ACTION, AFFILIATION, AND A DUTY OF CARE: PHYSICIANS' LIABILITY IN NONTRADITIONAL SETTINGS

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As healthcare delivery options drastically expand and change, patients and physicians continue to interact in unique ways. These interactions have become more complex and unconventional, challenging courts to establish whether a duty of care exists between the physician and patient in these new situations. Courts that answer this duty question affirmatively do so either by applying a more capacious understanding of the traditional physician-patient relationship or by deeming foreseeability of harm and reliance sufficient under certain circumstances, even in the absence of an actual physician-patient relationship.

This Note investigates this unresolved duty question in two contexts: curbside consultations—when a physician is informally consulted by a peer physician to give advice on a case—and when on-call physicians make healthcare decisions without directly contacting the patient. This Note argues that in the context of curbside consultations, courts should find that providing advice alone is insufficient to create a duty of care unless there is an affirmative act associated with it. In the context of on-call physicians, a physician's on-call status alone should be insufficient to create a duty of care unless there is a significant degree of affiliation between the on-call physician and the patient's case.

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INTRODUCTION

In 2014, Susan Warren arrived at a healthcare clinic complaining of abdominal pain, a fever, and chills.[1] Sherry Simon, a nurse practitioner, promptly ordered a battery of tests, which demonstrated that Ms. Warren had an unusually high level of white blood cells.[2] Nurse Simon suspected that Ms. Warren had an infection that required hospitalization and, therefore, she began the process of admitting her to a local hospital.[3] Per protocol, Nurse Simon contacted the local hospital and spoke with an on-call hospitalist, Dr. Richard Dinter, who determined—without personally examining Ms. Warren—that she was just suffering from diabetes and did not need to be admitted.[4] Three days later, Ms. Warren died from sepsis caused by an untreated staph infection.[5]

This case was not unusual.[6] Today, patients receive healthcare in a myriad of ways, such as through direct physician-patient interactions, telemedicine, outpatient facilities, or as a result of consultations and referrals between physicians.[7] Situations like those just described present a unique question that remains largely unanswered: When can a patient who did not directly seek care from a physician in a traditional health care encounter bring a viable claim against that physician? More specifically, do physicians owe a duty of care to these nontraditional patients, entitling them to damages resulting from negligence or medical malpractice claims?[8]

This question requires an investigation into the fundamentals of negligence law. Historically, many courts would not have found Dr. Dinter liable for Ms. Warren's death due to the absence of a traditional physician-patient relationship.[9] However, courts today engage in a more nuanced analysis of whether Dr. Dinter owes a duty of care to those such as Ms. Warren. They ask not only whether a nontraditional physician-patient relationship existed[10] but also whether, despite the absence of such a relationship, a duty of care existed on the basis of an undertaking, the creation of risk, foreseeability, or as matter of public policy.[11]

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1. Warren v. Dinter, 926 N.W.2d 370, 372 (Minn. 2019).

2. *Id.* A high white blood cell count can indicate a multitude of physiological conditions, including, but not limited to, the presence of an infection. *High White Blood Cell Count*, MAYO CLINIC (Nov. 30, 2018), https://www.mayoclinic.org/symptoms/high-white-blood-cell-count/basics/causes/sym-20050611 [https://perma.cc/4L26-SSRE].

3. *Warren*, 926 N.W.2d at 372.

4. *Id.* at 372–73.

5. *Id.* at 373.

6. *See infra* Part I.B.2.

7. *See infra* Part I.B.2.

8. *See infra* Part I.A.1. This Note refers to individuals bringing lawsuits based on care received indirectly or through a nontraditional interaction as nontraditional patients.

9. *See infra* Part I.B.1. For a definition of a traditional physician-patient relationship, see *infra* notes 45–47 and accompanying text.

10. *See infra* Part I.A.2.

11. *See infra* Part I.A.3.

This Note will examine the divergent approaches courts use to analyze the duty element in two scenarios in our modern health care system: when physicians engage in curbside consultations and when on-call physicians make decisions that affect patients they have never personally treated.[12] During curbside consultations, a treating physician contacts another physician informally to gain an opinion or recommendation on a patient's case.[13] In such scenarios, however, it is unclear whether providing advice can create a duty of care.[14] Similarly, when a physician is on call, there are certain expectations and obligations that follow.[15] However, it is unclear if and when they may owe a duty of care to patients when they are not physically present, are unreachable, or are supervising other healthcare professionals.[16] These unique situations challenge traditional tort law and have led to a nonuniform duty analysis among courts.[17]

This Note strives to clarify the doctrinal, practical, and policy decisions courts make in determining whether a physician owes a duty of care to a nontraditional patient. Based on the case law for curbside consultations and on-call situations and the basic principles and policies of tort law, this Note argues that courts should formulate a clear legal rule that balances the expectations of physicians and the interests of patients.[18] For curbside consultations, courts should find a duty of care only if there is an affirmative act associated with the provision of advice.[19] In the context of on-call physicians, a physician's on-call status alone should be insufficient to create a duty of care unless there is a significant degree of affiliation between the on-call physician and the patient's case.[20] Thus, in either scenario, foreseeability alone should not create a duty of care.

This Note is divided into three parts. Part I discusses the requirements, qualifications, and exceptions to the duty element in medical malpractice and negligence cases, along with current and historical approaches to these cases. Part II establishes the conflict among courts on the issue of whether there is a duty of care in the context of curbside consultations and on-call physicians. Finally, Part III proposes the creation of a clear legal rule, whereby courts look to either the presence of an affirmative act for a curbside consultation case or the degree of affiliation for a case involving an on-call physician. If these factors are not present, courts should not find a duty of care.

12. *See infra* Part II.

13. *Curbside Consultations*, PSYCHIATRY(EDGMONT), May 2010, at 51, 51 (stating that physicians generally view curbside consultations as low-risk and distinctly different from ordinary physician-patient interactions).

14. *See infra* Part II.A.

15. *See infra* Part II.B.

16. *See infra* Part II.B.

17. *See infra* Part II.

18. *See infra* Part III.B.

19. *See infra* Part III.B.

20. *See infra* Part III.B.

I. THE EVOLUTION OF THE DUTY ELEMENT

While the duty element in many negligence cases is easily established, there remains a set of negligence claims in which the duty question is harder to answer. One such example is when a nontraditional patient sues a healthcare professional for care that was indirectly received.[21] In these cases, defendants commonly argue there is no valid claim against them because there was no duty of care.[22] Two issues that raise these unique duty questions are curbside consultations and when physicians are on call.[23]

Physicians and patients traditionally interact in direct care settings. In a typical scenario, a patient: (1) makes an appointment or is referred to a physician; (2) is then diagnosed, treated, medicated, or operated on by the physician; and (3) is ultimately billed by the physician for the services provided. Sometimes, the patient may suffer from an injury due to a wrongful diagnosis, improper treatment, or failure of the physician to provide an essential service. In these situations, it is often obvious that the physician owed a duty of care to the patient, either because there was a clear physician-patient relationship or because it was foreseeable that the care could harm the patient if provided negligently.[24]

Not all claims against physicians arise out of direct care. Increasingly, physicians influence the care a patient receives through nontraditional interactions. They may perform curbside consultations when contacted by a colleague for an informal consult.[25] They may be affiliated with or provide supervision to nurses, residents, or other physicians.[26] Physicians may also perform independent medical examinations at the request of a third party.[27] Based on these circumstances, nontraditional patients may be inclined to sue these physicians for the indirect care provided to them if they are allegedly harmed. But, whether a duty of care exists between physicians and nontraditional patients is resoundingly unclear.[28] Thus, this section provides legal background on how courts have historically dealt with determining whether the physician owes a duty of care to a patient in a nontraditional health care setting.

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21. *See* Mead v. Legacy Health Sys., 283 P.3d 904, 909 (Or. 2012) (en banc).

22. *See, e.g.*, Reynolds v. Decatur Mem'l Hosp., 660 N.E.2d 235, 238–39 (Ill. App. Ct. 1996); Irvin v. Smith, 31 P.3d 934, 940 (Kan. 2001). *See generally* Hill *ex rel*. Burston v. Kokosky, 463 N.W.2d 265 (Mich. Ct. App. 1990); Warren v. Dinter, 926 N.W.2d 370 (Minn. 2019).

23. *See infra* Part II.

