufficiency."

[2] We note that the allegation in the plaintiff's complaint differs from the conclusion in the medical expert's report filed in conjunction with the good faith certificate, which provided in relevant part that Troncale's conduct fell below the standard of care in that he failed "to warn Ambrogio about the *risks* of driving with impaired mental functioning, resulting in whole or part, from hepatic insufficiency." (Emphasis added.) We overlook this inconsistency, however, and consider the broader question of whether Troncale fell below the standard of care by failing to warn Ambrogio about the risks of driving with impaired mental functioning because it is the more meaningful and relevant question and the medical expert's report was made part of the complaint by way of the good faith certificate.

[3] The plaintiff appealed to the Appellate Court from the trial court's judgment, and we transferred the appeal to this court pursuant to General Statutes § 51-199 (c) and Practice Book § 65-1.

[4] General Statutes § 52-190a (a) further provides in relevant part: "The complaint, initial pleading or apportionment complaint shall contain a certificate of the attorney or party filing the action or apportionment complaint that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant or for an apportionment complaint against each named apportionment defendant. To show the existence of such good faith, the claimant or the claimant's attorney, and any apportionment complainant or the apportionment complainant's attorney, shall obtain a written and signed opinion of a similar health care provider, as defined in section 52-184c, which similar health care provider shall be selected pursuant to the provisions of said section, that there appears to be evidence of medical negligence and includes a detailed basis for the

formation of such opinion. . . . The claimant or the claimant's attorney, and any apportionment complainant or apportionment complainant's attorney, shall retain the original written opinion and shall attach a copy of such written opinion, with the name and signature of the similar health care provider expunged, to such certificate. . . ."

[5] Although the dissent suggests otherwise, we do not conclude that this court has employed or endorsed a per se rule that such claims are categorically barred because of the absence of a physician-patient relationship but, rather, that "this court has exercised restraint when presented with opportunities to extend the duty of health care providers to persons who are not their patients." Part III A of this opinion.

[6] The dissent takes issue with our foreseeability analysis, arguing that we are extending the reasoning in *Fraser* to conclude that the harm to the plaintiff in the present case was unforeseeable. We disagree. We merely conclude that the foreseeability test, as previously applied by this court in this and related contexts, has required an identifiable victim, because the effect of a physician's conduct on third parties has been deemed too attenuated to extend liability beyond the patient. We further conclude that, even if the motor vehicle accident in the present case was foreseeable, the plaintiff was not an identifiable victim, and, therefore, given this court's prior reluctance to impose liability on a health care provider for injuries to an unidentifiable third party victim, our decision to do so in the present context must be supported by strong public policy reasons. Consequently, we do not extend the reasoning in *Fraser* to conclude that the harm to the plaintiff was unforeseeable but, rather, review the relevant public policy considerations to determine whether liability should be imposed.

[7] The public policy of limiting the liability of health care providers is even more apparent upon examining the history of § 14-46, which suggests that the legislature's decision to shield health care providers from liability may have been a reaction to more than a decade of experience with penalizing physicians for failing to report the names of persons with latent driving impairments. In its earliest form, the statute required physicians to report persons subject to recurrent epileptic seizures to the state department of health, which, in turn, was required to forward the reports to the department of motor vehicles. See General Statutes (Sup. 1953) § 1015c. In 1975, however, the legislature amended the statute to make the failure to report an infraction. See Public Acts 1975, No. 75-577, § 24. This remained the law until 1990, when the legislature again amended the statute by (1) expanding the class of persons with a latent driving impairment to include individuals with chronic health or vision problems, (2) authorizing, instead of requiring, physicians and optometrists to report, (3) directing that reports from physicians and optometrists be filed directly with the department of motor vehicles instead of the department of health, and (4) eliminating the penalty for a failure to report. See Public Acts 1990, No. 90-265, § 4. The legislature's deliberate elimination in 1990 of the mandatory reporting requirement and penalty when it expanded the class of persons who may be reported thus suggests an intent to limit physician liability for driving accidents caused by patients, which might otherwise have greatly increased when the class of persons was expanded.

[8] General Statutes § 14-46 provides in relevant part: "Any physician . . . may report to the Department of Motor Vehicles, in writing, the name, age and address of any person diagnosed by him or her to have any chronic health problem which in [the physician's] judgment will significantly affect the person's ability to safely operate a motor vehicle, or to have recurrent periods of unconsciousness uncontrolled by medical treatment. . . . Such reports shall be for the information of the commissioner in enforcing state motor vehicle laws, and shall be kept confidential and used solely for the purpose of determining the eligibility of any person to operate a motor vehicle on the highways of this state. . . ."

