No Physician-Patient Relationship Means No Duty, Right?

Warning: Get a Second Opinion

By Tracy L. Zuckett and Rachel E. Ryckman

A duty of care may be owed by a physician to someone even without a formal physician-patient relationship

The phone rings. It is Dr. E. Mergency, a former medical school classmate calling your client, Dr. Bones, a private practice pediatric orthopedic surgeon. Dr. E. Mergency has a four-year-old patient in his rural community hospital emergency room presenting with a spiral fracture of the humerus. There are no pediatric orthopedists on staff or on call at Dr. E. Mergency's hospital. Therefore, Dr. E. Mergency wants to discuss with your client the best method for immobilizing the fracture. Dr. Bones advises using a splint rather than a cast to allow room for swelling. The conversation ends after two minutes. Your client has this one-time, brief conversation with Dr. E. Mergency and nothing more. Your client does not have privileges to treat patients at the hospital where Dr. E. Mergency practices. Your client never observed or examined the patient, never performed an orthopedic consultation, and never reviewed the patient's medical record. Your client never interacted directly with the patient or the patient's parents. The patient develops a pressure ulcer as a result of the splint. The patient's parents subsequently sue the hospital and Dr. E. Mergency for medical malpractice, alleging that the fracture was improperly splinted. In discovery they learn of Dr. E. Mergency's telephone call to Dr. Bones and amend their complaint to include claims against your client, Dr. Bones.

You conclude that there is no physician-patient relationship between your client, Dr. Bones, and the plaintiff since she did not examine the patient. So that is the end of the inquiry, right? Wrong. A duty of care may be owed by a physician to someone even without a formal physician-patient relationship. Gone are the days of a clearly demarcated physician-patient relationship. E-health, telemedicine, and multidisciplinary approaches to enhanced patient care have contributed to an amorphous physician-patient relationship that is not uniformly defined in every situation. Further, courts across the country are finding general duties of care apply to a physician even when he or she does not have a conventional relationship with a patient.

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This article explores circumstances under which courts have determined that a physician owed a duty sufficient to support a negligence claim against that physician despite the absence of a clearly defined physician-patient relationship and offers suggestions to attorneys who are evaluating when a physician has those duties and providing a defense against the application of the duties to their clients.

Physician-Patient Relationship

The first inquiry of the duty analysis is whether there is a discernable physician-patient relationship. There is generally no common law duty of a physician to an injured party without a physician-patient relationship between the two parties. A physician's liability to a patient is traditionally predicated on the existence of a relationship with the patient. Louisell and Williams, 1-8 *Medical Malpractice*, Matthew Bender (2014) §8.03. If a physician-patient relationship exists, then the physician has a duty to exercise the degree of care, knowledge, and skill exercised by similarly situated providers.

A consensual relationship between a physician and his or her patient is easy to identify, and practitioners are probably most familiar with this type of relationship. This type of relationship is at least quasi-contractual in nature and is created when a patient knowingly seeks a physician's professional services, the physician agrees to treat the patient, and the patient consents to have medical care provided. Louisell and Williams, 1-8 *Medical Malpractice*, Matthew Bender (2014) §8.03[2][a]. Mutual consent between a physician and a patient, or a patient's surrogate, is the medium by which a physician serves a patient's needs. Am. Med. Ass'n Code of Medical Ethics, Op. 10.015—The Patient-Physician Relationship. The existence of a physician's duty arises from the professional relationship between a physician and his or her patient.

The identification of a duty of care owed by a physician is simple when a clear physician-patient relationship exists. The physician-patient relationship triggers the duty of care. The challenge of applying the duty principles arises where there is not a clearly defined physician-patient relationship. Therefore, even if you have determined that no formal physician-patient relationship exists, you must further explore whether there is an implied physician-patient relationship or a general duty of care that may be imposed on your client.