24. *See Mead*, 283 P.3d at 909 ("When a patient goes to a doctor's office and the doctor examines the patient, ordinarily no one disputes that an implied agreement to provide medical care has been formed and that consequently an implied physician-patient relationship arises.").

25. *See infra* Part I.C.1.

26. *See infra* Part I.C.2.

27. *See infra* note 68 and accompanying text.

28. *See infra* Part I.A.

A. The Hurdle: Establishing a Duty of Care

Patients alleging injuries negligently[29] caused by their physicians typically bring medical malpractice claims.[30] Originally a contract action, medical malpractice is now considered a subset of negligence law.[31] Therefore, a medical malpractice claim requires: (1) a duty of care owed by the defendant to the plaintiff, (2) a breach of that duty, (3) an injury, and (4) actual and proximate causation.[32]

The requirements for medical malpractice claims differ from ordinary negligence actions because of the specialized skills and expertise that physicians possess.[33] Thus, "conduct may be deemed malpractice, rather than negligence, when it 'constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician.'"[34] For example, expert testimony is necessary in medical malpractice cases to determine whether a breach occurred due to physicians' unique skills, which laypersons do not ordinarily possess.[35] More significantly, the duty element in medical malpractice claims often requires the showing of a physician-patient relationship.[36] For a nontraditional patient to bring a viable claim against a physician, the patient must first establish that a duty of care existed.[37]

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29. Sharon M. Glenn, Note, *Liability in the Absence of a Traditional Physician-Patient Relationship: What Every "On Call" Doctor Should Know:* Mozingo v. Pitt County Memorial Hospital, 28 WAKE FOREST L. REV. 747, 752 (1993).

30. *See* Patrick D. Blake, Note, *Redefining Physicians' Duties: An Argument for Eliminating the Physician-Patient Relationship Requirement in Actions for Medical Malpractice*, 40 GA. L. REV. 573, 575 (2006).

31. Glenn, *supra* note 29, at 752; *see* J. Gregory Lennon, Comment, *Easing the Medical Malpractice Crisis: Restricting the Creation of Duty Through an Implied Doctor-Patient Relationship*, 7 J. HEALTH CARE L. & POL'Y 363, 364 (2004) ("Originally, 'medical malpractice was recognized as a legal wrong before the rise of negligence as a separate tort and the development of modern contract principles,' but today it is somewhat of a hybrid of contract and tort theories." (quoting Corbet v. McKinney, 980 S.W.2d 166, 169 (Mo. Ct. App. 1998))).

32. Jennings v. Badgett, 230 P.3d 861, 865 (Okla. 2010).

33. *See* Gilinsky v. Indelicato, 894 F. Supp. 86, 94 (E.D.N.Y. 1995) ("[T]he theory of simple negligence does not require the existence of a physician-patient relationship.").

34. Scott v. Uljanov, 541 N.E.2d 398, 399 (N.Y. 1989) (quoting Bleiler v. Bodnar, 479 N.E.2d 230, 234 (N.Y. 1985)).

35. Blake, *supra* note 30, at 576 ("Imposing this different, and usually heightened, standard of care on physicians is grounded in the assumption that the public relies upon and trusts physicians' opinions to a greater degree than they do nonphysicians' opinions because physicians have technical expertise that is not easily comprehended by the general public.").

36. *See* Reynolds v. Decatur Mem'l Hosp., 660 N.E.2d 235, 238–39 (Ill. App. Ct. 1996); Irvin v. Smith, 31 P.3d 934, 940 (Kan. 2001); Hill *ex rel.* Burston v. Kokosky, 463 N.W.2d 265, 266 (Mich. Ct. App. 1990).

37. JOHN C. P. GOLDBERG ET AL., TORT LAW: RESPONSIBILITY AND REDRESS 74–76 (4th ed. 2016).

1. The Rule: A Physician-Patient Relationship

Many states require the patient to establish the existence of a physician-patient relationship in medical malpractice actions.[38] A physician-patient relationship is a consensual relationship whereby a patient "knowingly seeks the assistance of the physician and the physician knowingly accepts [them] as a patient."[39] This relationship is either express or implied.[40]

The physician-patient relationship is traditionally formed when the physician acts for the benefit of the patient or with the patient's express or implied consent.[41] The professional duty of a physician is "to bring skill and care to the amelioration of the condition" of the patient and this duty "has its foundation in public considerations that are inseparable from the nature and exercise of his calling."[42] This is a fiduciary relationship based on "the notion that the physician is learned, skillful, and experienced in an area of which the patient knows little, but which is of the most vital importance to him."[43] But this duty is limited to injuries inflicted within the scope of the professional relationship.[44]

The traditional definition of a physician-patient relationship often does not encompass nontraditional interactions between physicians and patients, including care given by on-call physicians and curbside consultations.[45] Despite suffering serious injuries, plaintiffs may be unable to seek redress from these physicians because they cannot satisfy the duty element as traditionally conceived.[46] Courts that recognize such claims more carefully assess whether they should deviate from their traditional understanding of a physician-patient relationship or find a duty of care notwithstanding the lack of such a physician-patient relationship.[47]

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38. *See supra* note 36.

39. Kim Baker, *United States: A Doctor's Legal Duty—Erosion of the Curbside Consultant*, MONDAQ (Nov. 5, 2003), https://www.mondaq.com/unitedstates/professional-negligence/23193/a-doctors-legal-dutyerosion-of-the-curbside-consultant [https://perma.cc/G8PT-HD3G].

40. *Id.*

41. Adams v. Via Christi Reg'l Med. Ctr., 19 P.3d 132, 140 (Kan. 2001); Kelley v. Middle Tenn. Emergency Physicians, P.C., 133 S.W.3d 587, 593 (Tenn. 2004).

42. Lennon, *supra* note 31, at 365 (quoting James L. Rigelhaupt, Annotation, *What Constitutes Physician–Patient Relationships for Malpractice Purposes*, 17 A.L.R. 4th 132 § 2 (1982)).

43. *Id.* (quoting DAVID M. HARNEY, MEDICAL MALPRACTICE 6–7 (1973)).

44. Nash v. Royster, 127 S.E. 356, 359 (N.C. 1925) (stating that a physician is "not bound to render professional services to everyone who applies, and he may therefore, by notice or special agreement, limit the extent and scope of his employment").

45. *See generally* Oliver v. Brock, 342 So. 2d 1 (Ala. 1976).

46. *See id.* at 4.

47. *See generally* Diggs v. Ariz. Cardiologists, Ltd., 8 P.3d 386 (Ariz. Ct. App. 2000); Corbet v. McKinney, 980 S.W.2d 166 (Mo. Ct. App. 1998); Lownsbury v. VanBuren, 762 N.E.2d 354 (Ohio 2002).

2. Qualification to the Rule: Implied Relationships

Modern courts are applying a more nuanced analysis to determine whether physician-patient relationships exist in medical malpractice cases.[48] Specifically, they are analyzing whether an implied physician-patient relationship exists.[49] But courts differ in their definitions of what constitutes an implied relationship.[50] Many courts have found that a relationship may exist when a physician accepts or undertakes to treat a patient, regardless of whether they explicitly said or thought they were doing so.[51] But the question of whether a duty is created implicitly by a physician's actions in the course of providing care in nontraditional settings is often challenging to answer.[52]

An implied relationship is "inferred by the courts from the actions of the parties or the terms of employment."[53] Traditionally, courts determined physician-patient relationships based on the physician's affirmative actions treating the patient or prescribing a course of treatment.[54] Thus, in cases involving implied physician-patient relationships, the question often becomes whether the physician took any affirmative action indicating that they accepted the individual as a patient.[55] Some courts have held that affirmative actions include those that involve examining, diagnosing, or treating a patient.[56]

3. Exceptions to the Rule: A Duty of Care Despite No Relationship

While some courts are addressing this duty question by expanding the scope of the physician-patient relationship, other courts have held that a duty of care may exist notwithstanding the absence of such a relationship.[57] Some jurisdictions do not require the showing of a physician-patient relationship.[58] Defendants who neither committed affirmative acts nor caused harm usually

