

# Note

## Rejecting the Logic of Confinement: Care Relationships and the Mentally Disabled Under Tort Law

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“A psychiatrist of long and fruitful experience once remarked that the chief difference between the normal man and the one who was mentally sick, was that the latter was inside the walls of a hospital and the former was not.”<sup>1</sup>

Contemporary tort law articulates a norm in favor of confinement for the mentally disabled.<sup>2</sup> It encourages their institutionalization and discourages their reintegration into the community.<sup>3</sup> This Note argues that a

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1. Milton D. Green, *Proof of Mental Incompetency and the Unexpressed Major Premise*, 53 YALE L.J. 271, 271 (1944) (quoting EDWARD A. STRECKER & FRANKLIN G. EBAUGH, PRACTICAL CLINICAL PSYCHIATRY 20 (4th ed. 1935)).

2. Courts and commentators have referred to those with mental disabilities in different ways over time. In order to avoid confusion, this Note adopts the term “mentally disabled” to refer to anyone who is either “mentally ill” or “mentally retarded.” One who is mentally ill suffers from either emotional disturbance or psychosis. Courts formerly referred to such people as “insane” or “lunatics.” See, e.g., *Weaver v. Ward*, 80 Eng. Rep. 284 (K.B. 1616). Mental retardation suggests diminished mental capacity, and in the past courts have used the terms “imbeciles” or “idiots” to characterize such people. See, e.g., *Buck v. Bell*, 274 U.S. 200, 207 (1927). The term “mentally incompetent” refers to that subset of people with mental disabilities who lack the capacity to control or appreciate the consequences of their actions. “Mentally incompetent” is a doctrinal conclusion rather than a prior category. See generally ROBERT M. LEVY & LEONARD S. RUBENSTEIN, *THE RIGHTS OF PEOPLE WITH MENTAL DISABILITIES* 9-13 (1996).

3. The concepts of the “community” and “confinement,” or “institutionalization,” are loaded and are hardly discrete and dichotomous categories. There exists a continuum of care settings, from the most restrictive institutions and nursing homes (what Erving Goffman would call “total institutions”); to intermediate arrangements such as group homes or community

rationale for holding mentally disabled individuals liable for their torts that relies upon a preference for confinement is misplaced, because it creates an incentive to confine a mentally disabled individual even when this might not be in the individual's best interest. Regardless of economic incentives, however, reliance upon a confinement rationale reflects an outmoded understanding of the proper place of the mentally disabled in contemporary American society. This rationale should be reconsidered by courts, commentators, and advocates. American civil rights law has shifted radically in its treatment of the mentally disabled since the early part of this century, while tort law has stagnated in this regard. This Note argues that when considering the negligence liability of the mentally disabled, courts should not focus upon "geography"—that is, upon whether a defendant is confined. Rather, courts should focus solely upon the *nature of the relationship between the parties*, their knowledge and expectations, and their relative abilities to prevent harm.<sup>4</sup>

This Note is divided into five Parts. Part I discusses how tort law has traditionally held mentally disabled people to an objective "reasonable person" standard for the torts they commit within the community.<sup>5</sup> One reason courts have given for imposing this liability is that it provides an incentive for family members to confine their mentally disabled relatives, in order to prevent harm to innocent strangers and to society as a whole.<sup>6</sup> Part II demonstrates that in the only four reported tort cases before 1991 to address the mentally disabled in care relationships, courts failed to recognize the importance of this unique relationship. This Part examines why courts continued to hold mentally disabled persons liable for their

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placements involving supervised living arrangements; to at-home care; to no care at all. This Note regards only "total institutions" as confinement. Any other residential arrangements involving a greater degree of integration should be understood as "the community." The cases that provide the focus of this Note all involve "total institutions": nursing homes and facilities providing in-patient care for the mentally disabled. For an analysis of "total institutions," see ERVING GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* (1961).

4. This should not be read to suggest that courts currently focus *solely* upon whether a defendant is institutionalized. Courts do examine the parties' relationship in many cases. Confinement is one factor among several that they consider. The primary argument of this Note is that confinement as such should not be relevant at all.

5. See *infra* Part I. Courts have carved out an exception to imposing liability for the mentally disabled where the disability has arisen suddenly and without warning. See, e.g., *Breunig v. American Family Mut. Ins. Co.*, 173 N.W.2d 619, 624 (Wis. 1970). But see *Bashi v. Wodarz*, 53 Cal. Rptr. 2d 635, 641 (Ct. App. 1996) (holding that a driver's sudden mental illness is no defense to negligent driving). A second exception to the traditional rule is that in assessing contributory negligence, courts often hold a mentally disabled plaintiff to a subjective standard. See, e.g., *Baltimore & P.R.R. v. Cumberland*, 176 U.S. 232, 238-39 (1900). See generally Note, *Contributory Negligence of Incompetents*, 3 WASHBURN L.J. 215 (1964). Even this exception has exceptions. See, e.g., *Worthington v. Mencer*, 11 So. 72, 73-74 (Ala. 1892) (finding that the plaintiff's "dull mind" was no defense to contributory negligence). These two exceptions are outside the scope of this Note.

6. See *infra* Subsection I.C.3 and cases cited therein.

torts, even against a caregiver, and even when family members had taken steps to obtain care for their mentally disabled relatives, either by placing them in institutions or by hiring nurses to provide at-home care.<sup>7</sup> Coupled with the small number of cases involving institutionalized defendants before 1991, this fact may have led commentators to downplay the importance of the logic of confinement as a rationale for imposing liability.

In a line of cases arising since 1991, however, the confinement rationale has become increasingly important. Part III addresses a line of cases creating a new exception to the duty owed by the mentally disabled. In these cases, a caregiver has sued a mentally disabled defendant under his or her care for negligent or intentional torts. In these cases, courts have carved out a new exception to the general rule imposing liability upon the mentally disabled.<sup>8</sup> Courts have uniformly held that a mentally incompetent defendant living in an institution *owes no duty of care* to a paid caregiver because imposing liability would provide no further incentives to confine the defendant. Some of these decisions have drawn the exception narrowly, so that future courts might apply it only in cases in which defendants reside in institutions. This focus on the logic of confinement, coupled with fact patterns involving institutionalized defendants, rather than mentally disabled defendants in home-care settings, reinforces the notion that the mentally disabled should properly reside within institutions.

Part IV argues that the no-duty rule adopted in these post-1991 cases is correct, but not because of the logic of confinement. A rule that focuses on the care relationship, rather than on the defendant's geography, would encourage a mentally disabled person to seek appropriate professional care, rather than confinement that may not be appropriate. This Part suggests a test for analyzing whether a duty of care should exist in a particular relationship. Finally, Part V argues that a no-duty analysis supports adopting a non-tort system to compensate injured caregivers. The no-duty rule implicates a tension between the need to avoid a logic of confinement and the desire to ensure compensation for injured caregivers. Such a system is necessary to ensure that qualified caregivers—regardless of whether they are employed by large state institutions or work as at-home nurses—continue to provide care for the mentally disabled without fear that an employment-related injury will go uncompensated. Such a system would ensure that trained professionals continue to work on behalf of the mentally disabled in the least restrictive environment, and that the mentally disabled seek appropriate medical treatment without fear of exposing themselves to tort liability.

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7. See *infra* Part II and cases cited therein.

8. See *infra* Part III and cases cited therein.

## I. TORT LAW AND THE MENTALLY DISABLED IN THE COMMUNITY

A. *The Traditional Rule*

American tort law has traditionally declared that mental disability is no defense to negligent or intentional torts by holding the mentally disabled to an objective, reasonable person standard.<sup>9</sup> Most scholars trace this rule back to dicta in the English case of *Weaver v. Ward*,<sup>10</sup> in which the court wrote: "[I]f a lunatick hurt a man, he shall be answerable in trespass: and therefore no man shall be excused of a trespass . . . except it may be judged utterly without his fault."<sup>11</sup> In a second English case, *Cross v. Andrews*,<sup>12</sup> the court upheld a suit against an innkeeper who failed to safeguard the property of his guests: "And to say he is of *non sane memory*, it lieth not in him to disable himself, no more than in debt upon an obligation."<sup>13</sup> Though some, such as Oliver Wendell Holmes, Jr., ardently supported this traditional rule and its importation into American common law,<sup>14</sup> others criticized it for effectively imposing liability without fault.<sup>15</sup>

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9. See, e.g., *Johnson v. Lambotte*, 363 P.2d 165 (Colo. 1961); *Swift v. Fitchburg Mut. Ins. Co.*, 700 N.E.2d 288, 292 (Mass. App. Ct. 1998); *Williams v. Hays*, 38 N.E. 449 (N.Y. 1894), *rev'd*, 52 N.E. 589 (N.Y. 1899); *Schapiro v. Tchernowitz*, 155 N.Y.S.2d 1011 (Sup. Ct. 1956); *Sforza v. Green Bus Lines*, 268 N.Y.S. 446 (Mun. Ct. 1934); *In re Meyer's Guardianship*, 261 N.W. 211, 214 (Wis. 1935). In contrast, Louisiana and other civil-law jurisdictions historically have not held insane persons liable for their torts. See *Yancey v. Maestri*, 155 So. 509 (La. Ct. App. 1934); Robert M. Ague, Jr., *The Liability of Insane Persons in Tort Actions*, 60 DICK. L. REV. 211, 211 (1956).

10. 80 Eng. Rep. 284 (K.B. 1616).

11. *Id.*; see also Francis Bohlen, *Liability in Tort of Infants and Insane Persons*, 23 MICH. L. REV. 9, 16 (1924) (explaining *Weaver* in greater depth).

12. 78 Eng. Rep. 863 (Q.B. 1598).

13. *Id.* (emphasis added).

14. See O.W. HOLMES, JR., *THE COMMON LAW* 108 (Boston, Little, Brown 1881) ("The law . . . takes no account of the infinite varieties of temperament, intellect, and education which make the internal character of a given act so different in different men."). Holmes also authored *Buck v. Bell*, 274 U.S. 200 (1927), upholding a statute under the Due Process Clause that allowed the sterilization of a mentally disabled woman. He wrote, "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind." *Id.* at 207. One should bear in mind when reading the "neutral" pronouncements of Holmes's legal scholarship that his attitudes toward the mentally disabled may have reflected this viewpoint.

15. See James Barr Ames, *Law and Morals*, 22 HARV. L. REV. 97, 103 (1908) ("[T]he early common law . . . [is] an instrument of injustice . . . permitting unmeritorious or even culpable plaintiffs to use the machinery of the court as a means of collecting money from blameless defendants."); Bohlen, *supra* note 11, at 33 ("It is only where fault is essential to liability that incapacity of such a person should logically relieve him."); W.G.H. Cook, *Mental Deficiency in Relation to Tort*, 21 COLUM. L. REV. 333, 335 (1921) (criticizing the dictum in *Weaver v. Ward* suggesting that mentally incompetent persons should be held liable for trespass as inconsistent with the excuse of "utterly without his fault"); William J. Curran, *Tort Liability of the Mentally Ill and Mentally Deficient*, 21 OHIO ST. L.J. 52, 65 (1960).

