ORAL ARGUMENT — 1/8/98
97-0630
VAN HORN V. CHAMBERS

SCHAEFER: My name is Dean Schaeffer. I represent Dr. Van Horn, whose summary judgment at the trial court should be reinstated by this court.

This case presents the question of whether a physician should owe a duty that transcends the physician/patient relationship. On the facts of this case, the duty would be unprecedented and specifically unprecedented under Texas law. The duty would also effectively require an obligation of clairvoyance on the part of an attending neurologist, Dr. Van Horn.

By way of background, this case begins with Dr. Van Horn's patient, Mr. Johnny Long. In April, 1991, Mr. Long presented to Hermann Hospital with a condition of seizure disorder. He had suffered several seizures that day and came to the ER in a combative state, disoriented, and was suffering badly from the seizures. He was admitted into the hospital through the ER, and eventually transferred into the neurology critical care unit. And within the NCCU, it was determined that his medications for seizures were out of align. He was under two medications: _____ and Tegratol. The physicians determined that they were out of equal liberum, and the mode of treatment was to bring the medications back into alignment.

He was admitted on April 20. As of April 21, with the adjustment of medications, he was noted to be pleasant and cooperative in the NCCU. As of April 22, he continued his positive trend, had stabilized in the CCU, and was prepared for transfer to a private room.

Thereafter, on April 23, a bazaar chain of events took place, that the attending neurologist, Dr. Van Horn, simply could not have predicted. Effectively, although the sequence is somewhat unclear, it appears what occurred is that Mr. Long, while in his private room was engaged in a confrontation. The confrontation moved from the room out into the hall. It traversed up and down the hall. Several members of the security team were called. When they arrived on the scene, Mr. Long eventually struck one of the members of this team it appeared in the face, and at that time all members of the team descended on Mr. Long. He crashed through a louvered wall panel, and what nobody knew at the time, including Dr. Van Horn, was that that louvered wall panel concealed an air shaft. Four people fell down the air shaft, 24 feet, two of the people died, two others were injured.

Suit subsequently ensued against the hospital, Dr. Van Horn, and others. The claim against Dr. Van Horn is brought by those who claim an injury from the fall down the air shaft. And the theory is that Dr. Van Horn should somehow have prevented this bazaar chain of events through the treatment of his patient.

HECHT: Is there related litigation involving this accident? Not everybody is here in this case.

SCHAFFER: There was a series of lawsuits as I understand it. Dr. Van Horn was the last defendant named to my knowledge. Of the four people who fell down the air shaft, three raised a claim against Dr. Van Horn. We obtained summary judgment as to all three at the TC, two of those parties have appealed, that is Chambers and Johnson who are here today. There was other litigation involving a fourth person who fell down the air shaft, a medical resident.

HECHT: The third person that you mentioned earlier is no longer appealing?

SCHAFFER: That's right. When we look at this unusual set of facts, it is somewhat surprising as I researched this matter, that the law in this area does follow a somewhat logical sequence, ad we have brought an exhibit to the court today that sets out in a very summarized fashion the way the law is developing in this area.

We are presented with a tort situation where much like in law school, we have general rules and what appear to be some emerging potential exceptions to the general rule. The general rule as we've stated on the exhibit begins with what I would consider the largest column of considerations, which is that a physician should not be accountable for alleged medical malpractice in the absence of a physician/patient relationship. And that is really just an issue. The only reason that I bring that to the court's attention today is that there is a notion of standing when it comes to any kind of medical malpractice related action.

The second more specific tenant of this general rule was stated recently by this court in the *Bird* case. Justice Enoch writing for the court held that there is no duty on the part of a treating health care provider (in the *Bird* case it was specifically a psychotherapist) to not negligently misdiagnose a patient, that is no duty that runs to third-parties.