48. *See* Glenn, *supra* note 29, at 747–48.
49. *See* cases cited *infra* notes 55–56.
50. *See infra* Part II.A.1.
51. *See generally Corbet*, 980 S.W.2d 166; *Lownsbury*, 762 N.E.2d 354.
52. *See* Lennon, *supra* note 31, at 367.
53. *Id.*
54. *Id.*
55. *See* Lopez v. Aziz, 852 S.W.2d 303, 306 (Tex. App. 1993) (holding that one telephone call between the consulting physician and the treating physician did not form the basis for a physician-patient relationship because the consulting physician did not perform any services, such as conducting or reviewing lab tests).
56. *Compare* Oliver v. Brock, 342 So. 2d 1, 5 (Ala. 1976) (holding that the consulting physician did not take any part in the treatment of the patient), *and Corbet*, 980 S.W.2d at 169 (observing that liability depends on whether a physician undertakes to examine, diagnose, or treat a patient), *with* Raptis-Smith v. St. Joseph's Med. Ctr., 755 N.Y.S.2d 384, 386 (App. Div. 2003) (holding that to give rise to an implied relationship, it is not necessary for a consultant to "see, examine, take a history, or treat the patient").
57. *See generally* Gilinsky v. Indelicato, 894 F. Supp. 86 (E.D.N.Y. 1995); Diggs v. Ariz. Cardiologists, Ltd., 8 P.3d 386 (Ariz. Ct. App. 2000); Millard v. Corrado, 14 S.W.3d 42 (Mo. Ct. App. 1999); Mozingo *ex rel.* Thomas v. Pitt Cnty. Mem'l Hosp., Inc., 415 S.E.2d 341 (N.C. 1992).
58. *See* cases cited *supra* note 57.

are not expected to take affirmative steps to protect others, unless an exception applies.[59] These exceptions include: (1) when physicians provide medical advice or care to someone who was not previously their patient,[60] (2) when physicians create an unreasonable risk,[61] and (3) when physicians act in nonmedical situations that do not involve professional judgment.[62] Within these exceptions, physicians may be under a duty of care to nontraditional patients despite the absence of a physician-patient relationship.[63]

Physicians may owe a nontraditional patient a duty of care if their words or conduct indicate that they intend to provide medical advice or attention to a person who was not previously their patient.[64] The basis for this comes from the Restatement (Second), section 324A, which states:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of a third person or his things, is subject to liability to the third person for physical harm resulting from his failure to exercise reasonable care to protect his undertaking, if (a) his failure to exercise reasonable care increases the risk of such harm, or . . . (c) the harm is suffered because of reliance of the other or third person upon the undertaking.[65]

Courts have found that physicians are in a unique position to prevent future harm to patients and nonpatients given their superior knowledge and experience.[66] Thus, a court may, for instance, analyze whether a physician was in the best position to impact the trajectory of the case in order to determine whether a duty of care exists.[67]

Some courts apply an "undertaking analysis" when physicians perform independent medical exams on nonpatients.[68] For instance, physicians may perform medical exams on prospective employees, prospective insurees, or litigation claimants.[69] Although physicians may be providing a service to the examinee in this role, courts are hesitant to find that a physician-patient

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59. *See generally* Adams v. Via Christi Reg'l Med. Ctr., 19 P.3d 132 (Kan. 2001).

60. *See* cases cited *infra* note 64.

61. *See generally* Smith v. Welch, 967 P.2d 727 (Kan. 1998); Eelbode v. Chec Med. Ctrs., Inc., 984 P.2d 436 (Wash. Ct. App. 1999).

62. *See generally* Taylor v. Smith, 892 So. 2d 887 (Ala. 2004); Cheeks v. Dorsey, 846 So. 2d 1169 (Fla. Dist. Ct. App. 2003) (holding that there was a duty of care when a physician gave methadone to a patient that was already on drugs, resulting in his incapacity, which caused a vehicular crash and killed the plaintiff's decedent and her daughter).

63. *See infra* Part I.A.3.

64. *See generally* Nold *ex rel.* Nold v. Binyon, 31 P.3d 274 (Kan. 2001); Fruiterman v. Granata, 668 S.E.2d 127 (Va. 2008).

65. RESTATEMENT (SECOND) OF TORTS § 324A (AM. L. INST. 1965).

66. *See* Green v. Walker, 910 F.2d 291, 295 (5th Cir. 1990).

67. *See* Diggs v. Ariz. Cardiologists, Ltd., 8 P.3d 386, 390 (Ariz. Ct. App. 2000).

68. *See* Stanley v. McCarver, 92 P.3d 849, 853 (Ariz. 2004) (en banc) (finding that the physician contracted with another to interpret plaintiff's x-rays and in so doing, "he undertook a professional obligation with respect to Ms. Stanley's physical wellbeing").

69. *See* Blake, *supra* note 30, at 613.

relationship existed.[70] Nonetheless, an examinee may be harmed as a result of the physician's action or inaction.[71] A physician may have failed to diagnose a serious condition,[72] failed to advise the plaintiff of a serious condition that was accurately diagnosed,[73] or reached an incorrect conclusion in the examination that led to the plaintiff's economic loss.[74] Thus, by agreeing to perform an examination on behalf of a third party, the physician may be considered to have undertaken the task of providing reasonable care.[75] Thus, there may be a duty of care notwithstanding a lack of showing of a physician-patient relationship.[76]

Physicians have also been liable when their affirmative acts created unreasonable risks.[77] If a duty of care is found in these cases, the physician owes a common-law duty of reasonable care to the plaintiff.[78] For example, in *HealthONE v. Rodriguez ex rel. Rodriguez*,[79] a physician left phenol—a drug that, when injected, destroys human tissue—on a cart with nerve block medicines that would be injected intravenously.[80] Another physician mistakenly picked up the phenol and injected it into a patient, who subsequently suffered serious brain damage.[81] The court held that the first physician owed a common-law duty of reasonable care to the patient given that the actions led to the creation of harm.[82]

Plaintiffs may also bring an ordinary negligence claim when a physician creates unreasonable risks to those outside the bounds of any potential physician-patient relationship. For example, a patient may drive dangerously and put others on the road at risk due to the side effects of medication the physician prescribed.[83] Additionally, a physician's failure to inform others about a patient's contagious disease may lead to others contracting that disease.[84]

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70. *See* Lee v. City of New York, 560 N.Y.S.2d 700, 701 (App. Div. 1990) (asserting that the "physician-patient relationship does not exist if the physician is retained solely to examine an employee on behalf of an employer").

71. *See id.*

72. *See id.*

73. *See* Ervin v. Am. Guardian Life Assurance Co., 545 A.2d 354, 355 (Pa. Super. Ct. 1988).

74. *See* Ney v. Axelrod, 723 A.2d 719, 721 (Pa. Super. Ct. 1999).

75. *See* Hoover v. Williamson, 203 A.2d 861, 863 (Md. 1964) (holding that a physician who had examined an employee for an employer and affirmatively advised the employee wrongly had undertaken to provide care).

76. *See id.*

77. *See generally* Smith v. Welch, 967 P.2d 727 (Kan. 1998); Eelbode v. Chec Med. Ctrs., Inc., 984 P.2d 436 (Wash. Ct. App. 1999).

78. *See supra* note 67 and accompanying text.

79. 50 P.3d 879 (Colo. 2002).

80. *Id.* at 885.

81. *Id.*

82. *Id.*

83. *See, e.g.*, Taylor v. Smith, 892 So. 2d 887 (Ala. 2004); Cheeks v. Dorsey, 846 So. 2d 1169 (Fla. Dist. Ct. App. 2003).

84. *See, e.g.*, DiMarco v. Lynch Homes–Chester Cnty., Inc., 583 A.2d 422 (Pa. 1990); Estate of Amos v. Vanderbilt Univ., 62 S.W.3d 133 (Tenn. 2001) (holding that the hospital owed a duty of care to the future husband of a patient to warn the patient that it had given her HIV-contaminated blood).