## B. *The Evolution of the Restatement*

The *Restatement of Torts* has evolved over time to reflect the traditional rule. The first *Restatement of Torts*, published in 1934, implied that insane persons had a defense to negligence actions: "Unless the actor is a child or an insane person, the standard of conduct to which he must conform to avoid being negligent is that of a reasonable man under like circumstances."<sup>16</sup> However, the American Law Institute created a tension in its position in the caveat following the section, which stated: "The Institution expresses no opinion as to whether insane persons are required to conform to the standard of behavior which society demands of sane persons for the protection of the interests of others."<sup>17</sup> An ambiguity remained as to the proper standard for assessing behavior.

The *Restatement (Second)* resolved this ambiguity in favor of a rule holding people with a mental disability to an objective, reasonable person standard by deleting the earlier exception. The revised position stated: "Unless the actor is a child, his insanity or other mental deficiency does not relieve the actor from liability for conduct which does not conform to the standard of a reasonable man under like circumstances."<sup>18</sup> By contrast, the *Restatement (Second)* held those with physical disabilities to the limited subjective standard of a "reasonable man under like disability."<sup>19</sup>

Numerous twentieth-century scholars have criticized the prevailing objective standard for holding mentally incompetent people liable without fault in a tort regime that generally premises recovery on fault,<sup>20</sup> for unjustifiably drawing distinctions between mental and physical incapacity,<sup>21</sup> and for failing to make sufficiently detailed factual inquiries into the nature of the defendant's mental incapacity.<sup>22</sup> The majority of scholars writing in this area have recommended that courts adopt a subjective standard to

16. RESTATEMENT OF TORTS § 283 (1934).

17. *Id.* at 744; see also William R. Casto, Comment, *The Tort Liability of Insane Persons in Negligence: A Critique*, 39 TENN. L. REV. 705, 710 (1972) (commenting on the evolution of the *Restatement*). This language was deleted in 1948, and the *Restatement (Second)* resolved the ambiguity in favor of an objective standard, as noted above. See Casto, *supra*, at 711 n.40.

18. RESTATEMENT (SECOND) OF TORTS § 283B (1965).

19. *Id.* § 283C.

20. See, e.g., Ames, *supra* note 15, at 103; Bohlen, *supra* note 11, at 33; Cook, *supra* note 15, at 335; Curran, *supra* note 15, at 65.

21. See, e.g., Wm. B. Hornblower, *Insanity and the Law of Negligence*, 5 COLUM. L. REV. 278, 284 (1905) ("Thus, if a man be *non compos mentis*, it would seem that he should be no more liable for negligence than if he were blind or paralyzed and thereby physically incapacitated from doing or refraining from doing what an ordinarily prudent man should do or refrain from doing."); Daniel W. Shuman, *Therapeutic Jurisprudence and Tort Law: A Limited Subjective Standard of Care*, 46 SMU L. REV. 409, 418 (1992).

22. See, e.g., Wm. Justus Wilkinson, *Mental Incompetency as a Defense to Tort Liability*, 17 ROCKY MTN. L. REV. 38, 57 (1944) (rejecting the courts' approach to insanity as "a blanket term which covers almost anything needing a label").

recognize unique factual distinctions among defendants and their differential capacities to comprehend and control their actions.<sup>23</sup>

### C. *Policy Rationales Behind the Traditional Rule*

In applying the traditional rule, courts have articulated several policy reasons for holding mentally disabled defendants to an objective, reasonable person standard. They have engaged in broad and policy-oriented analysis, rather than detailed factual inquiries about the defendants' mental disabilities. Though these underlying rationales are interconnected, this Section addresses each one—compensation, evidence/fakery, and confinement—in turn.

#### 1. *One of Two Innocents: The Compensation Rationale*

Courts have held that "where one of two innocent persons must suffer a loss, it should be borne by the one who occasioned it."<sup>24</sup> This rationale articulates a straightforward philosophy of compensation. If the tort regime should properly focus on compensation, rather than blameworthiness, then applying an objective standard might seem correct.<sup>25</sup> Several scholars have suggested that the imposition of liability upon a mentally disabled defendant under these circumstances provides evidence that moral notions of fault are not the underlying basis of the tort regime.<sup>26</sup> But the compensation rationale affects incentives to seek confinement. Holding someone to an objective standard he cannot meet might force him out of the community and away from contacts with others in order to prevent injury. As one scholar has noted, "So where one is blind, unless we would drive

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23. See, e.g., Bohlen, *supra* note 11, at 32-33; Curran, *supra* note 15, at 65-66 (arguing in favor of a greater factual understanding of mental illness rather than a social policy approach); cf. Ague, *supra* note 9, at 226-27 (recommending the creation of a "perpetual lunacy commission" to evaluate competence in individual cases). Even Holmes recognized that in extreme circumstances a mentally disabled person might be incapable of meeting an objective standard. He wrote:

There is no doubt that in many cases a man may be insane, and yet perfectly capable of taking the precautions, and of being influenced by the motives, which the circumstances demand. But if insanity of a pronounced type exists, manifestly incapacitating the sufferer from complying with the rule which he has broken, good sense would require it to be admitted as an excuse.

HOLMES, *supra* note 14, at 109. But cf. Hornblower, *supra* note 21, at 297 (advocating a blanket rejection of liability for *non compos mentis* defendants in negligence).

24. Seals v. Snow, 254 P. 348, 349 (Kan. 1927); cf. Beals v. See, 10 Pa. 56, 61 (1848) (containing the first reference to this principle in dictum in the context of an assumpsit case).

25. See Warren A. Seavey, *Negligence—Subjective or Objective?*, 41 HARV. L. REV. 1, 12 (1927).

26. See Richard A. Epstein, *A Theory of Strict Liability*, 2 J. LEGAL STUD. 151, 153 (1973) (noting that the lack of an "insanity" defense to tort actions provides evidence that morality was not the basis of the fault system); Richard Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29 (1972) (arguing against a moralistic view of negligence).

blind men from all contacts with others, we cannot require him to act as though he could see. . . . The blind or deaf man must use the streets if he is to have a decent life . . . .”<sup>27</sup> Courts have acknowledged that using an objective standard for the mentally disabled may drive them from contacts with others, just as such a standard would for the blind. But in contrast to their concern that the blind man must be allowed to live in the community to have a “decent life,” courts relying upon the logic of compensation have not shown the same concern for the mentally disabled. For the mentally disabled, such segregation is positively encouraged.

The Kansas Supreme Court noted this connection between the rationales of compensation and confinement:

If his mental disorder makes him dependent, and at the same time prompts him to commit injuries, there seems to be no greater reason for imposing upon the neighbors or the public one set of these consequences, rather than the other; no more propriety or justice in making others bear the losses resulting from his unreasoning fury, when it is spent upon them or their property, than there would be in calling upon them to pay the expense of his confinement in an asylum, when his own estate is ample for the purpose.<sup>28</sup>

Commentators have criticized this “one of two innocents,” or compensation, rationale as nothing more than a statement of strict liability,<sup>29</sup> and have rejected it for perpetuating injustice.<sup>30</sup> The compensation rationale also does not reach outside the confines of the tort system. It fails to reflect the possibility that a non-tort social insurance regime could compensate victims for their injuries.

## 2. *The Evidence/Fakery Rationale*

Courts have articulated a second rationale in favor of an objective standard, suggesting that such a rule avoids difficult evidentiary problems in verifying the existence and extent of a person’s mental disability.<sup>31</sup> Critics of this rationale have suggested that courts fail to take into account

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27. Seavey, *supra* note 25, at 13-14, 27.

28. *Seals*, 254 P. at 349 (citation and internal quotation marks omitted).

29. See sources cited *supra* note 15.

30. See Ames, *supra* note 15, at 99, 103.

31. See *Gould v. American Family Mut. Ins. Co.*, 543 N.W.2d 282, 286 (Wis. 1996); see also *German Mut. Fire Ins. Soc’y v. Meyer*, 261 N.W. 211, 215 (Wis. 1935) (“[T]ort-feasors shall not simulate or pretend insanity to defend their wrongful acts causing damage to others . . .”).

the stigma attached to raising a defense of mental disability, and that this stigma reduces the incentive to fake mental disability.<sup>32</sup>

The evidence/fakery rationale takes into account the concern that, for reasons of administrative feasibility, courts should not become entangled in factually complex and subjective analyses of mental disability. Rejecting the defense outright allows courts to avoid a costly and time-consuming inquiry into an individual defendant's disability.<sup>33</sup> However, this concern is inconsistent with judicial analysis in contracts and criminal law in which courts frequently engage in complex assessments of the mental states of parties.<sup>34</sup> Determinations of mental competence in "guardianship, commitment, testamentary capacity, and numerous other areas call upon triers of fact to decide whether an individual's mental condition warrants [different treatment] . . . ." <sup>35</sup> Such determinations have proceeded without undue strain on the courts. Concern about the difficulty of assessing this evidence is overstated in light of the factual determinations courts make even in tort law, as courts considering the contributory negligence of mentally disabled plaintiffs tend to hold such plaintiffs to a subjective standard.<sup>36</sup>

The evidence and confinement rationales are inherently interrelated as well. Courts, however, have not always noted this relationship. Prior confinement can constitute sufficient evidence of mental incapacity to allay a court's concerns about whether a defendant is "faking it."<sup>37</sup> However, in cases in which an institutionalized person has committed a tort outside the institution against a stranger, courts have nevertheless held the defendant to an objective standard.<sup>38</sup>

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32. See Curran, *supra* note 15, at 65. While this stigma might not, on its own, be forceful enough to prevent a dishonest defendant from faking mental disability in order to avoid liability, it represents one countervailing interest that makes such pretense less likely.

33. See *id.* at 64.

34. See Hornblower, *supra* note 21, at 283.

35. James W. Ellis, *Tort Responsibility of Mentally Disabled Persons*, 1981 AM. B. FOUND. RES. J. 1079, 1089 (1981).

36. See *id.* at 1090; *cf.* *Baltimore & P.R.R. v. Cumberland*, 176 U.S. 232 (1900) (discussing the contributory negligence of a child); *Seattle Elec. Co. v. Hovden*, 190 F. 7 (9th Cir. 1911); Note, *supra* note 5, at 215-16. Ellis suggests that a reason for the difference in the treatment of mentally incompetent plaintiffs and defendants arises from differences of sympathy, rather than any justifiable legal or policy analysis. See Ellis, *supra* note 35, at 1091-92.

37. Indeed, in several of the post-1991 cases, courts relied upon this rationale. See *infra* Part III.

38. See, e.g., *Johnson v. Lambotte*, 363 P.2d 165 (Colo. 1961) (holding liable a schizophrenic escapee from an institution, who had not been adjudged mentally incompetent, for negligently driving a car and causing an accident).



### 3. *The Confinement Rationale, or the "Logic of Confinement"*

While some commentators have suggested that the compensation and evidence/fakery rationales motivate the use of an objective standard, this Note argues that reliance upon a preference for confinement and segregation of the mentally disabled—termed here the “logic of confinement”—has begun to play an equally, if not more, important role. Courts have articulated a logic of confinement by stating that “public policy requires the enforcement of such liability in order that relatives of the insane person shall be led to restrain him.”<sup>39</sup> The American Law Institute reflected a similar attitude in its comments following section 283B of the *Restatement (Second)*, which state that “if mental defectives are to live in the world they should pay for the damage they do”<sup>40</sup> and note that “their liability will mean that those who have charge of them or their estates will be stimulated to look after them, keep them in order, and see that they do not do harm.”<sup>41</sup>

The desire to encourage individuals to confine their mentally disabled relatives, and to force the mentally disabled to pay for the damage they cause, suggests a belief that so-called “mental defectives” should properly be segregated from the general community. One text stated explicitly:

“[A psychiatrist’s] secondary function is to protect society from the disturbances which are caused by the highly anti-social types of mental disorder. This function is fulfilled by seeing that individuals so afflicted are removed from society and placed in institutions where their psychopathic behavior will not interfere with the lives of others. It is a function similar to quarantining . . . .”<sup>42</sup>

If they live in the community, the law must impose additional burdens upon them.