Implied Physician-Patient Relationship

The absence of a formal physician-patient relationship does not necessarily eliminate a duty of care to a patient. The requirement of a formal relationship has been quietly eroding in some jurisdictions. *Stanley v. McCarver,* 92 P.3d 849 (Ariz. 2004) (recognizing that absent an express agreement to enter a physician-patient relationship, the law may imply a relationship based on conduct that demonstrates consent to the relationship when public policy or other factors warrant a duty); *Sterling v. Johns Hopkins Hosp.*, 802 A.2d 440, 455 (Md. Ct. Spec. App. 2002), *cert. denied*, 808 A.2d 808 (Md. 2002) ("A physician-patient relationship may arise by implication where the doctor takes affirmative action to participate in the care and treatment of a patient").

One situation in which courts have found an implied relationship and therefore a duty has been when a treating physician has consulted another physician, often a specialist, regarding the care and treatment of a patient. It is common for physicians to call on a colleague in the medical profession to discuss an aspect of the care or treatment of a patient and to ask for advice. Several courts have found that no relationship existed between a consulted physician and another physician's patient, and therefore no duty, but warned that in some circumstances an implied physician-patient relationship could exist. *Irvin v. Smith,* 31 P.3d 934, 941 (Kan. 2001) ("an implied physician-patient relationship may be found where a physician gives advice to a patient by communicating the advice through another health care professional") (internal citation omitted)); *Oja v. Kin*, 581 N.W.2d 739, 743 (Mich. Ct. App. 1998) ("merely listening to another physician's description of a patient's problem and offering a professional opinion regarding the proper course of treatment is not enough" to create a physician-patient relationship, but a doctor who "receives a description of a patient's condition and then essentially directs the course of that patient's treatment, has consented to a physician-patient relationship"); *Corbet v. McKinney*, 980 S.W.2d 166, 169 (Mo. Ct. App. 1998) (finding that the liability of a physician who is consulted by a patient's treating or family physician generally depends on indicia of consent, including "whether the physician undertakes to examine, diagnose, or treat the patient, or merely undertakes to advise the patient's treating physician as to general patient care" (internal citation omitted)).

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Generally, a court will not find a physician-patient relationship if the consulted physician was not on call or otherwise associated with the hospital, the treating physician, or the patient involved. However, a physician's on-call status alone is insufficient to warrant a finding that the physician impliedly consented to a physician-patient relationship. *McKinney v. Schlatter*, 692 N.E.2d 1045 (Ohio Ct. App. 1997). Courts will also look for indicia of affirmative conduct by a physician that is related to a patient, such as participating in the diagnosis of the patient's condition or prescribing a course of treatment. *Mead v. Legacy Health Sys.*, 283 P.3d 904 (Or. Ct. App. 2012).

An implied physician-patient relationship may also arise when a physician has a supervisory role over other physicians. This type of relationship typically exists in teaching hospitals where fellows and residents provide care under the supervision of attending physicians who are employed by the hospital. In this context, a supervi-

sor likely owes a duty of care to a patient by virtue of a resident's or a fellow's relationship with the patient.

The courts in the cases referenced here, and in similar cases, conducted a fact-based analysis to determine whether an implied physician-patient relationship existed when a patient's only contact with a particular physician was through the patient's treating physician. While determining whether a duty exists is a question of law for a court to decide, informal physician-to-physician consultation case outcomes depend on the facts. Therefore, obtaining summary judgment on these grounds is difficult absent clear, undisputed facts.

Multiple jurisdictions have adopted the voluntary undertaking doctrine as a framework for imposing a duty of reasonable care on an individual who affirmatively undertakes to render services to another.

General Duty Without a Physician-Patient Relationship

Even without a physician-patient relationship, whether expressed or implied, a doctor may owe a duty of care in connection with his or her professional activities. Multiple jurisdictions have adopted the voluntary undertaking doctrine as a framework for imposing a duty of reasonable care on an individual who affirmatively undertakes to render services to another. *Restatement (Second) of Torts* §§323 and 324A.

Section 323 of the Restatement (Second) of Torts states:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if:
>
> (a) his failure to exercise such care increases the risk of such harm; or
>
> (b) the harm is suffered because of the other's reliance upon the undertaking.

Restatement (Second) of Torts §323 (1965); *see also* Restatement (Second) of Torts §324A (1965) (liability to third person for negligent performance of undertaking).