Now from those principles of the general rule our position is, that's as far as this court needs to go. The general rule is, even if we accept everything that the plaintiffs say is true, Dr. Van Horn owed no duty that could extend to third-parties to not negligently misdiagnose a patient. We've presented summary judgment proof to the court that clearly and conclusively establishes that Dr. Van Horn was in compliance with the standard of care. But even if we accept allegations that he was not, that he somehow misdiagnosed the patient, *Bird* stands for the proposition that there is not a duty that will translate to third-parties.

OWEN: If this patient had been involuntary committed, and was under an order of commitment and this doctor had released the patient, would we have a different situation?

SCHAFFER: We would have a very different situation.

OWEN: And should we impose a duty under those circumstances? What's the difference?

SCHAFFER: I think in that situation, in any situation, any hypothetical that the court will consider, we're eventually going to get to this 6-part test. That's on the second part of our exhibit here. The six-part test that balances foreseeability factors against the social factors that this court must consider whenever it imposes a _____. But in the case presented in that hypothetical, a hypothetical that I think is very similar to a case this court also dealt with recently, the *Kerrville State Hospital* case, in the case of a commitment order, and if we could add to the hypothetical the kind of commitment order that we had in *Kerrville State Hospital*, where there is a judicial declaration that a person that's a serious threat of imminent danger to people, and that's so declared by a court, we've got a very different situation where the risk of injury, the foreseeability of harm, and the seriousness of that type of harm, is much greater than the type of situation presented for Dr. Van Horn back in 1991.

HECHT: So if they wrestled out in the hallway and almost fallen down the shaft the day that Dr. Van Horn was there, he might have a duty?

SCHAFFER: Foreseeability is always going to be premised on what the actor knows or should have known.

HECHT: If there's a foreseeability as to duty, then there's a foreseeability as to cause, and the latter is case specific, and the former is a question of law presumably for categories of cases. How do you differentiate that? Is it as simple as saying that if Dr. Van Horn had been standing there when they almost got hurt the day before, he might have had no duty, and therefore, liability in this instance?

SCHAFFER: I think when we talk about foreseeability and the context of legal duty, we're looking at what Dr. Van Horn knew the last time he dealt with the patient. At that time, the patient was stable, the transfer was made. When we're talking about foreseeability in the context of the causation, proximate cause kind of issues, I think we can get into the issue of well what could have been known, and that's where we get to some of the other significant facts in this case, such as, "who could have ever expected that this tumble would have worked its way down the hall, crashed through a louvered wall panel that concealed an air shaft that nobody knew about either."

OWEN: But the creation of duty doesn't necessarily depend on foreseeing the actual playing out of events does it? It's just foreseeability that if you don't adequately restrain an agitated patient, that he can hurt someone. You may not foresee that they fall down an elevator shaft, or an air shaft, but you might foresee harm to another person. Isn't that the kind of thing we look at on the duty side, not the specifics of a given case?

SCHAFFER: On the duty side, yes, I would agree with that. On causation there is ultimately

some limit on that to get to.

OWEN: We're here talking about duty.

SCHAFFER: Absolutely. In this case, getting back to the way that you phrased the question, you've got to look to the issue of "was there a duty to restrain? Was there any knowledge, any foreseeability on the part of Dr. Van Horn that at the time of the injury producing event this patient needed..."

OWEN: But you're saying there is a duty if there is some evidence that there was an indication the patient was violent, that there is a duty if there is that evidence?

SCHAFFER: I'm not going quite that far. I'm saying that that is going to be one of the considerations in this balancing test. And if there is some evidence that the patient is representing a serious threat of imminent harm, then those foreseeability factors are going to start to weigh down a little bit more.

OWEN: So that's a fact question for the jury as to whether there was foreseeability of imminent harm in this case?

SCHAFFER: In this case and in any duty case it's ultimately going to be a question for the judge, for the court. That's my understanding of duty.

OWEN: What I just understood you to say, that physicians do have a duty where there's imminent foreseeability of harm to take some action to restrain the patient?