[9] Connecticut's motor vehicle insurance laws place responsibility for compensating the victim of a driver's *negligent* acts with the owner of the vehicle. *Farmers Texas County Mutual* v. *Hertz Corp.*, 282 Conn. 535, 542, 923 A.2d 673 (2007). As we explained in *Farmers Texas County Mutual*: "Our statutory and regulatory scheme guarantees coverage for *legal liability* incurred in the use of motor vehicles and allocates the responsibility for that coverage to the owner of the vehicle. General Statutes § 38a-371 describes the mandatory security requirements for the vehicle owner under the state's no-fault motor vehicle insurance scheme. That [statute] provides in relevant part that '[t]he owner of a private passenger motor vehicle required to be registered in this state shall provide and continuously maintain

throughout the registration period security in accordance with sections 38a-334 to 38a-343, inclusive [setting forth, inter alia, minimum insurance policy coverage mandated in conformity with regulatory requirements].' General Statutes § 38a-371 (a) (1). To ensure that a vehicle owner complies with security requirements, General Statutes § 14-12b prohibits the registration of a vehicle absent proof of the owner's requisite coverage, and § 38a-371 (e) ensures that, even if the owner allows insurance coverage to lapse on a vehicle, the owner will still be liable for damages in the event of an accident.

"Other statutes dictate that an owner is not relieved of liability simply because the owner is not the operator of the vehicle. General Statutes § 14-213b proscribes operation of an uninsured vehicle . . . and places responsibility for adherence to that rule on the owner, even when the owner is not the operator of the vehicle. In addition, General Statutes § 14-154a addresses owners who rent or lease their vehicles, providing in relevant part: '(a) Any person renting or leasing to another any motor vehicle owned by him shall be liable for any damage to any person or property caused by the operation of such motor vehicle while so rented or leased, to the same extent as the operator would have been liable if he had also been the owner. . . .'

"The legislature, therefore, has made clear, through its use of mandatory language and mutually reinforcing statutes, that, as a general matter, the owner of a vehicle registered in Connecticut is responsible for maintaining liability insurance on that vehicle." (Emphasis added.) *Farmers Texas County Mutual* v. *Hertz Corp.*, supra, 282 Conn. 542–43.

[10] General Statutes § 52-146o provides in relevant part: "(a) Except as provided in sections 52-146c to 52-146j, inclusive, and subsection (b) of this section, in any civil action or any proceeding preliminary thereto or in any probate, legislative or administrative proceeding, a physician or surgeon . . . shall not disclose (1) any communication made to him by, or any information obtained by him from, a patient or the conservator or guardian of a patient with respect to any actual or supposed physical or mental disease or disorder or (2) any information obtained by personal examination of a patient, unless the patient or his authorized representative explicitly consents to such disclosure.

"(b) Consent of the patient or his authorized representative shall not be required for the disclosure of such communication or information (1) pursuant to any statute or regulation of any state agency or the rules of court, (2) by a physician, surgeon or other licensed health care provider against whom a claim has been made, or there is a reasonable belief will be made, in such action or proceeding, to his attorney or professional liability insurer or such insurer's agent for use in the defense of such action or proceeding, (3) to the Commissioner of Public Health for records of a patient of a physician, surgeon or health care provider in connection with an investigation of a complaint, if such records are related to the complaint, or (4) if child abuse, abuse of an elderly individual, abuse of an individual who is physically disabled or incompetent or abuse of an individual with mental retardation is known or in good faith suspected."

[11] The ninth edition of Black's Law Dictionary defines a "duty to act" as: "A duty to take some action to prevent harm to another, and for the failure of which one may be liable depending on the relationship of the parties and the circumstances."

[12] To the extent the dissent argues that the "duty already exists" or that "physicians owe the same duty to the patient already," the dissent's duty analysis fails to recognize or accept the distinction between the persons to whom the legal obligation is owed, namely, the patient and the potential third party victim, and the warning required to satisfy the obligation, which would be the same for both patients and third party victims.

[13] In his brief, the plaintiff specifically argues that he is "*not* challenging any of [Troncale's] treatment decisions," and that "this case involves a driving impairment inhering in the patient's existing condition, not an impairment associated with a medication prescribed by a [physician]." (Emphasis in original.)

[14] In fact, the legislature was so concerned about regulating the recovery of damages for the sale of alcohol to intoxicated persons by purveyors of alcoholic beverages that it amended § 30-102 in 2003 to prohibit an injured person from bringing a "cause of action against [the] seller for negligence in the sale of alcoholic liquor to a person twenty-one years of age or older"; Public Acts 2003, No. 03-91, § 1; thus making it clear that the act occupied the field following this court's decision in *Craig*, which overruled earlier precedent establishing that the act precluded a common-law negligence

action against such a seller. See *Craig* v. *Driscoll*, supra, 262 Conn. 329–30.

[15] We thus need not reach the defendants' alternative ground for affirmance of the trial court's judgment, namely, that the plaintiff failed to plead the requisite causal connection between Troncale's alleged deviation from the standard of care and the claimed injury.