In general, courts evaluate the risk involved, the foreseeability and the likelihood of injury, the social utility of the actor's conduct, the magnitude of the burden guarding against injury or harm, and the consequences of placing the burden upon the actor. *See, e.g., Greenberg v. Perkins*, 845 P.2d 530 (Colo. 1993); W. Prosser & W. Keeton, The Law of Torts §53 at 359 n.24 (5th ed. 1984); 57A Am. Jur. 2d Negligence §87. The factors analyzed to determine whether to impose a duty vary by jurisdiction, however.

We highlight below five scenarios in which courts have found that a physician had a general duty of care without undertaking a formal physician-patient relationship. These scenarios do not exhaust the possibilities. Other scenarios exist under which a court may find a physician has a general duty of care.

The first two scenarios involve situations in which the physician had direct interaction with the patient, albeit outside a physician-patient relationship. The third scenario involves a tangential relationship between a physician and the plaintiff, through a family member patient of the physician. The final two scenarios involve situations in which there was absolutely no connection between the physician and the patient.

Scenario 1: The Authorized Examination

An examination by a physician retained by a third party—an insurer or an employer, for example—to examine an individual does not automatically generate a physician-patient relationship. However, a physician may owe a duty to the patient for negligence in conducting the examination and preparing the examination report. A physician performing an independent examination may also owe a duty to an examinee to diagnose the examinee correctly. *Lambley v. Kameny*, 682 N.E.2d 907 (Mass. App. Ct. 1997) (finding that despite the absence of a formal doctor-patient relationship, a job applicant's tort claim against a psychiatrist who erroneously diagnosed him and caused him to be passed over for a job, fell within jurisdiction of medical malpractice tribunal because a duty of reasonable care is imposed on the examining physician). The duty of an independent examiner may also extend to third parties. *Wharton Transp. Corp. v. Bridges*, 606 S.W.2d 521, 526 (Tenn. 1980) (physician owed duty to third party injured by disabled truck driver's negligence, where the physician was negligent both in his physical examination and certification of the truck driver for the employer).

Scenario 2: The Misfeasor

A physician *is generally not* liable for a failure to detect conditions about which he or she has no reason to know or to inquire. However, an examining physician may not increase the risk of foreseeable harm to the examinee. Similar to Scenario 1, above, but with its own unique circumstances, is *Greenberg v. Perkins*, 845 P.2d 530, 533 (Colo. 1993), in which the Colorado Supreme Court found a duty to act with reasonable care outside the physician-patient relationship. A party in an underlying bus accident case retained a physician to conduct an independent medical examination (IME) related to the plaintiff's reported neck and arm problems from the accident. The examining physician obtained a medical history learning of the plaintiff's history of back problems, four previous lower back surgeries, and current neck and arm complaints but prescribed a functional capacity evaluation, which included strength and range of motion testing. The physical therapist contacted the examining physician with concerns that the ordered testing would aggravate the plaintiff's lower back problems but was instructed to proceed. After the testing, the plaintiff experienced pain in her lower back that required surgery.

The *Greenberg* court noted a recognized distinction in the law between "misfeasance," an affirmative action that creates a new risk of harm, and "nonfeasance," a non-action that does not worsen a plain-

tiff's situation. 845 P.2d at 537. The court acknowledged that an examining physician is only required to exercise reasonable care when referring an examinee for additional tests. However, the court concluded that the examining physician referred the examinee for testing that would foreseeably result in injury. Therefore, despite no physician-patient relationship, the court imposed a general duty of care on the examining physician.

Scenario 3: The Failure to Warn

We will consider three distinct types of failure-to-warn scenarios, one involving a contagious infection, one involving a genetic disposition, and one involving a history of illness or previous treatment.