Over the years, both judicial and societal opinions have reflected a fear of the mentally disabled and a preference for their institutionalization. The mentally disabled have been considered witches or associates of the devil.<sup>43</sup>

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39. *Polmatier v. Russ*, 537 A.2d 468, 471 (Conn. 1988); *see also* *Jolley v. Powell*, 299 So. 2d 647, 648 (Fla. Dist. Ct. App. 1974) (“[L]iability without subjective fault, under some circumstances, is one price men pay for membership in society.”).

40. *RESTATEMENT (SECOND) OF TORTS* § 283B cmt. b(3) (1965).

41. *Id.* cmt. b(4); *see also* *Casto*, *supra* note 17, at 711 & n.43.

42. *Green*, *supra* note 1, at 271 (quoting *STRECKER & EBAUGH*, *supra* note 1, at 20).

43. *See* Deborah A. Dorfman, *Through a Therapeutic Jurisprudence Filter: Fear and Pretextuality in Mental Disability Law*, 10 N.Y.L. SCH. J. HUM. RTS. 805, 807 (1993); *see also* Michael L. Perlin, *On “Sanism,”* 46 SMU L. REV. 373, 391-98 (1992) (suggesting that people assume that the mentally ill are violent).

Justice Marshall's concurrence in *City of Cleburne v. Cleburne Living Center*<sup>44</sup> recognized this legacy of negative attitudes:

[T]he mentally retarded have been subject to a "lengthy and tragic history" . . . of segregation and discrimination that can only be called grotesque. . . . Fueled by the rising tide of Social Darwinism, the "science" of eugenics, and the extreme xenophobia of those years, leading medical authorities began to portray the "feeble-minded" as a "menace to society and civilization . . . responsible in a large degree for many, if not all, of our social problems." A regime of state-mandated segregation and degradation soon emerged that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow. Massive custodial institutions were built to warehouse the retarded for life . . . . State laws deemed the retarded "unfit for citizenship."

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. . . Prejudice, once let loose, is not easily cabined.<sup>45</sup>

Many states enacted compulsory sterilization laws for the mentally disabled such as those upheld by the Supreme Court in *Buck v. Bell*,<sup>46</sup> and some explicitly encouraged segregating people with disabilities, not only to minimize the harm they posed to society but also to benefit the mentally disabled themselves.<sup>47</sup>

The legal analysis underlying the logic of confinement flies in the face of a strong professional consensus in favor of comprehensive community treatment and integration into the least restrictive appropriate environment.<sup>48</sup> Such treatment would provide the disabled with dependable income, community housing options (such as group homes, depending upon

44. 473 U.S. 432 (1985).

45. *Id.* at 461-64 (Marshall, J., concurring in part and dissenting in part) (citations and footnotes omitted); see also GERALD N. GROB, FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA 302 (1991) (noting that in the early nineteenth century, "the mental hospital symbolized the means by which society fulfilled its moral and ethical obligations to mentally ill persons requiring assistance").

46. 274 U.S. 200 (1927).

47. See Brief Amici Curiae for the American Association on Mental Retardation, et al. Supporting Respondents at 9, *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999) (No. 98-536) [hereinafter AAMR Brief] (citing a 1914 article that advocated institutionalization as a benefit to the mentally disabled); Robert Burt, *Pennhurst: A Parable*, in IN THE INTEREST OF CHILDREN: ADVOCACY, LAW REFORM, AND PUBLIC POLICY 266, 267-68 (Robert H. Mnookin ed., 1985) (discussing one goal of the Pennhurst State School and Hospital as to protect "'normal' society from the degradations and dangers presented by these deviants," a goal that "almost displaced the more therapeutically-oriented claims for such institutions . . .").

48. See M. Gregg Bloche & Francine Cournos, *Mental Health Policy for the 1990s: Tinkering in the Interstices*, 15 J. HEALTH POL. POL'Y & L. 387, 402 (1990); see also AAMR Brief, *supra* note 47; Brief Amici Curiae for ADAPT, National Council on Independent Living, and TASH Supporting Respondents, *Olmstead* (No. 98-536); Brief Amici Curiae for the American Psychiatric Association and the National Alliance for the Mentally Ill Supporting Respondents at 21-22, *Olmstead* (No. 98-536) [hereinafter APA Brief].

patient needs), social and occupational services, and clinical services.<sup>49</sup> While reliance upon confinement might have made sense when large state institutions for the mentally disabled were the norm, as they were in the early part of this century, such reliance is profoundly out of date after the deinstitutionalization movement.<sup>50</sup> The common-law legal analysis in tort cases is also sharply at odds with current civil rights law. The legal climate has changed over the last half-century, and now recognizes the importance of integrating people with mental disabilities into the least restrictive settings possible in such legislation as the Americans with Disabilities Act.<sup>51</sup>

This past term, the Supreme Court recognized in *Olmstead v. L.C.*<sup>52</sup> that “[u]njustified isolation . . . is properly regarded as discrimination based on disability.”<sup>53</sup> This holding reflects the judgment that “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, education advancement, and cultural enrichment.”<sup>54</sup> Confinement involves discrimination because “[i]n order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice.”<sup>55</sup> *Olmstead* brings into sharp focus the extraordinary inconsistency between the law’s clear preference, in the civil rights context, for care in the least restrictive environment, and the reasoning in torts cases favoring confinement. One commentator, writing after the deinstitutionalization movement, rejected reliance upon a confinement rationale as outdated, suggesting that “[n]ew statutes and case law have transformed the areas of commitment, guardianship, confidentiality, consent to treatment, and institutional conditions . . . .”<sup>56</sup> Tort law should

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49. See Bloche & Cournos, *supra* note 48, at 402.

50. For an account of the deinstitutionalization movement and the transformation of modern health care policy toward the mentally disabled over the last century, see GROB, *supra* note 45. See also Burt, *supra* note 47, at 268-69 (discussing deinstitutionalization as a reform strategy in the 1960s).

51. See Americans with Disabilities Act, 42 U.S.C. § 12,132 (1994), and its implementing regulation, 28 C.F.R. § 35.130(d) (1998), which provides that a “public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”

52. 119 S. Ct. 2176 (1999).

53. *Id.* at 2185.

54. *Id.* at 2187.

55. *Id.*; see also Brief for United States as Amicus Curiae Supporting Respondents at 6-7, 17, *Olmstead* (No. 98-536).

56. Ellis, *supra* note 35, at 1079-80 (citations omitted). Despite his recognition that the confinement rationale plays an important role in shaping the traditional rule for imposing liability upon the mentally disabled, Ellis did not examine the doctrine in cases in which the mentally disabled have been confined to determine whether, doctrinally or factually, confinement actually

follow civil rights law in recognizing the full citizenship of the mentally disabled. Courts must take into account contemporary medical and social understandings, or else they risk perpetuating outdated stereotypes.

#### D. *Questioning the Logic of Confinement*

The confinement rationale is open to question from a number of angles. First, as an empirical matter, it is difficult to determine whether the tort system creates real incentives, particularly for those mentally disabled people who cannot control their actions:

The assumption is that these people are aware of their legal rights and liabilities, and will be consistently acting in respect to them. Such is seldom the case with the laymen who rarely realize the legal consequences of their own acts, to say nothing of expecting them to control the acts of one who is unpredictable.<sup>57</sup>

Related to this concern over the intensity of economic incentives is a concern that mistaken understandings about the law may also distort incentives. Because criminal law provides an insanity defense, some might incorrectly assume that a similar doctrine applies in civil tort actions.<sup>58</sup> This mistaken assumption would provide a countervailing weight to the incentives of the logic of confinement. Second, the confinement rationale assumes that guardians have great control over a mentally disabled person's acts, which may not be true.<sup>59</sup> Third, mentally disabled patients are often judgment-proof, relying solely on public assistance for their livelihood.<sup>60</sup> A person with no funds to lose has little incentive to change his behavior, given a rule that relies upon depriving him of nothing. Finally, it may be unrealistic to rely solely upon tort incentives when other interests—such as

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makes a difference. This Note examines the case law with close attention to the importance of confinement in these cases. Ellis's analysis looked broadly at the question of subjective and objective standards as appropriate for the mentally disabled, but did not look more closely at the doctrine within to notice the importance of duty. In contrast, this Note's examination suggests that courts must focus upon duties within the caregiver-patient relationship.

57. Ague, *supra* note 9, at 222.

58. See Casto, *supra* note 17, at 717.

59. See Ellis, *supra* note 35, at 1084-85. The confinement rationale relies upon an indirect effect, rather than upon vicarious liability. It assumes that guardians or relatives will act in certain ways based upon tort rules that affect their charges. One author rejects the indirect nature of the confinement rationale, suggesting that a more efficient way of providing incentives to the family would be to impose liability upon family members directly for the torts of their mentally disabled relatives. He argues that courts should conform their judgments to support the "reasonable expectations" of the victim. See David E. Seidelson, *Reasonable Expectations and Subjective Standards in Negligence Law: The Minor, the Mentally Impaired, and the Mentally Incompetent*, 50 GEO. WASH. L. REV. 17, 19-20 (1981).

60. See Elizabeth J. Goldstein, *Asking the Impossible: The Negligence Liability of the Mentally Ill*, 12 J. CONTEMP. HEALTH L. & POL'Y 67, 78-79 & nn.81-83 (1995).

love, concern, the cost of care, embarrassment, fear, or revulsion—may influence relevant parties' behavior more directly.<sup>61</sup>

A sole commentator suggests that an objective standard has a positive impact on incentives for deinstitutionalization and community integration. She suggests that an objective standard minimizes the burden of deinstitutionalization on the community, fosters community acceptance of the mentally ill, and encourages the mentally ill to become self-sufficient members of the community.<sup>62</sup> Her analysis does not consider, however, whether in the caregiver relationship in particular, other forms of non-tort compensation might encourage community acceptance of the mentally disabled without placing unfair burdens upon individuals who may be unable to conform to community standards.

Despite these concerns about whether the tort law creates real incentives, there are two reasons to recognize and ultimately reject the logic of confinement regardless of the rationale's economic impact. First, when direct causal links to behavior are difficult to determine, the tort system should remove even minor influences favoring the confinement of the mentally disabled if confinement is more restrictive than necessary. Second, the language and rhetoric of judicial decisions are extremely important for what they reveal about the underlying attitudes of those in the legal profession: advocates who make arguments based upon confinement and judges who decide cases relying upon confinement. The mentally disabled are full citizens and deserve equal concern and respect. The confinement rationale should be rejected because it reveals an outdated attitude about the mentally disabled, regardless of the rule's economic impact.<sup>63</sup>

The next Part examines the pre-1991 cases involving a patient-caregiver relationship. This analysis will demonstrate courts' reluctance to admit the importance of this relationship.

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61. See Ellis, *supra* note 35, at 1085.