4. A Public Policy Approach

When faced with a difficult duty question, some courts apply a public policy approach to determine whether a duty of care should exist as a matter of law.[85] An example comes from the California Supreme Court's decision in *Rowland v. Christian*.[86] This case presented a nuanced duty question that the court determined would not be properly addressed under the standard doctrinal approach.[87]

In *Rowland*, the court did away with its previous tripartite premises liability distinction and held one owes a general duty to anyone who is on one's property.[88] As a general matter, landowners were required to use ordinary care to prevent harm to others.[89] Any departure from this default rule required the balancing of seven policy factors.[90] Since then, courts, specifically California courts, have applied this approach to determine whether a duty of care exists in other types of relationships that present difficult duty questions, such as between nontraditional patients and physicians.[91] While some courts are creating very similar multifactor balancing tests,[92] others generally state that the presence or absence of a physician-patient relationship is just one factor to consider when determining the nature and scope of the duty owed.[93] Thus, courts have begun to create exceptions to the general requirement of a physician-patient relationship by analyzing various policy considerations.[94]

B. Historical Treatment and Current Trends

Patients have historically had trouble raising claims arising from indirect healthcare interactions because of the unclear duty question. However, as medicine has undergone tremendous change, courts have also changed their analyses and approaches in these cases.[95] Part I.B.1 describes courts' reluctance to extend the duty element in these cases and Part I.B.2 discusses how and why courts began to engage with the duty question more meaningfully.

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85. *See* Blake, *supra* note 30, at 593.
86. 443 P.2d 561 (Cal. 1968).
87. *See generally id.*
88. *Id.* at 569.
89. *Id.*
90. *Id.* at 564; *see* Blake, *supra* note 30, at 594.
91. *See* Blake, *supra* note 30, at 595. The California Supreme Court has applied this approach to determine whether a duty of care exists between independent medical examiners and nontraditional patients. *See, e.g.*, James v. United States, 483 F. Supp. 581 (N.D. Cal. 1980); Felton v. Schaeffer, 279 Cal. Rptr. 713 (Ct. App. 1991); Keene v. Wiggins, 138 Cal. Rptr. 3 (Ct. App. 1977).
92. *See, e.g.*, Stanley v. McCarver, 92 P.3d 849 (Ariz. 2004); Reed v. Bojarski, 764 A.2d 433 (N.J. 2001).
93. *See, e.g.*, Meena v. Wilburn, 603 So. 2d 866, 869–70 (Miss. 1992).
94. *See* cases cited *supra* notes 92–93.
95. *See* Blake, *supra* note 30, at 577.

1. Historical Reluctance to Extend the Duty Element

Historically, many patients could not bring cases against physicians in nontraditional care settings due to the limitations on the duty element.[96] Courts often did not recognize a duty of care in these cases because there was no established physician-patient relationship based on the circumstances.[97] They restricted the definition of a physician-patient relationship to direct contact with the patient,[98] which included a physical examination of the patient, knowing the patient's name,[99] having the patient referred to them,[100] or performing tests on the patient.[101]

This narrow view is exemplified by *Oliver v. Brock*.[102] In this case, the patient was admitted to a hospital following a car accident and put under the care of Dr. Whitfield and Dr. Ketcham.[103] During the course of providing care to the patient, Dr. Whitfield called Dr. Brock, a physician in another city, to discuss the care and treatment of another one of her patients.[104] While speaking on the phone, Dr. Whitfield also mentioned the plaintiff's case and current treatment, and Dr. Brock expressed his general agreement with Dr. Whitfield's treatment plan.[105] Following the call, Dr. Whitfield made note of the conversation in the patient's discharge summary, along with the general suggestions Dr. Brock made during their conversation.[106] Despite adherence to this treatment plan, the patient suffered serious injuries.[107]

The Alabama Supreme Court found that Dr. Brock's level of involvement in the patient's case was not sufficient to establish a physician-patient relationship.[108] Dr. Brock never saw the patient, requested to serve as a consultant, or offered any treatment advice.[109] Moreover, he received all case information from the treating physician and spoke with the treating physician during a phone conversation that originated while discussing another patient's treatment.[110] Therefore, the court determined that Dr. Brock's conversation with the treating physician was "completely gratuitous."[111] Because the court also deemed the existence of a physician-patient relationship critical to the existence of a duty of care, it concluded

96. Baker, *supra* note 39.
97. *See infra* Part II.A.
98. *See* Mead v. Legacy Health Sys., 283 P.3d 904, 909 (Or. 2012).
99. *See* Ingber v. Kandler, 513 N.Y.S.2d 11, 11 (App. Div. 1987).
100. *See* Hill *ex rel*. Burston v. Kokosky, 463 N.W.2d 265, 266 (Mich. Ct. App. 1990).
101. *See* cases cited *supra* note 56.
102. 342 So. 2d 1 (Ala. 1976).
103. *Id.* at 2–3.
104. *Id.* at 4.
105. *Id.*
106. *Id.*
107. *Id.*
108. *See id.*
109. *Id.* at 4–5.
110. *Id*.
111. *Id.* at 4. If a physician renders services gratuitously, this does not create a duty to exercise reasonable and ordinary care, skill, or diligence. Voss v. Bridwell, 364 P.2d 955, 963 (Kan. 1961).

that the plaintiff had no negligence claim against the consulting physician as a matter of law.[112]

Until the 1990s, courts were steadfast in limiting the definition of the physician-patient relationship, reasoning that expanding liability would have a chilling effect on the free flow of information between professionals.[113] They also wanted to preserve the treating physician's ultimate control over the patient's care and worried that recognizing the second physician's domain over the patient might obfuscate the primary physician-patient relationship.[114] Additionally, most courts believed that expanding the scope of liability would stifle efforts to improve medical knowledge.[115]

2. Phase of Relaxation: The Current Approach

Although many courts were historically reluctant to extend liability to physicians in nontraditional patient care settings, they are now examining the possible merits of this expansion more closely.[116] Some courts are treating the existence of a physician-patient relationship as a matter of fact.[117] Others are determining whether, as a matter of law, a duty of care exists regardless of whether the relationship is present.[118]

Today, several courts recognize that direct contact between the physician and patient is not dispositive to whether a relationship exists.[119] Several other questions are now at the forefront of courts' analyses, including: (1) whether the physician interacted with the patient's family member, even if not with the patient herself; (2) whether a physician provided a service; and (3) whether the physician acted affirmatively.[120] The latter two questions, if answered affirmatively, are sometimes said to create an implied

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112. *See Oliver*, 342 So. 2d at 5.

113. *See* Hill *ex rel*. Burston v. Kokosky, 463 N.W.2d 265, 268 (Mich. Ct. App. 1990) ("The extension of potential malpractice liability to doctors with whom a treating physician has merely conferred, without more, would unacceptably inhibit the exchange of information and expertise among physicians. This would benefit neither those seeking medical attention nor the medical profession.").

114. Baker, *supra* note 39.

115. Reynolds v. Decatur Mem'l Hosp., 660 N.E.2d 235, 240 (Ill. App. Ct. 1996) ("Plaintiffs suggest that what needs to be done is to find a physician-patient relationship to result from every such conversation. The consequence of such a rule would be significant. It would have a chilling effect upon the practice of medicine. It would stifle communication, education and professional association, all to the detriment of the patient. The likely effect in adopting plaintiff's argument also would be that such informal conferences would no longer occur."); *see also* Rainer v. Grossman, 107 Cal. Rptr. 469, 472 (App. Ct. 1973).

116. *See infra* Part II.

117. *See infra* Part II.A.1.

118. *See* Baker, *supra* note 39.

119. *See* Kelley v. Middle Tenn. Emergency Physicians, P.C., 133 S.W.3d 587, 593 (Tenn. 2004); St. John v. Pope, 901 S.W.2d 420, 424 (Tex. 1995).

120. *See, e.g.*, Adams v. Via Christi Reg'l Med. Ctr., 19 P.3d 132, 140 (Kan. 2001). The court held that a physician-patient relationship existed because the physician discussed the patient's condition with her mother and did not say he did not consider her daughter his patient. *Id.* Instead, he listened to the patient's mother and gave her his medical opinion in response. *Id.* Thus, it was "immaterial that he did not speak directly to [the daughter]." *Id.*

relationship.[121] On the question of what constitutes a service or affirmative act, courts' analyses differ significantly.[122] Accordingly, there are no dispositive factors that create an implied relationship, and many courts do not apply a stringent or uniform analysis.[123]

This phase of relaxation acknowledges that the previously unbending approach of requiring a relationship is outdated, as more physicians frequently interact with patients in nontraditional settings.[124] Physicians, as professionals and specialists, are in a unique position where they can directly impact the health of an individual.[125] Thus, it does not serve the patient, nor arguably tort law, to make redress unavailable simply because an outdated and narrow interpretation of physician-patient relationships shields physicians from liability.