Contagious Infection

In the case of a patient with an infectious disease, physicians may be liable for a failure to warn a patient's family member of the nature and risks of infection. A physician-patient relationship can trigger an affirmative duty to warn identifiable third persons in the patient's immediate family against foreseeable risks emanating from the patient's illness. This is despite the fact that the physician does not have a direct physician-patient relationship with the patient's family members. *See, e.g.,* Bateman, *Annotation, Liability of Doctor or Other Health Practitioner to Third Party Contracting Contagious Disease from Doctor's Patient*, 3 A.L.R.5th 370 (1992); 61 Am.Jur.2d Physicians and Surgeons §245 (1981); 70 C.J.S. Physicians and Surgeons §88 (1987); *Jones v. Stanko*, 160 N.E. 456, 458 (Ohio 1928) (finding the physician liable for injuries incurred by third person who contracted smallpox as result of physician's failure to warn).

Similarly, a physician who fails to diagnose a communicable disease in a patient may be liable to third parties who contract the disease from that patient. *Shepard v. Redford Comm'y Hosp.*, 390 N.W.2d 239, 241 (Mich. Ct. App. 1986), *appeal denied*, 430 N.W.2d 458 (Mich. 1988) (determining that a physician who failed to diagnose spinal meningitis in a patient owed a duty of reasonable care to the patient's child, a foreseeable victim of physician's conduct, who became infected and died of spinal meningitis).

Genetic Disposition

A physician's duty may extend beyond the interests of a patient to members of the immediate family of the patient who may be adversely affected by a breach of that duty, because it is foreseeable that an injury to one family member may affect other family members. *Schroeder v. Perkel*, 432 A.2d 834, 839 (N.J. 1981). In *Schroeder*, a physician diagnosed plaintiffs' four-year-old daughter with cystic fibrosis. The plaintiff parents were also tested and informed that they carried the cystic fibrosis gene. Plaintiff mother was eight months pregnant at the time of the diagnosis, and her baby was born with cystic fibrosis. The court determined that the pediatricians who failed to diagnose timely the cystic fibrosis in the plaintiffs' first child which could have enabled them to avoid the second pregnancy, had a duty not just to the first child, but also to her parents and younger sibling. The court predicted that plaintiffs could have avoided the second pregnancy had they been fully informed of the diagnosis. *Id.* at 839.

Similarly, in *Pate v. Threlkel*, 661 So.2d 278 (Fla. 1995), a physician performed surgery on a patient to treat medullary thyroid carcinoma, a genetically inherited condition. The daughter of the patient argued that the physician owed a duty to warn her mother to have her children tested, and had he warned her, the daughter would have been diagnosed early enough to treat and cure the cancer she inherited from her mother. Upon certified question, the Florida Supreme Court held that a physician owes a duty of care to a patient's children to warn the patient of the genetically transferrable nature of a condition for which the physician is treating the patient, assuming that the standard of care requires such a warning given the circumstances of the case.

History of Illness or Previous Treatment

In another Florida case, *Torres v. Sarasota Pub. Hosp. Bd.*, 961 So.2d 340 (Fla. App. Dist. Ct. 2007), a mother brought a medical malpractice action on behalf of her son against an obstetrician who was involved in the birth of the child's older sibling, but had no involvement in the son's birth. The previous delivery involved birth trauma resulting in Erb's palsy, but the defendant physician from the first delivery did not document the complications and did not inform the mother of the complications or instruct her to provide the information to subsequent obstetricians. Recognizing that no physician-patient relationship existed between the defendant physician and the plaintiff's unborn son, the court found the foreseeability of harm to future children was enough to support imposing a duty on the previous obstetrician to document complications properly.

An examining physician may not increase the risk of foreseeable harm to the examinee.

Another good example of courts imposing a duty for pre-conception actions lies in cases alleging a physician's failure to give a mother Rh immune globulin following the birth of a child, resulting in injuries to subsequent children. *See, e.g., Lynch v. Scheininger*, 744 A.2d 113 (N.J. 2000); *Lough v. Rolla Women's Clinic, Inc.*, 866 S.W.2d 851 (Mo. 1993); *Walker v. Rinck*, 604 N.E.2d 591 (Ind. 1992). Again, the primary basis for imposing the duty in these cases was the foreseeability of harm to future born children based on the relationship of the mother and physician.

Scenario 4: The Supervisor

Distinct from the situation explained above in which an implied physician-patient relationship may exist in a training hospital is a situation in which a hospital with a resident training program contracts with a private physicians group to provide on-call availability for supervisory services, but the supervising physician never interacts with the patient nor provides instruction to the resident.