62. See Stephanie I. Splane, Note, *Tort Liability of the Mentally Ill in Negligence Actions*, 93 YALE L.J. 153, 163-69 (1983). Ellis rejects this argument because it does not treat mentally incompetent adults "like other adults," on the grounds that "mentally typical adults are not held to a standard that they are definitionally incapable of meeting." Ellis, *supra* note 35, at 1108. Goldstein rejects Splane's arguments on the grounds that deterrence is impossible for some mentally ill or incompetent people who are unable to control their behavior, and that the rest of society, regardless of the actions or living conditions of the mentally disabled, may choose to avoid contact with them, regardless of subjective or objective standards. See Goldstein, *supra* note 60, at 88-89.

63. See Ellis, *supra* note 35, at 1085-86.

## II. TORT LAW AND THE MENTALLY DISABLED UNDER CARE AND SUPERVISION

In a small number of cases arising before 1991, courts addressed patient-caregiver liability in tort.<sup>64</sup> In each of these cases, a caregiver sued a mental patient alleging negligent or intentional torts for injuries arising out of that relationship. In each case, the court rejected both an insanity/mental disability defense and a defense based upon the relationship of the parties (such as assumption of risk for negligence, or consent to injury for intentional torts). The courts maintained the traditional rule that there is no exception to liability for a mentally disabled defendant, despite the existence of a care relationship between the parties. The first case addressing the care relationship involved an at-home nurse rather than an institutional setting. Thus, when other pre-1991 courts faced the fact pattern of a mentally disabled defendant injuring a caregiver within an institutional setting and looked to precedent, the rule was clear: There is no exception to liability for mentally disabled defendants.

### A. *The Pre-1991 Cases*

The first case to confront the issue of tort liability within a mental patient-caregiver relationship was *McGuire v. Almy*,<sup>65</sup> in which the Supreme Judicial Court of Massachusetts held that the defendant, an “insane” person, was liable for assault and battery against her caregiver.<sup>66</sup> The plaintiff, a trained, registered nurse, was employed to take care of the defendant at the defendant’s home.<sup>67</sup> The nurse locked the patient in her room except when they were together, having heard that she could at times be violent and hostile.<sup>68</sup> After the patient threatened to kill both the nurse and a maid, the nurse entered the patient’s room with the aim of preventing injury.<sup>69</sup> Upon her entry, the defendant struck her, causing grave injury.

In assessing whether the trial court ought to have directed a verdict for the defendant on the grounds of the defendant’s insanity, the court examined past cases and summarized the traditional rule:

[C]ourts in this country almost invariably say in the broadest terms that an insane person is liable for his torts. As a rule no distinction

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64. According to extensive electronic searches, the four cases discussed in this Part are the only reported cases arising before 1991 that address the question of whether a mentally disabled defendant may be liable to her paid caregiver for either intentional or negligent torts.

65. 8 N.E.2d 760 (Mass. 1937).

66. *See id.* at 763.

67. *See id.* at 761.

68. *See id.*

69. *See id.*

is made between those torts which would ordinarily be classed as intentional and those which would ordinarily be classed as negligent, nor do the courts discuss the effect of different kinds of insanity or of varying degrees of capacity as bearing upon the ability of the defendant to understand the particular act in question or to make a reasoned decision with respect to it, although it is sometimes said that an insane person is not liable for torts requiring malice of which he is incapable.<sup>70</sup>

Recognizing that past decisions rested primarily upon policy grounds, rather than detailed factual inquiries about either the defendant's capacity or the nature of the relationship between the parties, the court ultimately rejected a subjective standard for analyzing the defendant's conduct. But the court failed to consider a no-duty rule that would place the caregiver relationship outside the tort regime. The court finally recited several policy reasons supporting the objective standard, beginning with the idea that a "rule imposing liability tends to make more watchful those persons who have charge of the defendant . . . ." <sup>71</sup>

Before engaging in a detailed factual inquiry as to what the plaintiff might have known or consented to, the court voiced its support for the policy reasons underlying the traditional rule, despite its awareness of scholarly criticism.<sup>72</sup> Ultimately, the court held that the defendant was liable for intentional torts to the extent that she was capable of and did in fact entertain the necessary intent.<sup>73</sup> The court stated in dicta that an objective standard might be appropriate for assessing negligence liability.<sup>74</sup>

In examining the defense that the plaintiff had consented to the injury, a defense that relied upon the relationship between the parties, the court undertook a more in-depth factual analysis.<sup>75</sup> The defendant argued against liability "because the plaintiff, by undertaking to care for the defendant with knowledge of the defendant's condition and by walking into the room in spite of the defendant's threat under the circumstances shown, consented to the injury, or, as the defendant puts it, assumed the risk, both contractually and voluntarily."<sup>76</sup>

Ultimately, the court held that consent was no defense. It drew a distinction between consent to care for a person and consent to injury:

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70. *Id.* at 762.

71. *Id.*

72. *See id.* at 763 ("Fault is by no means at the present day a universal prerequisite to liability, and the theory that it should be such has been obliged very recently to yield at several points to what have been thought to be paramount considerations of public good.").

73. *See id.*

74. *See id.*

75. *See id.*

76. *Id.*

The plaintiff had assumed the duty of caring for the defendant. We think that a reasonable attempt on her part to perform that duty under the peculiar circumstances brought about by the defendant's own act did not necessarily indicate a voluntary consent to be injured. Consent does not always follow from the intentional incurring of risk.<sup>77</sup>

In analyzing the consent-to-injury defense, the court found no evidence of previous threat or attack. Nor did it find any "danger of actual physical injury . . . as a matter of law, plain and obvious up to the time when the plaintiff entered the room on the occasion of the assault."<sup>78</sup> However, the court never addressed whether the defendant was capable of performing her duty under the circumstances. The above analysis suggests that the court's ultimate concern was ensuring compensation for the victim. Though the case established precedent on the caregiver-patient relationship, it did not specifically address the issue of patient geography, as the defendant had not been confined to an institution.<sup>79</sup>

In a second case involving the care relationship, *Van Vooren v. Cook*,<sup>80</sup> the defendant, who suffered depression after military service, was confined to a mental institution.<sup>81</sup> The plaintiff was not a trained nurse or caregiver, but rather was responsible for waiting on patients at meals, making beds, and cleaning floors. He had been informed that some patients, including the defendant, were difficult and were at times locked up, and had been specifically instructed not to enter Cook's room alone.<sup>82</sup> The plaintiff was attacked violently when he disregarded this advice and went alone into Cook's room to help him out of bed. The court imposed liability upon the defendant for assault and battery, finding that the plaintiff had not consented to the injury. The court recited the policy reasons behind the traditional rule of imposing liability upon mentally disabled people for their torts.<sup>83</sup> Again, the court's recitation did not carefully assess or question the confinement rationale.

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77. *Id.*

78. *Id.* Seidelson suggests that in *McGuire v. Almy*, the court drew a distinction between the plaintiff's knowledge of the defendant's incompetence and the plaintiff's knowledge of the defendant's "predilection to inflict personal injury." Seidelson, *supra* note 59, at 45 n.106.

79. Subsequent cases involving the care relationship raised the issue of patient geography, but courts did not find it sufficient to trump the traditional objective standard.

80. 75 N.Y.S.2d 362 (App. Div. 1947).

81. *See id.* at 364.

82. *See id.*

83. The court stated:

[E]verybody is entitled to be protected against an invasion of his person, and, if the tort is committed by an insane person, there is no reason why the person who is offended against by the tort should stand a loss instead of the offending actor, and the liability placed upon insane persons may be an incentive to those interested in the insane person's person or property to guard against loss to society and the insane person.

*Id.* at 365.



As in *McGuire*, the defendant raised a consent-to-injury defense. The court rejected it, first on the ground that no court in the state had recognized a defense of "invitation" to assault, and second because "even though consent were a defense, the physical attack must not exceed the consent."<sup>84</sup> Here, the court found that the facts showed no consent as a matter of law, as the plaintiff entered the defendant's room to summon him to dinner and was at the time unaware of the defendant's irritability.<sup>85</sup> The court drew a distinction between a defendant's general propensity to violence and actual irritability immediately preceding the injury. The latter suggested a greater likelihood of actual injury, and was more important in the court's analysis.

However, two justices dissented, suggesting for the first time that both the plaintiff's factual knowledge at the time of injury and the nature of the relationship between the parties might relieve the defendant of liability. The dissent noted, "While there can be no question of the rule that a lunatic is as responsible for assault and battery as a sane person, nevertheless, there can be no assault and battery where one voluntarily engages in an encounter in which that may inevitably result."<sup>86</sup> The dissent also questioned whether the underlying policy reasons for imposing liability in fact applied, given the defendant's confinement:

Since one of the main reasons for imposing liability upon lunatics for their torts is that such a course tends to make those who should have an interest in the insane person, and so [are] possibly interested in his property, watchful of him, certainly that basis is not present here. It seems harsh to impose upon Cook confined in an institution for the care of the insane the same rules of liability for his torts as would be imposed upon Cook allowed, unattended, to roam the streets.<sup>87</sup>

The dissent envisioned the proper place for the mentally ill in institutions, and would have created an exception in keeping with the logic of confinement. The dissent's focus upon the relationship between the parties has been cited with approval in cases arising after 1991.

In a second case involving an institutionalized patient, *Mullen v. Bruce*,<sup>88</sup> the California District Court of Appeal held that an alcoholic patient who suffered from delirium and resided in a sanitarium could be held liable for both assault and negligence against her nurse. The defendant asserted the defenses of assumption of risk and implied consent to injury. The plaintiff had been informed of the defendant's delirium and told that

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84. *Id.* at 366.

85. *See id.*

86. *Id.* at 367 (Taylor, J., dissenting).

87. *Id.*

88. 335 P.2d 945 (Cal. Dist. Ct. App. 1959).

she was “violent and unmanageable” and “that she would probably have a rough night with her.”<sup>89</sup> The plaintiff had knowledge of both the defendant’s general condition and her state immediately preceding the incident. The plaintiff was injured while restraining the defendant, who knocked her to the floor.<sup>90</sup>

The court held that while the plaintiff voluntarily assumed the duty of caring for the defendant, this did not amount to assuming the risk of injury as a matter of law. Section 41 of the California Civil Code stated: “A minor, or person of unsound mind, of whatever degree, is civilly liable for a wrong done by him, but is not liable in exemplary damages unless at the time of the act he was capable of knowing that it was wrongful.”<sup>91</sup> Interpreting this provision, the court upheld the traditional rule imposing liability, including the lack of distinction between intentional and negligent torts.<sup>92</sup> The court’s reluctance to uphold an assumption-of-risk defense demonstrated its understanding that the employee may have entered the employment contract without full autonomy.<sup>93</sup> It also reasoned that she might not have fully appreciated the risks of the position, as she had attended to other potentially violent patients without incurring any injury. The court did not mention the *Van Vooren* dissent’s reasoning that when a patient was confined, the policy reasons imposing liability might not apply.