Patients are bringing both ordinary negligence and medical malpractice claims against physicians.[126] Courts have recognized that "when a risk of harm has been identified through the exercise of medical judgment, a failure to follow through by taking measures to prevent the harm may constitute actionable ordinary negligence."[127] Thus, a plaintiff may bring an ordinary negligence claim if the jury is able to evaluate the reasonableness of the physician's conduct based on their own common knowledge and everyday experiences.[128]

In the last few decades, the delivery of healthcare services has changed, requiring courts to redefine the physician-patient relationship and change legal presumptions about duty.[129] Medical advances have expanded the ability of physicians to specialize in their practices, which may spur the need for informal consultations.[130] Technological innovations also allow physicians and healthcare professionals to connect with each other instantaneously.[131] Patients in hospitals may be treated by large teams of healthcare providers.[132] Telemedicine, in which physicians provide services

121. *See* Meghan C. O'Connor, *The Physician–Patient Relationship and the Professional Standard of Care: Reevaluating Medical Negligence Principles to Achieve the Goals of Tort Reform*, 46 TORT TRIAL & INS. PRAC. L.J. 109, 112 (2010).

122. *See generally* Gilbert v. Miodovnik, 990 A.2d 983 (D.C. 2010); Jennings v. Badgett, 230 P.3d 861 (Okla. 2010).

123. *See infra* Part II.A.1.

124. Blake, *supra* note 30, at 613.

125. *See generally* Diggs v. Ariz. Cardiologists, Ltd., 8 P.3d 386 (Ariz. Ct. App. 2000).

126. *See, e.g.*, Gilinsky v. Indelicato, 894 F. Supp. 86 (E.D.N.Y. 1995); Sterling v. Johns Hopkins Hosp., 802 A.2d 440 (Md. Ct. Spec. App. 2002); Meena v. Wilburn, 603 So. 2d 866 (Miss. 1992); Millard v. Corrado, 14 S.W.3d 42 (Mo. Ct. App. 1999).

127. *Gilinsky*, 894 F. Supp. at 94 (quoting Miller v. Albany Med. Ctr. Hosp., 464 N.Y.S.2d 297, 299 (App. Div. 1983)).

128. *See id.*

129. *See, e.g.*, Adams v. Via Christi Reg'l Med. Ctr., 19 P.3d 132 (Kan. 2001); Mead v. Legacy Health Sys., 283 P.3d 904 (Or. 2012).

130. *Mead*, 283 P.3d at 910; Blake, *supra* note 30, at 613.

131. *See* Baker, *supra* note 39.

132. *See* Mozingo *ex rel*. Thomas v. Pitt Cnty. Mem'l Hosp., Inc., 415 S.E.2d 341, 345 (N.C. 1992) ("In the delivery of health care services . . . it is increasingly difficult to determine factually who is in control of whom . . . . [T]he matter of the right to control another's actions becomes a very difficult question both as a matter of fact and of law.").

through electronic communications, also involves complex interactions between physicians and patients.[133] Additionally, a physician's contract with a hospital or healthcare facility may count as an undertaking of a physician-patient relationship with certain patients.[134] Given such changes, many courts are resolving the difficult determination of when the duty of care exists in nontraditional settings.[135]

C. Scenarios Highlighting Differing Courts' Analyses

As physicians interact with patients in nontraditional settings, courts must determine when a physician owes a duty of care to a patient outside the scope of a traditional physician-patient relationship. Key questions of duty arise when physicians are on call or perform curbside consultations. In both sets of cases, courts must determine the scope of the physician-patient relationship, primarily by determining the bounds of an implied relationship. They must also determine whether a duty of care can be established in the absence of a physician-patient relationship.

1. Curbside Consultations

Curbside consultations, or informal consultations, occur when the treating physician seeks informal advice about patient care.[136] The consults are usually based on the treater's presentation of the case.[137] The treating physician typically offers only brief, simple, and nonspecific information to the consulting physician, while the consulting physician usually does not examine the patient, review or edit the patient's chart, participate directly in the care plan, or charge for the services performed.[138] Unlike curbside consultations, in formal consultations, the consulting physician may provide any of the above services.[139] These services generally point toward the recognition of a duty of care between the physician and patient.[140]

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133. Some states are codifying the definition of a physician-patient relationship by statutorily requiring physicians to personally document the patient's medical history and perform a physical examination before forming a relationship. *See, e.g.*, IDAHO CODE § 54-1821 (2020); S.C. CODE ANN. § 40-47-113 (2020) (stating that, for medical malpractice cases, a physician-patient relationship is not formed when a physician provides a consultation to another physician without seeing or examining the patient and without the expectation of payment for the consultation).

134. *See generally* Lownsbury v. VanBuren, 762 N.E.2d 354 (Ohio 2002).

135. *See* Glenn, *supra* note 29, at 747.

136. *See Curbside Consultations*, *supra* note 13, at 51–52.

137. *See id*.

138. *See id.*

139. *See* Thaddeus Mason Pope, *Curbside Consults: New Liability Risks to Avoid When You Are Not a Patient's Physician*, THE ASCO POST (June 25, 2019), https://www.ascopost.com/issues/june-25-2019/new-liability-risks-to-avoid-when-you-are-not-a-patient-s-physician [https://perma.cc/A33R-EEAF].

140. *See id.*

Curbside consultations are a recommended and valuable practice in the medical community and benefit not only professionals but also patients.[141] The free exchange of information and expertise among clinicians facilitates communication and education.[142] But if a patient is injured or harmed as a result of or during a curbside consult, the chief course of redress is bringing a negligence or medical malpractice action against both the treating and consulting physician.[143] However, courts have not clarified whether the consulting physician may be held liable for the impact of an informal consultation because the physician-patient relationship is hard to prove.[144]

In determining if an implied relationship exists, courts consider whether the consultant went beyond giving general advice, whether a preexisting contract between the consulting physician and hospital created the requisite relationship, and whether the consultant's expertise made it foreseeable that the treating physician would rely on the consultant's opinion.[145] Other jurisdictions determine whether a duty of care existed not on the basis of a physician-patient relationship but on the basis of an undertaking, a creation of unreasonable risk, or public policy.[146] Regardless of the method of analysis, courts are engaging in this complicated duty question.[147]

2. On-Call Physicians

Similar to curbside consultations, courts are divided as to when an on-call physician can be held liable.[148] "On call" is a status that many hospitals and healthcare facilities use to indicate that a physician may be reached to treat patients or answer any questions that physicians, residents, or nurses may have during the course of their work.[149] Hospitals and facilities generally have rules governing their expectations for on-call physicians.[150]

Confusion arises when a physician is not physically located in the hospital but is called for an opinion and a patient is ultimately injured.[151] Sometimes physicians may also be implicated if they are on call and supervising residents.[152] However, the mere fact that a physician is on call does not in and of itself create a duty of care.[153] Rather, evidence is necessary to show

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141. *See* Douglas Mossman, *Malpractice Rx: 'Curbside' Consults: Know Your Liability*, CURRENT PSYCHIATRY, June 2012, at 42, 42; Pope, *supra* note 139.
142. Pope, *supra* note 139.
143. Baker, *supra* note 39.
144. *See infra* Part II.A.1.
145. *See* Baker, *supra* note 39.
146. *See infra* Part II.B.
147. *See* Gilinsky v. Indelicato, 894 F. Supp. 86, 94 (E.D.N.Y. 1995); Irvin v. Smith, 31 P.3d 934, 940 (Kan. 2001); Cogswell *ex rel.* Cogswell v. Chapman, 672 N.Y.S.2d 460, 462 (App. Div. 1998); Jennings v. Badgett, 230 P.3d 861, 868 (Okla. 2010).
148. *See supra* Part I.C.1.
149. *See* Lennon, *supra* note 31, at 363–64.
150. *See id*; *see also* Glenn, *supra* note 29, at 747.
151. *See* Oja v. Kin, 581 N.W.2d 739, 742–43 (Mich. Ct. App. 1998); Lennon, *supra* note 31, at 367–68.
152. *See* Lennon, *supra* note 31, at 368.
153. *See* Mead v. Legacy Health Sys., 283 P.3d 904, 913 (Or. 2012).

the on-call physician accepted responsibility for the patient.[154] This is based on the common-law notion that physicians are not bound to treat all patients who are in need of medical attention.[155]

II. THE DIFFERING CASE LAW

As physicians more frequently perform services for patients and nonpatients alike, it is increasingly unclear when and how a duty of care is established between physicians and patients.[156] Part II.A investigates the existence of a duty of care for physicians providing curbside consultations. Part II.B. analyzes the creation of the duty element when physicians are on call.