SCHAFFER: No, I didn't mean to state it like that. My response is that that is one consideration. We have on the alternate side the social factors, the social factors about what is the utility of the doctor's conduct in the situation? what is the magnitude of the burden to place a duty on the physician to guard against this kind of injury?

OWEN: And I'm trying to in my own mind see where there is a distinction between a commitment order and actual knowledge that a patient is dangerous where there's no commitment order?

SCHAFFER: In the instance of a commitment order, and I think we would have to assume it's an active commitment order like was the case in *Kerrville State Hospital* case, you have that added assurance, a judicial declaration that this person is a serious threat of imminent harm to other people. In the kind of situation we have there is no imminent threat, there is no threat of serious injury and no voice of a threat.

OWEN: But what if there is? There's no commitment order, but there are facts from

which a jury could say: there was an imminent threat. Do you have a duty under those circumstances?

SCHAFFER: Again, I think it's going to depend on this countervailing set of considerations what we call the "social factors."

OWEN: And how do you balance that out, do you have a duty or not?

SCHAFFER: I think there, we look at the type of patient that we're dealing with, the type of physician and the expertise that that physician brings, we look at the other circumstances and the whole totality of circumstances. If the physician happens to be a psychiatrist whose speciality is in determining whether somebody is a serious threat, and whether they ought to be subject to a commitment order, it's a different set of considerations than if we've got a neurologist who was treating seizure disorder.

GONZALEZ: Something that concerns me in trying to understand the facts in this case and the law, let me give you a hypothetical: I go to the hospital because I have some ailment; I stay in the hospital a day, the doctor hasn't bothered to come by and see me, I get agitated, I feel better, I say: bye, I'm out of here. What gives the hospital personnel any right to restrain a person who is voluntarily in the hospital? Mr. Long, for example, goes there in an agitated state, his medication is out of whack, he is stabilized and for whatever reason isn't he free to leave, and what gives the hospital personnel any authority to try to tackle him and by force restrain him there?

SCHAFFER: In that instance in the absence of some kind of confinement order...

GONZALEZ: Well there was no confinement order here. Mr. Long was free to leave. Now why should the hospital personnel and Van Horn and anybody else that had something to do with this case not be responsible for the conduct that develops after the fact in trying to restrain an individual who is free to leave?

SCHAFFER: I think in that case, we are getting so remote from the treating physician and that the focus should instead turn on those people who deem it at the time to be a security threat, and look to whether "are we creating a false imprisonment situation, is there actually an active imminent threat of serious danger?" That's a set of considerations for the security folks who were called to the scene. When those considerations are not even...

GONZALEZ: Were not acting under Dr. Van Horn's orders, directions or instructions.

SCHAFFER: There are intervening events that no one can predict. There is a case in Texas that we've discussed in the briefs, the *Williams* case out of El Paso, that specifically declined to recognize a duty on the facts of that case when a patient climbs the wall of a state hospital and runs out onto the street. The court talked about how you just cannot account for unpredictable patient

behavior.

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RESPONDENT

OLER: This is a summary judgment case. It was a negligence case that was disposed of on summary judgment on the basis that there was no duty on the part of Dr. Van Horn to exercise reasonable care to guard against injury to Ron Chambers and Edward Johnson.

GONZALEZ: Under the facts of this case what is it that you're saying that Dr. Van Horn failed to do that he should have done?

OLER: He failed to exercise reasonable care.

GONZALEZ: What does that mean? Connect the dots for me. What specifically did Dr. Van Horn fail to do?

OLER: He failed in the first place to control a person that was within his charge and care that had known dangerous propensities in violation of §319 of the Restatement, and in violation of *Otis Engineering v. Clark*, and the teaching of this court in the *Kerrville Hospital* case.

GONZALEZ: The patient was stabilized?