The final pre-1991 case, *Burrows v. Hawaiian Trust Co.*,<sup>94</sup> also rejected a defense based upon the relationship of the parties in favor of imposing liability. The plaintiff, a private-duty registered nurse, sued the defendant, an alcoholic suffering delirium under the plaintiff’s care, for assault and battery. The defendant asserted assumption of risk as a defense. The trial court allowed instruction on assumption of risk, and the jury found for the defendant. The Supreme Court of Hawaii held that no instruction on assumption of risk should have been given as a matter of law.<sup>95</sup> The court focused upon the contractual nature of the relationship.<sup>96</sup> As the nurse was an independent contractor, her contract required her to “employ the skill, knowledge and care commonly possessed and exercised by members of the profession . . . according to the circumstances of the case.”<sup>97</sup> Ultimately, the court concluded that assumption of risk could be a defense to this injury only “if by the exercise of due care she should have prevented the injury, or

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89. *Id.* at 946.

90. *See id.*

91. CAL. CIV. CODE § 41 (West 1982) (amended 1992).

92. *See Mullen*, 335 P.2d at 947.

93. *See id.* The court hypothesized that she may have risked losing her job altogether, had she not accepted this particular assignment, and thus her actions may not have been completely voluntary.

94. 417 P.2d 816 (Haw. 1966).

95. *See id.* at 823.

96. *See id.* at 821 n.2.

97. *Id.* at 821.

if the hazard was one which it was not reasonable for her to accept in the performance of her duty as a nurse.”<sup>98</sup> The court did not focus upon incentives, nor did it recognize the role of non-tort compensation systems such as workers’ compensation in addressing the risks of “hazardous” employment. In fact, while each pre-1991 case recognized the need for compensation to the victim for the assault, no case mentioned the possibility that compensation could or should be borne by a non-tort regime.

#### B. *Common Themes in the Pre-1991 Cases*

The pre-1991 cases involving the tort liability of mentally disabled defendants shared a number of key themes. First, patient geography did not matter very much, despite the oft-recited pronouncement that a tort rule should give incentives to confine a mentally incompetent defendant and prevent harms against innocent strangers. The courts drew no distinction between care at home and care within an institution. This suggests that while early courts recited the confinement rationale, they did not take seriously its implications in cases in which the family had taken steps to confine the defendant or prevent harm by hiring a caregiver. Though this fact seems to be at odds with the renewed importance that the logic of confinement has played in the post-1991 cases, discussed below, there is an alternative explanation. Of these pre-1991 cases, only two involved institutionalized defendants; the other two involved defendants in at-home care under the supervision of a nurse. Only one of the four involved an institutionalized defendant injuring a trained nurse. Thus these cases can be factually distinguished from the post-1991 cases in which the defendants were all confined in nursing homes or state psychiatric institutions, the plaintiffs were almost all trained professional caregivers, and the mental disability—either senile dementia from Alzheimer’s disease or serious psychotic tendencies<sup>99</sup>—may have been taken more seriously by courts than the symptoms of detoxification or depression.

The second common theme is that in all cases the plaintiffs had at least a general knowledge of the defendant’s disposition to violence and, in some cases, had knowledge of a violent outburst immediately preceding the injury. Despite this knowledge, courts still rejected the defense of consent to injury on the grounds that the plaintiffs lacked specific intent to confront the harm at the time of injury.

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98. *Id.* at 821-22; *see also id.* at 821-22 n.3 (citing cases holding that there can be a duty to exercise due care in restraining an insane person from inflicting injury). The court also made clear that it would not allow a defense of contributory negligence to assault and battery to creep in under the guise of assumption of risk. *See id.* at 822.

99. *See infra* Part III and cases cited therein.

Third, courts' policy analyses did not explore beyond the narrow confines of the tort regime. When the primary goal was to compensate victims for their injuries, each court looked only to the defendant and did not recognize the potential contribution of social insurance mechanisms such as workers' compensation or other non-tort systems.<sup>100</sup> Nor did courts recognize the potential negative incentives that imposing liability in the caregiver relationship might have had on the decision to hire a caregiver, especially if a mere warning was not sufficient to insulate the mentally incompetent person from liability.

### III. RECENT DOCTRINAL CHANGES

In a line of cases arising since 1991, courts have begun to carve out an exception to the general rule imposing liability on the mentally disabled. In each case, a caregiver has sued a mentally disabled patient for injuries arising out of the care relationship.<sup>101</sup> The courts have uniformly held that a mentally incompetent patient owes no duty of care to refrain from negligence to a paid caregiver, because within that relationship, and within the confines of an institution, the policy reasons in favor of imposing liability do not apply. The irony of these decisions is that rather than overturning the traditional rule to implement a subjective standard for mentally incompetent defendants regardless of where they live, the courts have provided greater support for the notion that mentally disabled people should be segregated from society. By creating a narrow exception rather than supplanting the rule, these decisions are consistent with and reinforce a paradigm of separation.

Juxtaposing the pre- and post-1991 cases demonstrates the shift in how courts have treated this particular relationship. A close examination of the post-1991 cases suggests that what underlies the new exception is a new focus upon the issue of duty and the relationship between the parties, as well as a residual, unexamined belief that mentally disabled individuals should properly reside outside the community.

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100. In all fairness to these courts, workers' compensation may not have covered at-home caregivers, and other non-tort mechanisms, such as those suggested *infra* Part V, did not exist.

101. The cases cited herein are the only reported cases addressing this particular fact pattern and the legal question of what duty a mentally disabled person owes her paid caregiver for negligence. Search of Westlaw, ALLCASES-OLD and ALLCASES databases (Sept. 1, 1999).

### A. *The Post-1991 Cases*<sup>102</sup>

The first case to create an exception to the rule governing the caregiver relationship, *Anicet v. Gant*,<sup>103</sup> involved a violently insane resident of the South Florida State Hospital who was involuntarily committed. Within the hospital, the defendant resided in the ward designed for the lowest-functioning patients.<sup>104</sup> At the time of the incident, he was locked in a day room. The plaintiff, a unit treatment specialist who was specifically responsible for treating and restraining the defendant, was aware of Anicet's propensity for violence.<sup>105</sup> After the defendant threatened another patient, the plaintiff entered Anicet's room and Anicet threw an ashtray at him. The plaintiff sued for assault and battery.

The court held that, while as a general rule insane persons are liable both for intentional torts and for negligence on public policy grounds,<sup>106</sup> courts should not impose liability when the rationales behind the rule do not apply. The court wrote, "[W]e revert to the basic rule that where there is no fault, there should be no liability."<sup>107</sup> Yet this statement is inaccurate,

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102. Because of space constraints, this analysis excludes *Colman v. Notre Dame Convalescent Home*, 968 F. Supp. 809 (D. Conn. 1997), which held that an institutionalized Alzheimer's patient owes no duty of care to a paid caregiver to refrain from negligence, but may be held liable for intentional torts; and *Muniz v. White*, 979 P.2d 23 (Colo. App. 1998), *cert. granted*, (Colo. June 28, 1999), which held an institutionalized Alzheimer's patient liable for assault and battery against an employee of a facility providing care when the defense did not raise the issue of the plaintiff's status as caregiver. In addition, though it is outside the scope of this Note, the fact that the defendants in these cases are overwhelmingly Alzheimer's patients may have had an impact on judges' willingness to apply the logic of confinement. It may be socially acceptable to see nursing homes as therapeutic institutions for the elderly and to apply what seems to be a forgiving rule of liability in such cases, without considering how future courts considering defendants with other kinds of mental disability might build upon that precedent. One case in this line, *Creasy v. Rusk*, 696 N.E.2d 442 (Ind. Ct. App. 1998), uniquely held that the question of duty owed by a mentally disabled defendant to a caregiver is a mixed one of law and fact. However, this opinion was later transferred and vacated. See *Creasy v. Rusk*, 714 N.E.2d 442 (Ind. 1999).

103. 580 So. 2d 273 (Fla. Dist. Ct. App. 1991).

104. See *id.* at 274.

105. See *id.*

106. In addressing the fact that the court refers to "intentional" torts and "negligent" ones, Judge Schwartz qualified the words in quotation marks with the following caveat: "[A]s the authorities uniformly recognize, it is impossible to ascribe either the volition implicit in an intentional tort, the departure from the standard of a 'reasonable' person which defines an act of ordinary negligence, or indeed any concept of 'fault' at all to one who, like Anicet, is by definition unable to control his own actions through any exercise of reason." *Id.* at 275 (citing cases). Despite recognizing this fact, the court did not seek to overturn the general rule imposing liability without fault.

107. *Id.* at 277. One author discusses *Anicet* alongside *Breunig v. American Family Mutual Insurance Co.*, 173 N.W.2d 619 (Wis. 1970), as exemplifying a major exception to the reasonable person standard in negligence actions: that of sudden unforeseen illness. Her overall argument is that a subjective standard of liability ought to be imposed upon those mentally ill people who cannot avoid the harm they cause because their disease is sudden or untreatable. She suggests that both *Breunig* and *Anicet* provide support for overturning the objective standard. With regard to *Anicet*, she writes that "the court's reasoning is equally persuasive in all negligence cases where the plaintiff could not ex ante prevent the harm caused due to mental illness." Goldstein, *supra*

because the court did not reject the traditional rule to impose a subjective standard, as commentators had hoped. Instead, it created a narrow exception under limited circumstances, an exception which reinforced the policies behind the rule itself. The court's actual holding relied upon the presence of three crucial factors. First, the court reasoned that the plaintiff was not wholly innocent, as he was aware of violent action immediately preceding the injury. Second, the court found Anicet "entirely blameless" as he had "no control over his actions and [was] thus innocent of any wrongdoing in the most basic sense of that term."<sup>108</sup> Finally, the court noted the existence of workers' compensation.<sup>109</sup> Ultimately, the court found no duty:

We emphasize that we deliberately do not put the doctrine of this case in terms of 'assumption of risk,' in the sense of that principle which refers to conduct of the plaintiff which bars reliance upon an otherwise existing tort. . . . Rather we conclude that no *duty* to refrain from violent conduct arises on the part of a person who has no capacity to control it to one who is specifically employed to do just that.<sup>110</sup>

The court did not place all of its emphasis upon confinement; another crucial variable here was incapacity to control one's behavior. Confinement provided convenient evidence of that incapacity. At one point in the opinion, in discussing the "two innocents" rationale, the court mentioned *Kaczer v. Marrero*,<sup>111</sup> which, according to the *Anicet* court, "upheld the right of an innocent workman to recover from an *unconfined* insane person who stabbed him."<sup>112</sup> The reference to confinement is telling. Confinement did not merely symbolize some fact about the defendant's capacity. The court viewed confinement as crucial to determining what the plaintiff expected and knew. Gant was an employee who was paid "to encounter, and knowingly did encounter, just the dangers which injured him."<sup>113</sup>

In addressing the confinement rationale directly, the court noted that "Anicet, his relatives, and society did as much as they could do along these lines by confining him in the most restricted area of a restricted institution that could be found. Hence, it would serve no salutary purpose to impose

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note 60, at 82. In contrast, this Note suggests that the proper mode of analysis is not at the level of subjective or objective standards. Rather, a proper analysis ought to focus on whether the defendant owes a duty to the plaintiff given the particular circumstances of their relationship.

108. *Anicet*, 580 So. 2d at 277, 276.

109. *See id.* at 276.

110. *Id.* at 277.

111. 324 So. 2d 717 (Fla. Dist. Ct. App. 1976).

112. *Anicet*, 580 So. 2d at 275 (emphasis added).