In *Mozingo v. Pitt County Mem. Hosp., Inc.*, 101 N.C. App. 578 (N.C. Ct. App. 1991), the hospital was a teaching hospital for the local medical school and had an obstetrics residency program. The medical school contracted with a private obstetrical group that employed the defendant physician. The contract allowed the supervising physicians to provide supervision from home

during "on-call" hours as long as they were immediately available by telephone to respond to requests for assistance regarding obstetric patients admitted to the hospital. The defendant physician received a call from a resident during a delivery of a patient with concerns for shoulder dystocia. The defendant physician, who lived only two miles from the hospital, immediately went to the hospital, but the baby was delivered before he arrived. The *Monzingo* court found no physician-patient relationship and reversed summary judgment for the defendant physician. The court determined that a factual question existed regarding whether the defendant physician owed the injured child a duty of care arising from his supervisory role over the resident who delivered the child. The court reached this conclusion despite the fact that the defendant physician had never treated the mother, did not give any instructions for treatment or make a diagnosis over the phone, and was not present for the delivery.

If there is not a discernable physician-patient relationship, then evaluate whether a general duty of care may be imposed.

Scenario 5: The Disconnected

Another scenario under which a general duty of care may arise is when the physician and the patient have no direct association. For example, in *Meena v. Willburn*, 603 So.2d 866, 867–68 (Miss. 1992), a treating physician asked his partner to remove the surgical staples from one of his patients while he was away. The nontreating physician assumed the care and treatment of the treating physician's patient. However, the defendant physician, the partner, directed a nurse to remove the surgical staples from the wrong patient, resulting in significant health problems for that patient. The defendant physician argued that the plaintiff could not maintain a negligence action against him as a result of the absence of a physician-patient relationship. But, the *Meena* court held that the presence or absence of a physician-patient relationship is simply one factor to consider when determining the type or nature of duty owed, if any, to an injured patient or someone else. Therefore, the court upheld the jury's verdict for the plaintiff, concluding that the absence of a physician-patient relationship was not fatal to the negligence action against the physician.

Factors That Courts Consider

The cases in these scenarios focus primarily on the foreseeability of harm to support a finding that a physician owed a duty of care to a plaintiff. However, there are other factors to evaluate or to consider in the analysis. *HealthONE v. Rodriguez*, 50 P.3d 879 (Colo. 2000) provides a good example of the consideration of these additional factors.In *HealthONE*, the defendant physician performed a nerve block on his own patient and left a partially used vial of the nerve block agent on the cart in violation of HealthONE's policies requiring unused portions of medications to be discarded. Three weeks later, a different physician performed an intravenous nerve block on a different patient, the plaintiff and inadvertently used the leftover vial, which was packaged identically to the intended vial. The leftover medication was toxic if used intravenously and caused severe damage to the plaintiff's arm. The plaintiff sued the physician who left the partially used vial on the cart.

As in many of the other cases discussed in this article the court in *HealthONE* discussed foreseeability, but it also evaluated the risk of harm, the social utility of the defendant's actions, and the burden of placing a duty upon him. For example, the court found that there was great risk of injury in leaving an extremely caustic medication on the cart that was packaged identically to other medications on the cart. The court then compared the social utility of maintaining the unused medication—a cost savings of four dollars per bottle—to the burden to the defendant to guard against the injury by throwing away the unused medication as the facility policy required and concluded that the balance tipped in favor of imposing a duty on the defendant physician.

Practice Pointers and Other Considerations

Whether a physician's conduct will give rise to a duty of care to a patient is a two-fold inquiry. First, determine whether there is a physician-patient relationship, either expressed or implied. If there is not a discernable physician-patient relationship, then evaluate whether a general duty of care may be imposed. Closely examine each of the factors that your jurisdiction applies in determining whether one owes a duty of care to another. A court will examine the facts and circumstances of each case independently to determine whether a duty of care exists because "the scope of the physician's duty of care to a nonpatient… raises difficult issues that should be resolved in the context of each individual case presenting such issues." *HealthONE*, 50 P.3d at 890. Therefore, be prepared to address as many of the factors as possible in your case.