OLER: Let me address that. That is an incorrect statement. Not by the court, because the court's picking that up from Dr. Van Horn. This patient (let me talk about the time here because counsel is a day off on his time) came to Herman Hospital at 8:00 on April 20. On April 21, he was transferred to the neurological critical care unit where Dr. Van Horn became his attending physician. He stayed there until the evening of April 22, which is the next day, and Dr. Van Horn transferred him to 5 Cullen, which is a general nursing floor in the Cullen Pavilion.

GONZALEZ: He made an assessment that there was no longer a need for critical care, and the person could go to the general population to a private room or another hospital that's not as restrictive.

OLER: It gave orders for transferring to 5 Culen, and he did that at the time he discontinued the measures that were keeping this patient under control. Those were simultaneous. When he came into the critical care unit, he was restrained on all four extremities with leather restraints.

GONZALEZ: That's when he came in?

OLER: That's when he came in.

GONZALEZ: Were the leather restraints ever taken off?

OLER: Only on the very moment he transferred him to 5 Cullen. There was no interval between the time he ordered the transferred and the time the leather restraints were taken off. They were taken off and he was transferred. He didn't monitor him to see if he really wouldn't...

GONZALEZ: So he went from one hospital to another hospital in shackles, restraints?

OLER: No, he took the restraints off and sent him over there without restraints. He sent him over there without sedation, without alcohol treatment.

SPECTOR: How long was he in the hospital where he was transferred before this incident occurred?

OLER: He arrived there at 5:00 p.m. on April 22. This happened at 8:00 a.m. the next morning. And the hospital records say that when he arrived at 5:00 p.m. on the 22nd, he was agitated. Dr. Van Horn comes in here and says, "the patient was stabilized." He didn't know if he was or not. Would you be stabilized if you were in handcuffs? Would you be stabilized if you were strapped down?

HANKINSON: It's your contention that the doctor was negligent in his diagnosis of the patient?

OLER: No, it is not. We did not bring a malpractice action on this. I agree with counsel, that the malpractice rules apply only in the physician/patient relationship. And I don't represent that patient. I represent the people the patient hurt, and their heirs.

HANKINSON: But for the fact that Dr. Van Horn was the patient's physician and made the decision to transfer him from the neurological ICU to the regular floor without restraints, this incident would not have occurred. So the duty flows originally from the doctor/patient relationship, does it not?

OLER: We say it's a common law duty that...

HANKINSON: Does it or does it not flow originally from the patient/physician relationship?

OLER: No, I would say it is not limited to the physician/patient relationship.

HANKINSON: I'm asking you where the duty originates?

OLER: In the factual context, Johnny Long, Sr., who was the patient of Dr. Van Horn, and Dr. Van Horn had charge of him, control over him, made the orders about him, strapped him

down, and did all of these things.

HANKINSON: So whether or not you call it a duty to control, whether or not you call a duty to a patient to diagnose properly, the origination of the duty in this case arises from the patient/physician relationship between Dr. Van Horn and Mr. Long?

OLER: Only to the extent that because of that relationship and the way it came in, Dr. Van Horn had control of and charge of this patient within the meaning of §319 of the Restatement.

HANKINSON: So it does originate then as a result of the relationship between Dr. Van Horn and Mr. Long?

OLER: I don't think Dr. Van Horn knew him before he came in...

HANKINSON: I'm just trying to see how this whole ball got started rolling forward, and it began as a result of a physician/patient relationship between Dr. Van Horn and Mr. Long?

OLER: Yes. I don't think the duty that we're talking about here is a physician/patient duty. Now counsel wants to put it in that context. But what we're talking about here is a common law duty that applies whether you're a doctor or not. And §319 of the Restatement just as *Otis Engineering v. Clark* talks about this duty arising when a person has control over another person and §319 specifically addresses if that person is dangerous. It's elemental, and this court has said that people who possess and have control of dangerous things for example, substances, explosives, electricity, the law exacts from them a duty to exercise reasonable care to protect the public from that. Now that's the basis for §319 of the Restatement. The predicate to it is the person has charge, that's one aspect, and the other is, the person and the charge is dangerous. Now if that's the case, he has a duty to the public to exercise reasonable care to control the patient or control the person.