113. *Id.* at 276.

the extra financial burden of a tort recovery.”<sup>114</sup> The decision rested also upon analogies to the fireman’s rule—that “as a member of society or as an employer, one who has ‘paid’ another to encounter a particular danger should not have to, so to speak, pay again for the very danger—even, as bears repeating, if he has been guilty of fault in creating it.”<sup>115</sup>

The court rejected or distinguished *Mullen*,<sup>116</sup> *Van Vooren*,<sup>117</sup> and *McGuire*, cases that potentially contradicted its holding. The *Anicet* court tellingly distinguished *McGuire* on the grounds that it “concerns a private nurse hired to care for the lunatic in her home and thus directly raises the ‘encouragement of further restriction’ principle which is notably absent from this case.”<sup>118</sup> Thus, the role of confinement, though not clearly at the forefront of the court’s holding, crept into its reasoning in subtle ways.

*Anicet*’s holding is broader than subsequent courts have recognized. The court’s ultimate holding, that “no duty to refrain from violent conduct arises on the part of a person who has no capacity to control it to one who is specifically employed to do just that,”<sup>119</sup> makes no specific mention of confinement or institutionalization. Yet the court’s method of distinguishing *McGuire* and its discussion of the confinement rationale suggest that geography matters. *Anicet*’s treatment of this issue provided a crucial toehold for later courts. Examination of later cases adopting this rule demonstrates that courts have limited the holding to these facts—the caregiver relationship within an institution—rather than suggesting that the no-duty rule would apply more broadly to any caregiver relationship at all, including one involving home care.

A subsequent Florida case, *Mujica v. Turner*,<sup>120</sup> addressed the rule only briefly in one paragraph, but narrowed its holding to cover only persons residing in institutions. In that case, the defendant’s decedent resided in a nursing home and suffered from an advanced stage of Alzheimer’s disease. The plaintiff was in charge of the “daily living activity program” at the center.<sup>121</sup> *Mujica* was injured in the process of trying to prevent the defendant’s decedent from strangling herself with a bathrobe sash.<sup>122</sup> The court rejected the plaintiff’s negligence suit:

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114. *Id.*

115. *Id.*

116. The court rejected *Mullen* on the grounds that the *Mullen* court was interpreting a provision of the California Civil Code to which there was no Florida counterpart. *See id.* at 277.

117. The court rejected *Van Vooren* as a “three to two decision in which we think that the dissenting opinion is by far the better reasoned.” *Id.*

118. *Id.*

119. *Id.*

120. 582 So. 2d 24 (Fla. Dist. Ct. App. 1991).

121. *Id.* at 24.

122. *See id.*

[W]e conclude that as a matter of law the defendant's decedent, as an institutionalized Alzheimer's patient, owed no duty of due care to plaintiff who was the decedent's caretaker at the Greenbriar Nursing Home. Although we agree that ordinarily a mental incompetent is responsible for his own torts, . . . we have recently held that this rule is inapplicable when the incompetent has been institutionalized, as here, because of her mental incompetency and injures one of her caretakers while in such [an] institution.<sup>123</sup>

Rather than discussing the case as a relationship between caregiver and patient as the *Anicet* court had done, the *Mujica* court focused primarily on the fact of institutionalization.

In *Gould v. American Family Mutual Insurance Co.*,<sup>124</sup> the Wisconsin Supreme Court explicitly rejected a subjective standard for mentally disabled persons in assessing their liability for negligence.<sup>125</sup> Instead, the court held that "an individual institutionalized, as here, with a mental disability, and who does not have the capacity to control or appreciate his or her conduct cannot be liable for injuries caused to caretakers who are employed for financial compensation."<sup>126</sup> In this case, the defendant suffered from advanced Alzheimer's disease, and his family admitted him to a health care center, where Gould worked as head nurse of the dementia unit.<sup>127</sup> The defendant injured Gould when she tried to direct him to his own room and he pushed her to the floor.

*Gould* affirmed the traditional rule that a mentally incompetent person should be held to a reasonable person standard, citing the *Restatement (Second)* and *Weaver v. Ward*, and affirmed the public policy rationales behind the rule despite the transition to a fault-based tort regime.<sup>128</sup> The court recognized that limited exceptions to this rule exist, such as for sudden mental incapacity.<sup>129</sup> Rather than overturning the traditional rule, or questioning the continued relevance of the confinement rationale, the court recognized that "[p]ublic policy considerations may preclude liability."<sup>130</sup>

The court determined that Gould was aware of the defendant's health status. By drawing an analogy to the firefighter's rule, the court found that she was hardly an "innocent member of the public unable to anticipate or safeguard against the harm when encountered. Rather, she was employed as a caretaker specifically for dementia patients and knowingly encountered

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123. *Id.* at 25 (citation omitted).

124. 543 N.W.2d 282 (Wis. 1996).

125. *See id.* at 283.

126. *Id.*

127. *See id.*

128. *See id.* at 284.

129. *See id.* at 285 (citing *Breunig v. American Family Mut. Ins. Co.*, 173 N.W.2d 619 (Wis. 1970)).

130. *Gould*, 543 N.W.2d at 286.



the dangers associated with such employment.”<sup>131</sup> Thus, the court did address the relationship between the parties.

The court confronted the issue of confinement, but did not question whether simple reliance upon the confinement rationale made sense:

[The defendant]’s relatives did everything they could to restrain him when they placed him in a secured dementia unit of a restricted health care center. When a mentally disabled person is placed in a nursing home, long-term care facility, health care center, or similar restrictive institution for the mentally disabled, those ‘interested in the estate’ of that person are not likely in need of such further inducement.<sup>132</sup>

The court also addressed confinement as convenient evidence that the defendant had not simulated mental disability over a period of years simply to avoid negligence liability.<sup>133</sup>

The court recognized that other courts, namely those in *Mujica* and *Anicet*, “have rejected the common law rule within the limited context of severely mentally disabled persons confined in institutions based on similar public policy considerations.”<sup>134</sup> Again, the court’s treatment of the facts and precedent overemphasized the importance of the confinement rationale in precluding liability at the expense of a focus on the care relationship.

A California case, *Herrle v. Estate of Marshall*,<sup>135</sup> is the broadest holding of this line, but in some ways it is the most open to question. The court held that the defendant, a patient suffering from Alzheimer’s disease and senile dementia who struck a certified nurse’s aide, did not owe any legal duty because of the relationship of the parties. In this case, the court focused less upon the fact of confinement itself than upon economic policy, the nature of the relationship, and a “cheapest cost avoider”<sup>136</sup> economic approach—asking who would be in the best position to prevent injury. The court feared imposing liability: “Were we to reach a contrary conclusion, nurses working in an infectious disease unit could sue a patient for giving them tuberculosis. Were that view to prevail, risks most efficiently allocable to and traditionally borne by the health care industry would be shifted to individual patients and their families.”<sup>137</sup> The court reasoned that ultimate liability rests not with the patient but with the nurse’s employer or health-care facility for its failure to fulfill its duty to care for the defendant.

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131. *Id.*

132. *Id.* at 287.

133. *See id.*

134. *Id.* at 287 n.7.

135. 53 Cal. Rptr. 2d. 713 (Ct. App. 1996).

136. *See generally* GUIDO CALABRESI, THE COSTS OF ACCIDENTS 244-46 (1970) (discussing the “cheapest cost avoider” paradigm in the context of the employment relationship).

137. *Herrle*, 53 Cal. Rptr. 2d at 719.

The court noted, "The hospital assumed the primary duty to protect defendant and those who might be harmed by her."<sup>138</sup> The court recognized that workers' compensation covered the plaintiff, thus spreading the burden of compensation.<sup>139</sup>

The *Herrle* court only briefly mentioned the confinement rationale. Institutionalization provided "strong evidence of the individual's mental incompetency"<sup>140</sup> that obviated the need for extensive litigation on that issue. The court also noted that the defendant, "through the agency of her relatives, took steps to protect both herself and others from the very injury suffered by plaintiff, by entering a convalescent home which cared for persons who could not control their actions."<sup>141</sup> Though the court mentioned the convalescent home as a potential risk-bearer, the opinion's language was sufficiently broad to recognize that families could take other steps to absolve the mentally disabled of liability within certain relationships. The case's ultimate holding looked beyond the fact of confinement: "Because of the nature of the activity, caring for the mentally infirm, and the relationship between the parties, patient and caregiver, mentally incompetent patients should not owe a legal duty to protect caregivers from injuries suffered in attending to them."<sup>142</sup>

The *Herrle* court focused almost exclusively on the relationship, rather than on geography. Subsequent courts could rely upon this rule to bring home care within the ambit of the no-duty exception to liability for the mentally disabled. If families hired an at-home nurse and an injury resulted from that relationship, a court could rely upon *Herrle* as precedent to relieve the defendant of liability within the care relationship, though the defendant did not reside within an institution. Such broad applicability of the court's holding and reasoning is compatible with the contemporary notion that unnecessary segregation of the mentally disabled constitutes discrimination.<sup>143</sup> A mentally disabled person ought not be required to enter a mental institution in order to be relieved of liability to a paid caregiver when at-home care is more appropriate under all the circumstances.

The *Herrle* court explicitly rejected the reasoning in the prior California case of *Mullen* as outmoded and inapposite.<sup>144</sup> While *Mullen*'s secondary assumption-of-risk analysis required factual inquiries about what the plaintiff knew, *Herrle*'s primary assumption-of-risk or duty-of-care analysis focused on legal conclusions about a relationship: "[L]egal duties are not discoverable facts of nature, but merely conclusory expressions that, in

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138. *Id.*

139. *See id.* at 720.

140. *Id.* at 717.

141. *Id.* at 716-17.

142. *Id.* at 719.

143. *See supra* text accompanying notes 52-55.

144. *See Herrle*, 53 Cal. Rptr. 2d at 717.

cases of a particular type, liability should be imposed for damage done.”<sup>145</sup> The *Herrle* court found no body of case law that “stands for the proposition that health care providers can sue their patients for injuries inherent in the very condition for which treatment was sought”<sup>146</sup> even outside the context of the mentally disabled. The court concluded with a cheapest-cost-avoider approach, noting that “[i]t is the health care provider, not the patient, who is in the best position to protect against the risks to the provider rooted in the very reason for the treatment.”<sup>147</sup> The patient should not pay twice: first for the care itself, and second for insurance to cover the cost of injury compensation.

However, the dissent in *Herrle* suggested that though the majority properly focused on relationships, it mistook the relationship between the two parties and made bad law, ultimately placing the most vulnerable elderly citizens at risk. The plaintiff’s main job was not to care for the patient, but rather to change bedpans and help the elderly to their beds:

[S]he was not hired for the *sole* purpose of preventing potentially violent Alzheimer’s patients from injuring themselves and others. Additionally, the mere fact that a family contracts with a private convalescent hospital to care for an incompetent family member should not bar *every* employee who may come into contact with the patient, regardless of how remote the contact may be, from recovering for injuries the patient may inflict.<sup>148</sup>

The dissent rightly focused on the relationship and on the nature of the plaintiff’s responsibilities. While an assumption-of-risk analysis would rest upon a factual inquiry into what the plaintiff knew, the duty analysis focuses more properly on the relationship between the parties. The *Herrle* rule, though focusing on the relationship between the parties, may have subconsciously relied upon the institutional setting of that relationship to relieve the mentally disabled defendant of duty to a nurse’s aide. It is unclear whether the court would have found no duty had the injury taken place outside the confines of an institution.