In addition to identifying the evidence in your case that will support the argument for not imposing a duty, you should also evaluate potential policy arguments associated with providing medical care, particularly in scenarios involving informal consultation. Imposing a duty on a doctor for receiving a call from a former medical school classmate to discuss one of the former classmate's medical cases as described in the scenario with which we opened this article would discourage doctors from consulting one another and benefitting from the experience of others. Doctors have a responsibility to "pursue continually the acquisition of new knowledge by reading, attending conferences and courses, and consulting colleagues." *Winfield v. Brandon HMA, Inc.*, 100 So.3d 974, 981 (Miss. Ct. App. 2012) (quoting *Scafide v. Bazzone*, 962 So.2d 585, 593 (Miss. Ct. App. 2006); Steven E. Pegalis, *American Law of Medical Malpractice* 3D, 204 (2005)). Public policy encourages conversations among colleagues, and imposing liability for these conversations would "discourage doctors from giving informal advice, which in turn would decrease the occasions in which doctors would uphold this beneficial professional standard of seeking the advice." *Id.*

Finally, you should also consider advising clients prospectively about the types of situations in which they can be sued for medical malpractice even when they do not have a traditional, formal physician-patient relationship with patients. Many physicians believe that without an expressed physician-patient relationship, there are no bases for malpractice lawsuits against them. This is particularly true in the case of informal consultations. Advise your clients of the factors evaluated by the courts in determining whether to impose a duty and discuss the importance of recognizing conduct that crosses the line between merely advising a colleague regarding aspects of general patient care and specifically interjecting oneself in the diagnosis or treatment of another physician's patient.

Another consideration in these situations is whether your client should document his or her informal involvement. Most likely, because a physician does not equate informal involvement with treatment, he or she will not document the involvement. Instead, when the doctor is sued, typically a few years later, the physician has to rely on his or her memory, if any, of a single telephone call or passing conversation about the patient because the doctor's involvement ended there. Given the fact-driven analysis used to determine if a physician took affirmative action to participate in the care and the treatment of a patient, not having documentation can complicate the defense of a physician arguing that he or she did not undertake to examine, diagnose, or treat the patient. On the other hand, if the treating physician documents the consultation but does so inaccurately or incompletely, this can put the consulted physician who did not actually treat the patient in the difficult position of disputing the extent or nature of the consultation.

Of course, on the opposite side of that coin someone could argue that documenting the physician's informal involvement may create the appearance that the physician consented to a physician-patient relationship. Additionally, given the number of informal discussions that medical providers have each day, documenting each discussion can become an onerous task and create other issues related to storing and later accessing the documentation.

If a physician chooses to document instances when he or she informally consulted with other treating doctors, the documentation should contain a complete list of the information provided by the treating physician. The documentation should further include information about the consultation's limits and parameters, pointing out, for example, that the consulted doctor did not review imaging studies or lab results. Most importantly, the documentation should make clear the limited role of the consulted physician, perhaps even containing a disclaimer that by discussing the patient with the treating physician, the consulted physician has not consented to a physician-patient relationship with the treating physician's patient.

Conclusion

In the case of Dr. Bones and Dr. E. Mergency, mentioned at the beginning of this article, does Dr. Bones owe a duty of care to the plaintiff? Dr. Bones was not on-call or even on the staff of the hospital, and she did not assist in the patient's diagnosis. However, Dr. Bones arguably participated in the patient's treatment when she suggested the proper method for immobilizing the type of fracture described by Dr. E. Mergency. Under this scenario, Dr. Bones likely has enough evidence that she merely advised a colleague regarding aspects of general patient care to defeat the imposition of a duty. However, if Dr. Bones had received and reviewed x-rays through telemedicine or instructed Dr. E. Mergency in the specific manner of splint placement, the answer could differ.

The moral of the Dr. Bones story is not to end your inquiry with determining whether or not a traditional physician-patient relationship existed. Become familiar with the factors evaluated by your jurisdiction for the duty analysis and prepare to analyze each factor within the framework of your case. FD