GONZALEZ: He was there voluntarily. He could have left anytime. How can he possibly be under Dr. Van Horn's control?

OLER: The facts show that he was under the control. He went with orders.

GONZALEZ: Back to my question. What does that mean? A patient who goes to a hospital can always walk away and say, "I don't like the treatment you are giving me here, I'm leaving this hospital." Is that true?

OLER: I think that is true.

GONZALEZ: Well if that is true, how can you say that Mr. Long was under Dr. Van Horn's control?

OLER: He was the attending physician, and he gave orders and the orders were executed and submitted to.

GONZALEZ: Was there an order here, "Keep Mr. Long here at all cost, restrain him, tackle him, do whatever it takes to keep him in this facility?"

OLER: No. There was an order to strap him down on all four extremities. There was an order to give this man massive dosage of _____. There was an order to give this man massive doses of Tegratol(?) and _____. There was an order to give him treatment for alcohol withdrawal syndrome. And this man is there and he has an attending physician who is in his charge. Surely I'm not going to say here that this man was not in Dr. Van Horn's charge, and surely Dr. Van Horn won't say that. He was the attending physician, and this man was violent. He came into the hospital biting, kicking, hitting, and trying to hurt people, and Dr. Van Horn had charge of him. And the thing about it is that he put the measures on that worked. They worked. He knew he had the duty but he discharged the duty for awhile.

ENOCH: Ms. Schaffer is saying that the *Bird* case really controls this. And you're trying to distinguish that because this isn't a misdiagnosis issue. But isn't the crux of your argument that the doctor's medical knowledge, it was the doctor's medical knowledge that gave the doctor the power to restrain this individual, the doctor's medical knowledge that sedated the individual. And ultimately aren't we relegated to accepting that it's the doctor's medical knowledge that's in question here, because if the medical knowledge was correct, the doctor had no basis for continuing the restraint? If the doctor's medical knowledge was incorrect, then maybe there was a basis for continuing the restraint and ultimately isn't this a case simply of the injured parties claiming the doctor misdiagnosed the condition of Mr. Long, and released the restraints too soon?

OLER: I don't think so. He correctly diagnosed them in my view. Because the measures he put on him worked, and it protected the people that were around him and nobody got hurt until he took those measures off.

GONZALEZ: Under your theory, the restraints should never have been taken off, ever?

OLER: No.

GONZALEZ: Why?

OLER: He had a duty to exercise reasonable care to control this person, to protect the interest of others, and it's a fact question as to whether they should have been taken off at that time or not, whether they should be taken off without monitoring. That's what happened. All of those restraints were taken off, and he never checked. He took them off, transferred him, and when the man arrived at 5 Cullen, he was already agitated. And I think that is a question for the jury to decide. It relates not to duty as much as to causation and the breach of the duty.

The point here is that, and I think Texas imposes a duty to exercise reasonable care for the protection of third-persons in three ways. One, is this restatement, §319; and in that same category is *Otis Engineering v. Clark*; but there's also the *Gooden v. Tipps*, and that is a duty of reasonable care that arises when a doctor helps create the situation that caused the problem. In *Gooden v. Tipps* it was prescribing a medication that made the patient drowsy when he drove. *Flinn* was distinguished from that, because the doctor did not help create the situation in that sense. *El Chico v. Poole* is in the same order with *Gooden v. Tipps* because there the bartender helped create the situation that caused the problem. And the third is the *Tarasoff* situation, and that is, where the duty runs to the foreseeable victim of the patient and the doctor does not have to create that situation.

PHILLIPS: You're not claiming that that latter duty is available here are you?