Of all the post-1991 confinement cases, *Herrle* most explicitly pointed out the tension between a no-duty rule and a concern about fairness—that caregivers should be compensated for their injuries. The California Psychiatric Association filed an amicus brief suggesting that the majority’s ultimate ruling would increase incentives to seclude and restrain patients within institutions as health care providers sought to protect themselves and

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145. *Id.* (quoting *Christensen v. Superior Court*, 820 P.2d 181, 190 (1991)).

146. *Id.* at 719.

147. *Id.*

148. *Id.* at 722 (Wallin, J., dissenting).

other patients.<sup>149</sup> This position ignores the extensive state and federal regulations that prevent overuse of restraints within hospitals and nursing homes.<sup>150</sup> For example, the implementing regulations of the Nursing Home Quality Reform Act<sup>151</sup> mandate that nursing home residents have “the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.”<sup>152</sup> Government-owned homes may be state actors for the purpose of constitutional liability.<sup>153</sup> Penalties for violation of state and federal regulations may include decertification, suspension or revocation of the home’s license, or civil monetary penalties.<sup>154</sup> Some states have classified the inappropriate use of restraints as criminal “elder abuse” and have provided stiff penalties.<sup>155</sup> At the same time, patients subjected to unnecessary restraint may use the tort system to bring actions against health care providers.<sup>156</sup> Despite these regulations, a rule finding no duty within the care relationship must confront the challenge *Herrle* raised: to ensure proper compensation for caregivers.

#### B. *Common Themes in the Post-1991 Cases*

The post-1991 cases share a number of common themes. First, they primarily involve negligent, rather than intentional, torts. Doctrinally, the courts analyze whether a duty of care exists between the parties, given the nature of the relationship, the parties’ relative capacities and expectations, and (in some cases) the availability of workers’ compensation. They do not ask two crucial questions suggested by duty-of-care analysis in other contexts:<sup>157</sup> whether the activity (of giving and receiving care) or the

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149. *See id.* at 724.

150. *See* Marshall B. Kapp, *Nursing Home Restraints and Legal Liability*, 13 J. LEGAL MED. 1, 16-22 (1992); *see also* Elyn R. Saks, Note, *The Use of Mechanical Restraints in Psychiatric Hospitals*, 95 YALE L.J. 1836, 1839-40 & n.19 (1986). *But see id.* at 1841-42 & n.25 (noting that despite legal prohibitions on unnecessary restraint, hospitals do in fact restrain patients).

151. 42 U.S.C. § 1396r (1994).

152. 42 C.F.R. § 483.13(a) (1998).

153. *See* Kapp, *supra* note 150, at 16.

154. *See id.* at 17.

155. *See id.*

156. *See* Steven J. Schwartz, *Damage Actions as a Strategy for Enhancing the Quality of Care of Persons with Mental Disabilities*, 17 N.Y.U. REV. L. & SOC. CHANGE 651 (1989-1990) (advocating patient lawsuits to reduce the use of restraints).

157. The most comprehensive recent duty/no duty analysis for negligence has arisen in the context of sports: whether a player owes a duty to refrain from negligence toward another player. For example, a recent Connecticut Supreme Court case, *Jaworski v. Kiernan*, 696 A.2d 332 (Conn. 1997), held that an amateur soccer player owes no duty to a teammate to refrain from negligent conduct. Another athletic case, *Knight v. Jewett*, 834 P.2d 696, 704 & n.5, 708-12 (Cal. 1992) (en banc), held that one teammate cannot sue another teammate for negligence because no duty of care exists to avoid negligence. *See also* *Kabella v. Bouschelle*, 672 P.2d 290 (N.M. Ct. App. 1983) (same).

relationship is one that courts should encourage, and whether the rule will open the floodgates to litigation. Part IV addresses the importance of these factors in this setting.

Second, the focus on duty of care allows courts to engage in broad policy analysis. They examine the rationales supporting the traditional rule of imposing liability (two innocents/compensation, evidence/fakery, and confinement) and suggest that these reasons do not apply in cases where a person has been confined to an institution. Following the reasoning in the *Van Vooren* dissent, courts' policy analyses do not question the assumptions underlying these policy rationales. No court asks whether the tort system *should* create incentives to confine a mentally incompetent or disabled person. The courts only ask which rule is proper when a defendant is confined, given a policy favoring confinement.

Third, the holdings of these cases vary in their breadth. Some rely more heavily upon the confinement rationale, while others focus on the relationship between the parties. Holdings that focus on the relationship between the parties could be interpreted to encompass the relationship involved in at-home care, or care closer on the continuum to community living. One goal of the tort system is to ensure compensation. A second is to provide incentives for desirable behavior, such as encouraging the mentally disabled to seek appropriate care relationships. In this particular fact setting, the two goals are fundamentally interconnected. Sometimes they work at cross purposes. If we recognize that much care can take place in community placements or at home, a no-duty rule focusing on the care relationship serves this end better than a no-duty rule relying upon a confinement rationale. Courts should focus upon the importance of the relationship between the parties, their expectations, and the availability of other forms of non-tort compensation. While the results in these cases would be the same, reasoning relying upon relationship and duty would suggest a nuanced appreciation that confinement ought not to be the paradigm under which the mentally disabled are assessed.

#### IV. A PROPER DUTY ANALYSIS

##### A. *The Test*

Courts are not questioning the logic of confinement as strenuously as they should. By continuing to recite and analyze the public policy reasons behind the traditional rule, courts have imported into modern reasoning an outdated rationale that assumes a background norm of institutionalization. When deciding cases involving mentally disabled defendants, courts ought to be aware of the anachronistic assumptions that their analyses bring into play. Countering this negative trend requires a new focus upon the duty of

care and the relationship between the parties. This Part suggests an analysis to assess the duty of care in a caregiver relationship. The test considers five factors to determine whether a duty exists in a particular case. These factors generally favor a no-duty rule for a mentally disabled defendant in a caregiver relationship.

Several courts have articulated a test for determining the existence of a duty to refrain from negligence in other cases primarily involving injured team athletes.<sup>158</sup> A modified test, based upon this “fellow athlete” rule, should be imported into assessing care relationships, because many of the same considerations apply.<sup>159</sup> Assessing whether a duty of care exists in negligence, courts have recognized the importance of several factors, including: (1) the foreseeability of harm; (2) the “normal expectations of participants” in the activity (such as the care relationship or a soccer game); (3) the “public policy of encouraging continued vigorous participation” in the activity or relationship while taking safety into account; and (4) the need to avoid increased litigation.<sup>160</sup> Finally, courts should consider (5) whether there exist alternative mechanisms for compensating the injured victim. One scholar notes that a no-duty rule “may also reflect the judgment that the social values the tort system is meant to promote are already being well served through other institutional arrangements” such that a tort remedy is redundant.<sup>161</sup>

Applied to the caregiver relationship, these factors tend to favor a no-duty rule on the part of a mentally disabled defendant. The fifth factor, the existence of alternative compensation mechanisms, is cross-cutting, and permeates the discussion of the first four factors. Because compensation is so important, this Note addresses it separately in Part V.

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158. Analysis of a limited duty of care has arisen in two main contexts, according to one exhaustive study: athletics and professional risk. See John L. Diamond, *Assumption of Risk After Comparative Negligence: Integrating Contract Theory into Tort Doctrine*, 52 OHIO ST. L.J. 717, 740, 742-43 (1991) (“In certain classes of activities, the courts do not want to impose liability for risks inherent or frequently associated with those activities. . . . Limiting the defendant’s duty where the court determines there should be an enclave from liability . . . avoids the risk that the defendant will be held liable in a factual context where the courts want to protect the defendant even when the plaintiff fails to appreciate a risk as required by assumption of risk.”).

159. One post-1991 court used several of these factors from the athletic injury context. See *Colman v. Notre Dame Convalescent Home*, 968 F. Supp. 809, 812-13 (D. Conn. 1997) (using an analysis based upon *Jaworski*, 696 A.2d 332, to determine the duty to refrain from negligence within a care relationship based upon the duty rule applied in athletic cases).

160. See, e.g., *Knight*, 834 P.2d at 708-12; *Jaworski*, 696 A.2d at 336-37 (finding also relevant to the determination of whether a duty exists what other jurisdictions have decided under similar circumstances).

161. Stephen D. Sugarman, *Assumption of Risk*, 31 VAL. U. L. REV. 833, 846 (1997). This argument provides the strongest support for the notion that the “two innocents” principle requiring compensation of an innocent victim is no longer persuasive, at least not in the employment context.

### B. *Applying the Analysis to Caregiver Relationships*

The above analysis supports recognizing that a mentally disabled defendant owes no duty to avoid negligence within the caregiver relationship. First, the harm is *foreseeable*. This factor might initially seem to weigh in favor of imposing a duty upon the defendant, as foreseeability of harm usually does. But the foreseeable harm—injury to self or others—is precisely the reason for the mentally disabled person's entry into the care relationship. Because this foreseeable harm is what the plaintiff is trained to prevent, this factor cuts in the opposite direction—that is, in favor of a no-duty rule.<sup>162</sup> Since the plaintiff is trained to confront the kind of behavior that led to injury, it is the plaintiff, not the defendant, who can adjust her behavior more easily to address foreseeable harm.<sup>163</sup>

Second, a plaintiff's *normal expectations* most certainly include the expectation of compensation for any injuries. A mentally disabled person in such a relationship expects to receive appropriate care, not to be sued for the type of conduct that led him to enter a caregiver relationship in the first place. A no-duty rule need not frustrate either party's expectations; rather, it would shift the burden of compensation away from the mentally disabled defendant to a non-tort mechanism. As long as a compensation system exists, this shift would not provide the wrong incentives to the mentally disabled or to caregivers to avoid the care relationship for fear of liability or injury, respectively. Currently, the workers' compensation system covers some, but not all, caregivers. For covered workers, the expectations of compensation will be satisfied, and thus this second factor is at least neutral toward a no-duty rule. However, some caregivers, such as independent contractors or at-home nurses, are not generally covered by workers' compensation and would have their expectations of compensation frustrated. This tension may be resolved through several non-tort mechanisms, each of which is discussed in Part V, below. In the absence of a functioning non-tort regime of compensation, the second factor raises a tension.

Third, it is crucial to recognize the importance of encouraging *continued participation in the activity*—the caregiver relationship. A rule that imposes liability upon mentally disabled defendants who enter care relationships can provide a disincentive to seek further care, especially when lack of ability to control their actions may have been the reason for seeking care in the first place. A rule that excuses liability solely upon the grounds that a defendant is confined could create incentives to seek confinement when it is more restrictive than necessary. The no-duty rule, in

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162. See *Colman*, 968 F. Supp. at 813.

163. See *id.*

contrast, which focuses on the relationship between the parties, can encourage a mentally disabled person or her family to seek care in a less restrictive environment than a "total institution," without fear that inevitable accidents will result in large tort judgments. To find no duty would simply shift the burden of compensation from the defendant to a non-tort system.

Opponents of a no-duty approach argue that health care providers will use greater restraints in order to prevent otherwise unavoidable accidents.<sup>164</sup> This fear is unfounded for two reasons. First, there exist other competing regulations over the use of restraints in psychiatric relationships and within facilities.<sup>165</sup> Second, as the next Part of this Note discusses in greater detail, the modification or creation of alternative non-tort forms of insurance (such as workers' compensation or other social insurance) could provide alternative compensation.<sup>166</sup> A no-duty rule would place the burden upon a different regime to determine who must compensate whom.