A. Detailed Examination of Curbside Consultation Case Law

Because curbside consultations involve the informal exchange of information between two physicians, it is difficult to determine when a duty of care to the patient is created.[157] Courts that conclude the duty element is satisfied in such situations often either: (1) find an implied relationship by expanding the scope of the physician-patient relationship[158] or (2) find there was an undertaking or the creation of risk or harm by the physician, regardless of whether a physician-patient relationship existed.[159]

1. Qualification: An Affirmative Act

In curbside consult cases, many courts do not apply a standard test or analyze a dispositive set of factors to determine whether an implied physician-patient relationship exists.[160] Instead, the critical question is whether the physician affirmatively acted, such that they provided a service to the patient.[161] This requirement stems from the consensual nature of the physician-patient relationship.[162] Therefore, "where there is no ongoing physician-patient relationship, the physician's express or implied consent to advise or treat the patient is required for the relationship to come into being.

154. *See* Glenn, *supra* note 29, at 766.
155. *Id*. at 763.
156. Blake, *supra* note 30, at 601.
157. *See supra* Part I.C.1.
158. *See infra* Part II.A.1.
159. *See infra* Part II.A.2.
160. *See* Gilinksy v. Indelicato, 894 F. Supp. 86, 93–94 (E.D.N.Y. 1995); Irvin v. Smith, 31 P.3d 934, 941 (Kan. 2001).
161. *See Gilinsky*, 894 F. Supp. at 94; *Irvin*, 31 P.3d at 941; Cogswell *ex rel.* Cogswell v. Chapman, 672 N.Y.S.2d 460, 462 (App. Div. 1998) (holding that a "doctor-patient relationship can be established by a telephone call when such a call 'affirmatively advis[es] a prospective patient as to a course of treatment' and it is foreseeable that the patient would rely on the advice'" (alteration in original) (citation omitted) (quoting Miller v. Sullivan, 625 N.Y.S.2d 102, 104 (App. Div. 1995))); Jennings v. Badgett, 230 P.3d 861, 868 (Okla. 2010).
162. *See* Adams v. Via Christi Reg'l Med. Ctr., 19 P.3d 132, 140 (Kan. 2001); Lopez v. Aziz, 852 S.W.2d 303, 306–07 (Tex. Ct. App. 1993).

Stated otherwise, the doctor must take some affirmative action with regard to treatment of a patient."[163]

There is no universal definition for what constitutes a sufficient affirmative act. Courts often consider whether a physician examined, diagnosed, treated, or charged for their services.[164] If a physician does none of these, it is likely that the physician did not provide services to a patient.[165] It is unclear, though, whether completing just one of these acts would be sufficient to establish a relationship. Some specific actions that may be significant include physically examining the patient, reviewing the patient's hospital chart, ordering tests, reviewing tests, or providing recommendations that cannot be ignored.[166]

Given the unclear meaning of affirmative action, courts disagree about whether a consulting physician who only provides advice to a treating physician has affirmatively acted and created an implied physician-patient relationship.[167] Many courts find that without any other service or act, merely providing advice, which the treating physician is free to accept or reject, is not an affirmative act.[168] However, embedded in this analysis are principles of foreseeability, reliance, and the formation of an undertaking.[169]

a. Providing Advice Is a Sufficient Affirmative Act

A few courts purport to hold that providing advice alone is sufficient to establish affirmative action.[170] Specifically, these courts hold that when a consulting physician advises as to the patient's treatment and the treatment actually causes further injuries, a relationship may be found between the physician and the patient.[171]

In *Gilinsky v. Indelicato*,[172] a patient suffered a stroke while under the care of Dr. Parks, who was enrolled in a postdoctoral chiropractic neurology residency program.[173] Dr. Indelicato was the senior neurologist assigned to monitor Dr. Parks.[174] Dr. Parks called Dr. Indelicato about a patient with unusual symptoms, informing Dr. Indelicato of the patient's vital signs and

163. *Adams*, 19 P.3d at 140.
164. *See* Corbet v. McKinney, 980 S.W.2d 166, 169 (Mo. Ct. App. 1998).
165. *See Jennings*, 230 P.3d at 867.
166. *See, e.g.*, Ingber v. Kandler, 513 N.Y.S.2d 11, 11 (App. Div. 1987) (holding there was no relationship because the physician did not contact the patient or see any of the patient's records).
167. *Compare* Gilinksy v. Indelicato, 894 F. Supp. 86, 93–94 (E.D.N.Y. 1995), *with* Irvin v. Smith, 31 P.3d 934, 941 (Kan. 2001).
168. *See infra* Part II.A.1.c.2.
169. *See infra* Part II.A.1.c.2.
170. *See, e.g.*, *Gilinksy*, 894 F. Supp. at 93–94; Adams v. Via Christi Reg'l Med. Ctr., 19 P.3d 132, 140 (Kan. 2001) ("A physician-patient relationship may be created in any number of ways, including the act of a physician agreeing to give or giving advice to a patient in person or by telephone.").
171. *See infra* note 208 and accompanying text.
172. 894 F. Supp. 86 (E.D.N.Y. 1995).
173. *Id.* at 87.
174. *Id.*

symptoms after a chiropractic manipulation.[175] Dr. Indelicato believed the patient was suffering from cervical disequilibrium and instructed Dr. Parks to perform some tests, which Dr. Parks then completed.[176] Over the next few hours, Dr. Parks and Dr. Indelicato had six other phone calls, three of which Dr. Indelicato initiated.[177] During the course of the thirty-eight minute combined consultation, Dr. Parks did not tell Dr. Indelicato about the plaintiff's full medical history, did not identify her by name, and did not forward any records for review, nor did Dr. Indelicato bill for his services.[178]

The court held that at some point, Dr. Parks ceased to seek consultative advice; rather, he sought actual direction from Dr. Indelicato.[179] The court found that Dr. Indelicato, in providing advice to Dr. Parks, exercised his professional judgment in a matter bearing directly on the plaintiff.[180] Therefore, while Dr. Indelicato did not physically examine the patient, review the patient's entire medical history, or bill for his services, the court still found a relationship on the basis of his advice—which included a proffered diagnosis as well as subsequent treatment instructions and persuasive direction.[181]

While the court here found a physician-patient relationship because the consulting physician affirmatively advised on a patient's case, other affirmative acts were imbedded in this advice, including diagnosing and creating a treatment plan for the patient.[182] Therefore, it is not the giving advice itself that is the impactful act; it is the impact of that advice on the patient's examination, diagnosis, or treatment that seems to create the relationship.

b. Providing Advice Alone Is Not a Sufficient Affirmative Act

By contrast, many courts have held that conversations between a consulting physician and a treating physician regarding a specific patient's case "even when the treating physician relies on the [consulting] physician's opinion, without more, is insufficient to establish a physician-patient relationship."[183] Thus, in the absence of a physician examining, diagnosing, treating, or charging a patient for any services, simply providing advice to a colleague would not be a sufficient affirmative act.

For instance, in *Irvin v. Smith*,[184] a patient brought a medical malpractice action after an undiagnosed ventriculoperitoneal shunt malfunction caused permanent brain damage.[185] The patient suffered from seizures, nausea,

175. *Id.* at 88.
176. *Id.*
177. *Id.*
178. *Id.*
179. *Id.* at 93–94.
180. *Id.*
181. *Id.* at 88, 93–94.
182. *See id.* at 94.
183. Jennings v. Badgett, 230 P.3d 861, 868 (Okla. 2010).
184. 31 P.3d 934 (Kan. 2001).
185. *Id.* at 938.

vomiting, and neck and back pain in connection with the malfunctioning shunt.[186] Dr. Smith, a pediatric intensivist, called Dr. Gilmartin for a "neurological consult" because Dr. Smith thought Dr. Gilmartin was "the best consultant" to evaluate the patient.[187] The two physicians discussed performing a shuntogram,[188] after which Dr. Smith ordered a shuntogram and EEG for the next day.[189] The next morning, the patient's condition deteriorated and the shuntogram was performed.[190] However, the patient suffered permanent brain damage and alleged that the delay in performing the shuntogram constituted negligence by both physicians.[191]

The court found there was no relationship between Dr. Smith and the patient.[192] Although the physicians jointly developed the patient's treatment plan, the court differentiated the consultant's call from a formal consultation.[193] The consultant did not examine the patient, review her hospital chart, or speak with her or her parents.[194] He also did not enter any orders and only discussed the case in general terms with the treating physician, agreeing to a consult the next day.[195] The court held that agreeing to consult the next day, by itself, does not create a physician-patient relationship.[196] Thus, the giving of advice alone was not a sufficient affirmative act.