OLER: Yes.

PHILLIPS: That Dr. Van Horn could readily identify these particular people working around the hospital, who this person might lash out at?

OLER: The way the law is developing on *Tarasoff*, *Tarasoff* first said "a readily identified victim," but the development of the *Tarasoff* doctrine is a foreseeable, a readily identified...

PHILLIPS: I thought it was shrinking back in California?

OLER: Well the Arizona court and it's quoted in the footnote in the CA's opinion in the *Kerrville State Hospital* case says "that the *Tarasoff* doctrine expands to foreseeable victims of the patient's violence." Now, injury to hospital employees was foreseeable in this case, that's what he had been doing before these restraints were put on him, before this treatment was given to him. And this doctor was aware as everybody there at the NCC knew was aware, that if this person is released there is a potential for harm to hospital employees.

Now, counsel says "but he had stabilized." Had he? That's a fact question.

OWEN: If we adopt the duty you're asking, we're essentially saying people in the mental health professions are taking on a pretty heavy responsibility aren't we? Anytime you have a mental patient who has a history of violence it's a pretty precarious thing for the mental health professional to undertake care isn't it?

OLER: Well I think there's some risks in there. I think it is. I think there is risk in our profession. I think there is risk in handling dangerous commodities, such as, construction people. We don't try to shelter ourself from all the risks. What we do is use reasonable care, commence it with the risk and dangers that are there. And that's what we say did not happen here.

OWEN: Do you think imposing this kind of duty will lead to more restraint and more chemical restraint, medication of mental patients?

OLER: No. I think it will avoid a summary release of a patient who has been under heavy restraint without some time to monitor and check it. But really, that's not for us to decide, that's for a jury to decide.

HANKINSON: The dissenting opinion below criticizes the majority opinion for not conducting a graph analysis before recognizing this duty. What is your response to the dissenting opinion below?

OLER: That's the bottom half of the chart over here. This is not a new duty that we're talking about. *Graph v. Beard*...

HANKINSON: Assume it is a new duty, how would *Graff* be applied in this instance, so that this duty could be recognized? I understand that's not your position, but assume with me so that we can get your response to that dissenting opinion.

OLER: I don't think that on these factors that he's got at the bottom of the seesaw that there's anything there that is unduly burdensome either in social utility or to the profession. And magnitude of the burden to guard against, there's no magnitude of the burden in this case. They had this man. What happened is as soon as this incident happened what did they do? They put it back over there and they put all of this same stuff back on it.

HANKINSON: The argument that has been raised in this case and the dissenting opinion talks about and the amicus briefs in this case talk about is the fact that we have to balance the physicians duty to treat the patient using the least restrictive means against what you are talking about which is imposing a duty to control the patient. Can you specifically address how you would interpret that balancing?

OLER: Let me just say with regard to the duty to treat the patient in the least restrictive means, there is nothing in this record that says there is that duty, that's an assumption.

HANKINSON: I understand. You're asking for us to address a question of a legal duty, which is a question of law not a question of fact. So how would you interpret the balancing? I'm giving you the chance to respond to arguments that have been presented to us since you've filed your brief.

OLER: The matter of least restrictive means is a matter of judgment of the physician. It's not a duty. Whereas, the duty to exercise reasonable care to protect others from a dangerous patient is a duty. And I know the amicus brief said, "well this puts the physician between two competing duties." Not so. There is one duty here that we're talking about here. This least restrictive means is more lawyer talk than it is anything else.

In summary, the time span involved is very short. The argument that this patient was stable and ready to go to a general nursing floor was made too quick in my view, but that's for a jury to determine. We know, and the facts are, that the restraints that had been so successful in controlling this person were taking off simultaneously with his transfer to an unsecured general floor without time to check to see if he would remain nonviolent without those restraints. By the time he got there at 5:00 p.m., he was already agitated again.