Finally, a no-duty rule serves the need to decrease litigation. If courts recognized a duty in this relationship, any caregiver trained to care for those who cannot control their actions would be able to sue any patient for injuries, even those resulting from the precise behavior that caused the defendant to seek treatment in the first place. This factor created great consternation for courts in the *Anicet* line of cases, and many found it inappropriate to allow recovery under these circumstances.<sup>167</sup>

The most important benefit of this analysis is that it does not depend upon whether the defendant is confined in an institution. Within the caregiver relationship, regardless of whether a mentally disabled person is confined in an institution, courts ought to impose no duty of care.

## V. A SOLUTION TO THE PROBLEM OF COMPENSATION

One of the central challenges of a no-duty rule in the context of caregiver relationships is ensuring that the plaintiff is compensated for her loss when tort recovery is no longer available. As noted above in Part III, courts have mentioned the importance of the workers' compensation system as an alternative source of compensation in these cases. The logic proceeds as follows: If the central goal of the tort regime is to compensate the plaintiff for her injuries, an employee of an institution receives workers' compensation regardless of her ability to collect a tort judgment from the

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164. See *supra* text accompanying note 149.

165. See Kapp, *supra* note 150, at 16-22.

166. For a detailed examination of the workers' compensation system, see ORIN KRAMER & RICHARD BRIFFAULT, *WORKERS COMPENSATION: STRENGTHENING THE SOCIAL COMPACT* (1991).

167. See *supra* Part III.



third party (here, the mentally disabled defendant).<sup>168</sup> Thus a no-duty rule does not completely foreclose the possibility of compensation.

An argument that relies upon workers' compensation, however, may still reinforce the logic of confinement by affecting incentives for caregivers and courts. Because workers' compensation is available only for employees of institutions that are covered by the system, independent contractors, such as at-home nurses, are not covered and will not be compensated.<sup>169</sup> Thus, if compensation is a crucial element in a caregiver's decision to choose employment in a large institution or as an at-home attendant, reliance upon the workers' compensation system may discourage her from working in at-home settings. Courts in the post-1991 cases have not recognized this problem, perhaps because none of the plaintiffs in the cases arising after 1991 have been at-home caregivers.

Reliance upon the workers' compensation system may lead to a second perverse incentive—this time for courts. If courts remain concerned with compensating plaintiffs for their injuries, then the lack of available compensation to at-home caregivers may lead courts to continue to impose tort liability upon mentally disabled defendants in home-care situations, while relieving of liability those mentally disabled defendants who reside in large institutions where workers' compensation is available. Perverse incentives both for caregivers and for courts remain consistent with a continued logic of confinement. Several possible solutions exist.

The first potential solution would rely upon the so-called "veterinarian's rule," which resolves the compensation problem through contract. The rule holds that a veterinarian cannot recover in tort from the owner of an animal that bites him, as the owner owes no duty of care to the veterinarian to prevent conduct that is an inevitable "occupational hazard."<sup>170</sup> This is true regardless of where the veterinarian treats the

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168. See, e.g., *Anicet v. Gant*, 580 So. 2d 273, 276 (Fla. Dist. Ct. App. 1991).

169. See, e.g., *Stewart v. Carter Realty Co.*, 518 So. 2d 118, 119 (Ala. 1987) (recognizing that Alabama workers' compensation applies only to the relationship "between the worker and his employer" and not to independent contractors); *Bowers v. Eastern Aluminum Corp.*, 214 A.2d 924, 925 (Md. Ct. App. 1965) (holding that an independent contractor is not an employee for purposes of the Workmen's Compensation Act); *Commissioners of the State Ins. Fund v. Fox Run Farms*, 600 N.Y.S.2d 239, 241 (App. Div. 1993) (recognizing that independent contractors are not employees covered by the Workers' Compensation Law). If at-home nurses are employees of a larger organization, this concern may not apply.

170. *Rosenbloom v. Hanour Corp.*, 78 Cal. Rptr. 2d 686, 688 (Ct. App. 1998) (holding that a shark owner owes no duty of care to a shark handler's assistant for injury that occurred "during the course of treating an animal under his control, an activity for which he was employed and compensated and one in which the risk of being attacked and bitten is well known" (citation omitted)); *Cohen v. McIntyre*, 20 Cal. Rptr. 2d 143, 146 (Ct. App. 1993) (holding that a dog owner owes no duty of care to a veterinarian for a dog bite incurred during the veterinarian's treatment of the dog on the grounds that "this is the classic situation where a defendant's ordinary duty of care is *negated* due to the nature of the activity and the relationship of the defendant to the plaintiff," and noting that the subjective knowledge of the plaintiff is irrelevant); *Willenberg v. Superior Court*, 229 Cal. Rptr. 625, 626 (Ct. App. 1986) (holding that a veterinarian could not

animal. Despite the extremely unfortunate analogy, one could argue that because the two parties can contract for wages and other benefits, the defendant should not have to pay the plaintiff twice for encountering a known risk inherent in the profession or the project for which the caregiver is specifically hired. While this solution seems superficially appealing, it also seems unfair to impose these burdens upon the parties alone, given the social benefit that results from encouraging care relationships and the hardship to the individual parties of bearing additional burdens of purchasing insurance. In addition, although diffuse market forces often drive down the prices of private insurance costs, a private contract solution may ignore market inefficiencies as well as power imbalances between the parties in negotiating contract terms.<sup>171</sup> Finally, as the dissent in *Herrle* noted, caring for people is not comparable to caring for animals, especially because a veterinarian might use restraints that would be unacceptable in the context of caring for people.<sup>172</sup>

The second potential solution would build upon the existing workers' compensation system, but would require legislative action to expand the pool of workers who are covered to include at-home caregivers. This would solve the perverse incentive problem that arises when a caregiver must choose between employment at a large institution (with coverage) and an at-home setting (without coverage). It would also address the incentive for courts to distinguish between settings in which a plaintiff will be compensated and those in which she will not.

This solution, however, also suffers from a major flaw. While the availability of compensation for the plaintiff is important both to increase fairness and to avoid perverse incentives, the source of the payment matters. Workers' compensation currently places responsibility for purchasing insurance upon the employer. Normal risk-spreading takes place

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recover on the grounds that "a visit to the veterinarian's office can bring about unpredictable behavior in a normally docile animal, and this is an inherent risk which every veterinarian assumes"); *Nelson v. Hall*, 211 Cal. Rptr. 668, 672 (Ct. App. 1985) (holding that a veterinarian is barred from recovery against a dog owner when "[t]he risk of dog bites during treatment is a specific known hazard endemic to the very occupation in which plaintiff voluntarily engaged," but also noting that the plaintiff received workers' compensation); cf. *Davis v. Gaschler*, 14 Cal. Rptr. 2d 679, 683-84 (Ct. App. 1992) (holding that where the plaintiff was an experienced breeder and handler of dogs, but not employed by the dog owner of the dog who injured her, the defendant dog owner owed a duty of care to the plaintiff). In these cases, it is important to note that the court draws no distinction between the veterinarian and the assistant. Secondly, the courts rely upon the relationship between the parties, following the logic of *Knight v. Jewett*, 834 P.2d 696, 707-08 (Cal. 1992) (en banc), rather than focusing upon the skills of the plaintiff, see *Davis*, 14 Cal. Rptr. 2d at 684-85, or upon the subjective knowledge of the plaintiff about a particular animal. The focus is more appropriately upon the nature of the relationship in a more objective sense.

171. For a more in-depth treatment of contract solutions, see Kenneth S. Abraham & Lance Liebman, *Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury*, 93 COLUM. L. REV. 75, 86-88 (1993).

172. See *Herrle v. Estate of Marshall*, 53 Cal. Rptr. 2d 713, 722 n.2 (1996) (Wallin, J., dissenting).

when an employer purchases insurance and then passes its costs on to consumers. One assumes that consumers are not the potential defendants. In contrast, in the case of the care relationship, the consumers of the employment's "products" (the care services) are the mentally disabled defendants. Though the employer-source compensation would not involve the symbolism of a tort judgment, ultimately such a system would distribute the risk to those who already shoulder the burdens of the cost of care. Though not as strong a perverse incentive, the increased cost of care might discourage entry into the care relationship or make it prohibitively expensive.

A third solution, the solution this Note advocates most strongly, would be to set up a system of public compensation through which the risk and cost of insurance could be spread across the public as a whole. This logic underlies the "firefighter's rule," which bars a firefighter from suing members of the public who negligently start a fire that injures him. Courts have noted that a no-duty rule prevents the public from paying twice: The firefighter encounters known risks of employment and receives extra compensation, disability benefits, and a pension to compensate for encountering additional risk. This rule applies in several states to public safety employees on the grounds that the public already pays taxes.<sup>173</sup> The analogy between the firefighting and caregiving is imperfect, in particular when caregivers are private, rather than public, employees. However, the fact that a public compensation system exists to protect against a risk that could happen to anyone,<sup>174</sup> suggests that creating a similar system is one possible way to address the problem of compensation within the care relationship, even in the case of privately-employed caregivers.<sup>175</sup> The principles are similar in both cases: Courts support the firefighter's rule in part because the tort system ought not to discourage the public from calling firefighters for fear of exposing themselves to liability. By analogy, courts should not let the tort system discourage people with mental disabilities from seeking appropriate care relationships for fear of subjecting themselves to large tort judgments. Society as a whole benefits from

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173. See, e.g., *Young v. Sherwin-Williams Co.*, 569 A.2d 1173 (D.C. App. 1990); *England v. Tasker*, 529 A.2d 938 (N.H. 1987); *Zanghi v. Niagara Frontier Transp. Comm'n*, 649 N.E.2d 1167 (N.Y. 1995); *Maltman v. Saver*, 530 P.2d 254 (Wash. 1975). *But cf.* *Boyer v. Anchor Disposal*, 638 A.2d 135 (N.J. 1994) (recognizing abrogation of the firefighter's rule by statute).

174. The particular defendants in these cases tend to be Alzheimer's patients. Perhaps the public insurance scheme could insure against the risk that any member of the public could one day suffer from senile dementia.

175. This distinction between public and private employees, if imported into the care context, would run the risk of creating perverse incentives for caregivers to choose state employers rather than private employers. Courts, too, might find no duty in state settings where plaintiffs would be compensated, but might impose a duty in private settings where plaintiffs would not be compensated. However, the fact that such a public fund to compensate injured workers exists is enough to demonstrate that such a system could cover private, as well as public, safety employees.

ensuring that mentally disabled individuals seek and receive appropriate care.

## VI. CONCLUSION

This Note has argued that courts' continued and unquestioning reliance upon the logic of confinement reflects an outmoded understanding of the proper place of the mentally disabled in society. In order to avoid providing the wrong incentives to confine the mentally disabled when this may not be in an individual's best interest, courts should focus upon a duty-of-care analysis that recognizes the special importance of the patient-caregiver relationship. At the same time, a tension exists between a no-duty rule that avoids the logic of confinement and the need to be fair to caregivers who deserve compensation for their injuries. This Note has articulated several possible solutions. Each is imperfect. But each attempts to ensure that all parties seek appropriate care relationships—without relying upon a logic of confinement. Tort law should not impose unnecessary burdens upon the mentally disabled who seek appropriate and necessary care.