In *Hill ex rel. Burston v. Kokosky*,[197] a mother gave birth to an infant with cerebral palsy and brought a medical malpractice suit against the consulting doctors who provided advice on child birthing alternatives.[198] The consulting doctors spoke with the treating physician over the phone and gave their opinions based on the case history the treating physician had relayed to them.[199] The treating physician did not refer to the patient by name and neither defendant contacted the patient, examined her, or reviewed her chart.[200] The court found no relationship between the physicians and the patient because: (1) neither defendant knew the patient; (2) neither defendant examined the patient; (3) neither defendant spoke with the patient; (4) the patient was not referred to the defendants for treatment or consultation; (5) the defendants' medical opinions were addressed directly to the treating

186. *Id.*
187. *Id.* at 938–39.
188. "A shuntogram is a procedure which involves injection of a radioactive isotope into the shunt to check for shunt blockage." *Id.* at 939.
189. *Id.*
190. *Id.*
191. *Id.*
192. *Id.* at 940.
193. *Id.* at 948 (Lockett, J., dissenting) (noting the majority's statement that a formal consultation includes a full bedside review of the case and a physical examination of the patient, which had not taken place in this case).
194. *Id.* at 942–43.
195. *Id.* at 943.
196. *Id.*
197. 463 N.W.2d 265 (Mich. Ct. App. 1990).
198. *Id.* at 266.
199. *Id.*
200. *Id.*

physician as a colleague; and (6) their opinions were in the form of a recommendation to be accepted or rejected by the plaintiff's treating doctor as he saw fit.[201]

The court opined that the physicians did not prescribe a course of treatment to the patient.[202] Instead, they provided recommendations that the treating doctor could have accepted or rejected.[203] The court compared this act to one where a treating doctor consults a medical article or treatise for advice.[204]

The above cases hold that providing advice alone is not a sufficient affirmative act.[205] The courts mentioned possible services that could create a relationship, including directly or physically examining the patient, ordering tests, reviewing specific test results, preparing reports, or viewing the entire patient chart.[206] While these courts outlined acts that were missing from the incidences at hand, it remains unclear which, if any, of these services would be dispositive to the creation of a relationship.[207]

c. Application of Negligence Principles

While some courts differ as to whether providing advice to another colleague is sufficient to constitute an affirmative act, courts do not focus exclusively on this question.[208] Such courts use other principles of negligence, such as foreseeability, reliance, and undertaking, to determine whether an affirmative act occurred and created an implied relationship.[209]

Some courts grapple with whether it is reasonably foreseeable that a patient may be injured as a result of the consulting physician's actions.[210] They take into account "the likelihood of injury, the magnitude of the burden of guarding against it, and the consequences of placing that burden on the defendant."[211] While foreseeability alone is not sufficient to establish a relationship, it is a relevant factor in determining whether an implied physician-patient relationship exists.

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201. *Id.* at 267.
202. *Id.*
203. *Id.*; *see also* NBD Bank, N.A. Tr. Div. *ex rel.* Rountree v. Barry, 566 N.W.2d 47, 49 (Mich. Ct. App. 1997).
204. *See Hill*, 463 N.W.2d at 267.
205. *See id.*; *see also* Irvin v. Smith, 31 P.3d 934, 941 (Kan. 2001).
206. *See* cases cited *supra* note 205.
207. *See* cases cited *supra* note 205.
208. Courts also consider the length of the conversation between physicians, the number of calls, who contacted whom, and whether the physician knew the name of the patient. *See* Gilinsky v. Indelicato, 894 F. Supp. 86, 93 (E.D.N.Y. 1995) (holding that a relationship did exist because "the nature of the consultation . . . was not fleeting and informal . . . but rather was continuous, and substantial, spanning . . . approximately 38 minutes"); *NBD Bank*, 566 N.W.2d at 49; Ingber v. Kandler, 513 N.Y.S.2d 11, 11 (App. Div. 1987).
209. *See Gilinsky*, 894 F. Supp. at 94. *See generally* Bovara v. St. Francis Hosp., 700 N.E.2d 143 (Ill. App. Ct. 1998); Corbet v. McKinney, 980 S.W.2d 166 (Mo. Ct. App. 1998).
210. *See, e.g.*, *Bovara*, 700 N.E.2d at 146.
211. *See* Reynolds v. Decatur Mem'l Hosp., 660 N.E.2d 235, 239 (Ill. App. Ct. 1996).

For instance, in *Bovara v. St. Francis Hospital*,[212] the family of a patient who died after receiving an angioplasty brought a medical malpractice action against the physicians and the hospital.[213] The patient met with the treating physician at the hospital because of the patient's heart disease[214] and brought the results of a previous angiogram of his coronary blood vessels with him.[215] The treating physician was not trained in reading angiograms or in performing angioplasties. He therefore gave the patient's angiogram to Drs. Edgett and Bliley, two cardiac interventionists at the hospital, who then reviewed the angiogram.[216] The treating physician was told that the interventionists believed the patient could have an angioplasty, news the treating physician then relayed to the patient.[217] The patient later died during the procedure.[218]

In considering the reasonable foreseeability of the patient's injury, the court asked whether the consulting physicians knew or should have known that the treating physician and the patient would rely on their opinions and advice.[219] The court held that the defendant cardiac interventionists "knew or should have known" that: (1) the treating cardiologist was not trained to read angiograms; (2) their medical opinions would be transmitted to the patient; and (3) their medical opinions were critical in deciding the patient's treatment plan, specifically whether or not to undergo an angioplasty.[220] Thus, reasonable foreseeability and reliance helped determine whether an implied physician-patient relationship existed between the consulting physicians and the patient.[221]

Additionally, some courts consider whether the consulting physician undertook to advise the treating physician in such a way that the treating physician would rely on the recommendation or opinion, thus increasing the risk of harm.[222] Where there is such reliance, courts sometimes find an implied relationship.[223] The key consideration in these cases is whether the treating physician was free to accept or reject the recommendations given by the consultant.[224]

In *Corbet v. McKinney*,[225] a patient was treated by an emergency room physician, Dr. Ockner.[226] While treating the patient, Dr. Ockner called Dr.

212. 700 N.E.2d 143 (Ill. App. Ct. 1998).
213. *Id.* at 145–46.
214. *Id.* at 144.
215. *Id.* at 144–45.
216. *Id.*
217. *Id.*
218. *Id.* at 146.
219. *Id.*
220. *See id.* at 147–48.
221. *See id.*
222. *See, e.g.*, Reynolds v. Decatur Mem'l Hosp., 660 N.E.2d 235, 239 (Ill. App. Ct. 1996); Irvin v. Smith, 31 P.3d 934, 951–52 (Kan. 2001); Corbet v. McKinney, 980 S.W.2d 166, 170 (Mo. Ct. App. 1998).
223. *See* cases cited *supra* note 222.
224. *See* cases cited *supra* note 222.
225. 980 S.W.2d 166 (Mo. Ct. App. 1998).
226. *Id.* at 168.