This patient had not stabilized and the stabilization argument here is an after thought. What we're asking this court to do is to reject Dr. Van Horn's arguments about all of these things that have to be considered and focus on the established three duties that I have mentioned here. They are not new. They have been in the law a long time.

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REBUTTAL

SCHAFFER: To follow-up on your line of inquiry. Three justices at the CA and TMA in the amicus brief all would go through this duty analysis as set forth in *Graff* and the progeny of cases up at this court. That 6-part test is what controls here. There is no duty recognized in the State of Texas that would apply to Dr. Van Horn on the facts of this case. And when we look to these factors balancing the foreseeability factors on the one-hand, which are remote as pointed out by Justice Taft in the dissent below, against the social factors on the other-hand, which create immense burdens on treaters like Dr. Van Horn...

GONZALEZ: Let's talk about those factors. What do you think would be so egregious in trying to balance these factors and looking particularly at the social utility consequences, etc?

SCHAFFER: The utility of Dr. Van Horn's conduct, we as a society want doctors to be treating seizure disorder patients. It's good for us, it's good for the seizure disorder patient. When you create the specter of liability on facts like we've got here doctors are going to be much less inclined to treat those patients.

Let me take it to a more specific level. Counsel talked about how the least restrictive means, that's something that his lawyer talked. Well that is talk that comes directly out of the two affidavits in front of the court, affidavits by two imminently qualified neurologists, who talk about "you want to be treating a seizure disorder patient in the least restrictive means." And there are reasons for that, medical reasons that certainly make sense. The patient gets better quicker.

OWEN: Where does a hospital or doctor get the authority to restrain a patient like Long, physically restrain him if it's against his will?

SCHAFFER: If we look at Mr. Long at the time that he arrives at the ER. If in the doctors' medical judgment that patient is posing a serious threat, an imminent threat of serious harm to

himself or to others, then they're within medical judgment there will be some steps that the physician can take. I think ultimately if we are going to get to Justice Gonzalez's question, if you're going to confine them, ultimately you might have to get some kind of a confinement order, a commitment order, which did not...

OWEN: When he was put in the restraints, did his family give them that authority, and what if he had said: take these off of me, I'm leaving." Where is the legal authority for the doctor to say, no?

SCHAFFER: His family brought him to the hospital in this disoriented state because he needed the treatment after suffering 5 seizures that day. His family was the one to get him this care. The physicians who received him in the ER did see that at that time he posed a danger to himself or perhaps to others.

OWEN: And where does that come from? Where is the legal authority for said physician to make that judgment and hold that patient against his will?

SCHAFFER: I think the doctors would say that it comes from their medical judgment. Where they get the authority within the law presumably that's the consent that comes with this physician/patient relationship that the doctor can treat the patient.

SPECTOR: If we assume there is a duty, and that it was breached, do you still win on your summary judgment because of the circumstances after the duty was breached?

SCHAFFER: We did raise causation grounds. Just the unforeseeability when it comes to proximate cause, the fact that this air shaft existed and nobody knew about, that was all so remote and unknown to Dr. Van Horn in a way that he couldn't have known about it. We would argue that even with those findings, that we should still be entitled to summary judgment.

SPECTOR: Would you agree that if a patient in this state comes to the hospital with a weapon of some sort and he's allowed to keep it, that that would be a breach of a duty?

SCHAFFER: I think in that instance these foreseeability factors loom a little bit larger than what we've got here. Before I finish, I want to get back to Justice Gonzalez's question on these other points, the magnitude of the burden. The neurologist can't be a clairvoyant. The magnitude of that burden, we can't put that burden on anybody. We can't make the doctor the insurer for the patient. And when we talk about the final factor, consequences and placing the burden on the actor, you do put the physician in a position of competing duties that creates this _____ choice, and the dissent talked about it. They are darned if they do - and darned if they don't. And this court should not impose that kind of duty on the facts of this case.