McKinney, an ear, nose, and throat specialist.[227] Dr. Ockner presented the patient's case to Dr. McKinney over the phone and provided details about the complaints in her medical chart.[228] Dr. McKinney stated that he had a case or two similar to the patient's and that he believed it was "usually a viral illness."[229] Dr. Ockner did not ask Dr. McKinney to examine the patient while she was in the emergency room.[230] Dr. Ockner diagnosed and treated the patient for acute labyrinthitis and told the patient to follow up with Dr. McKinney in two days.[231] Dr. McKinney did not receive a phone call from Dr. Ockner about the patient, nor did he ever speak with or examine the patient.[232] The patient subsequently suffered permanent deafness in her right ear and alleged that Dr. McKinney's failure to properly diagnose her led to the injury.[233]

The court found that Dr. McKinney did not have a physician-patient relationship with the patient because he "merely [undertook] to advise the patient's treating physician," had "no explicit contractual obligation to the patient, treating physician, or treating hospital to provide care," and did "not take actions which indicate knowing consent to treat a patient who has sought that treatment."[234] Dr. McKinney did not meet, speak with, examine, or diagnose the patient.[235] Instead, he "only offered a recommendation for treatment which was addressed directly to Dr. Ockner as a colleague and not indirectly to [the] patient."[236] Nothing suggests that the defendant knew whether his recommendation would be followed, and Dr. Ockner was free to accept or reject Dr. McKinney's recommendation at his discretion.[237] Thus, Dr. McKinney did not undertake to provide care, because Dr. Ockner did not rely on his expertise, such that it could give rise to future harm to the patient.[238]

This case demonstrates how courts apply principles of reliance and undertaking to determine whether a physician-patient relationship exists.[239] Therefore, while the affirmative act requirement is imperative to most courts' analyses, many are informed equally by negligence principles.

2. Exception: A Duty of Care Despite No Relationship

While some courts are redefining the physician-patient relationship, others are extending physician liability by finding a duty of care regardless of

227. *Id.*
228. *Id.*
229. *Id.*
230. *Id.*
231. *Id.*
232. *Id.*
233. *Id.*
234. *Id.* at 170.
235. *Id.* at 171.
236. *Id.*
237. *Id.*
238. *See id.* at 170.
239. *See id.*

whether a relationship exists.[240] Thus, patients are also bringing ordinary negligence claims against physicians for incidents involving medical care.[241] In some medical malpractice cases, a duty of care is found not on the basis of a physician-patient relationship but on the basis of an undertaking, a degree of reliance, or the creation of unreasonable risk.[242] Regardless of whether the duty question is analyzed by determining whether an implied physician-patient relationship exists, the analysis for establishing that relationship is one in the same with ordinary negligence duty analysis in that both emphasize principles of foreseeability, reliance, and undertakings as predicates for a duty of care.[243]

a. Undertaking, Reliance, and the Creation of Risk

In *Diggs v. Arizona Cardiologists, Ltd.*,[244] the court found that a cardiologist who had "informally" consulted with a physician had a duty of care to the patient because of the risk of harm created to the patient and the primary physician's reliance on the cardiologist's opinion and interpretation.[245] One day, Mrs. Diggs had severe chest pain and arrived at the hospital, where she met with an emergency room physician, Dr. Johnson.[246] Dr. Johnson took her medical history, examined her, and ordered an electrocardiogram ("EKG") and an echocardiogram.[247] Although the EKG suggested otherwise, Dr. Johnson believed the patient was suffering from pericarditis.[248] However, because Dr. Johnson was not trained to interpret echocardiograms, he could not complete his differential diagnosis.[249] He briefly discussed Mrs. Diggs' case with Dr. Valdez,[250] a cardiologist who was visiting another patient in the emergency room.[251] Dr. Johnson presented Mrs. Diggs' clinical history and the results of the physical exam, which Dr. Valdez reviewed before interpreting the EKG results.[252] Accordingly, Dr. Valdez agreed with Dr. Johnson that the patient should be discharged and that her pericarditis should be treated with a nonsteroidal anti-

240. *See* Gilinsky v. Indelicato, 894 F. Supp. 86, 94 (E.D.N.Y. 1995); Diggs v. Ariz. Cardiologists, Ltd., 8 P.3d 386, 387 (Ariz. Ct. App. 2000).
241. *See generally Gilinsky*, 894 F. Supp. 86.
242. *See* cases cited *supra* note 240.
243. *See* cases cited *supra* notes 222, 240.
244. 8 P.3d 386 (Ariz. Ct. App. 2000).
245. *See id.* at 389–91.
246. *Id.* at 387.
247. *Id.*
248. Pericarditis is an inflammation of the sac around the heart. *Id.*
249. *Id.*
250. *Id.* at 388. Dr. Valdez was not the on-call cardiologist at the time of the consultation. *Id.* Dr. Johnson merely saw Dr. Valdez attending to another patient and informally consulted with him about Mrs. Diggs. *See id.*
251. *Id.*
252. *Id.*

inflammatory medication.[253] Three hours after being discharged, Mrs. Diggs died of cardiopulmonary arrest.[254]

The court found that Dr. Valdez, the consulting physician, owed a duty of care to Mrs. Diggs in a medical malpractice action because he created an unreasonable risk to her life.[255] The court noted that Dr. Valdez voluntarily undertook a duty of care to the patient because his opinion and interpretation of the EKG were the primary factors that led to the primary physician's diagnosis and treatment plan.[256] By his negligent undertaking, Dr. Valdez increased the risk of harm to Mrs. Diggs.[257] Even though Dr. Valdez acted under a gratuitous agreement with Dr. Johnson, he still owed a duty of care to Mrs. Diggs.[258] Dr. Valdez was in a unique position to prevent future harm to the patient because Dr. Johnson was not fully qualified to interpret the EKG; thus, he relied on Dr. Valdez's interpretation and diagnosis.[259] As such, the court found that Dr. Valdez undertook to give treatment advice to Dr. Johnson knowing that he would rely on his advice.[260]

b. Viability of Ordinary Negligence Claims

By analyzing the duty element regardless of whether a physician-patient relationship exists, courts are recognizing the viability of ordinary negligence claims.[261] In doing so, courts ask whether the physician was in a unique position to prevent future harm to the patient given the physician's superior knowledge and experience.[262]

In *Gilinsky*, the court held that the duty element in the ordinary negligence claim was fulfilled because the physician attempted to "rescue" the plaintiff.[263] When a risk of harm has been identified through the exercise of medical judgment, a failure to follow through with measures to prevent the harm may constitute actionable ordinary negligence.[264] Here, the court concluded that a reasonable jury could find that the consultant's comments crossed "the boundary that divides mere advice from actual direction."[265] By attempting to rescue the plaintiff, the consultant subjected the plaintiff to a

253. *Id.*
254. *Id.* Following her death, another cardiologist determined that Mrs. Diggs did not suffer from pericarditis but suffered from an acute myocardial infarction while in the emergency room. *Id.*
255. *See id.* at 390.
256. *See id.*
257. *See id.*
258. *See id.*
259. *See id.*
260. *See id.*
261. *See* GOLDBERG ET AL., *supra* note 37, at 74–76. Unlike ordinary negligence claims, expert testimony is necessary to prove whether a physician breached the standard of care. Baker, *supra* note 39.
262. *See* Gilinsky v. Indelicato, 894 F. Supp. 86, 94 (E.D.N.Y. 1995).
263. *Id.*
264. *Id.*
265. *Id.*

foreseeable risk of harm.[266] Even without the aid of expert testimony, a jury, drawing on their own experiences, could conclude that "the defendant, by attempting to diagnose and direct the treatment of the plaintiff over the telephone, failed to act as a reasonably prudent person under like circumstances, and that such conduct was a substantial contributing factor in bringing about the plaintiff's injuries."[267]

This case represents the viability of an ordinary negligence claim against a physician based on their undertaking to provide medical advice.[268] There was no analysis of the existence a physician-patient relationship.[269] Instead, the duty analysis turned on whether there was an undertaking.[270]

B. Detailed Examination of On-Call Cases

While there are similarities between how courts analyze the duty question in curbside consultations and for on-call physicians, interactions between treaters and on-call physicians present unique circumstances that influence the duty analysis.[271] For cases dealing with on-call physicians, courts primarily determine the degree of affiliation between the primary physician and the on-call physician.[272] The affiliation carries some authority or obligation, which often leads to a finding of a duty of care.[273]

The existence of a physician-patient relationship depends on the degree of affiliation between the treater and the on-call physician.[274] Notions of undertaking and foreseeability are often applied in both establishing an implied relationship and in determining the existence of a duty of care regardless of the relationship.[275] Thus, while courts may categorize their analysis as a qualification of the rule or an exception, the nuts and bolts of their analysis often look very similar.[276] Ultimately, these principles inform

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266. *Id.*
267. *Id.*
268. *See id.*
269. *See id.*
270. *See id.*
271. *Compare id.*, *and* Diggs v. Ariz. Cardiologists, Ltd., 8 P.3d 386, 387 (Ariz. Ct. App. 2000) (showing how courts analyze the duty question in curbside consultation cases), *and* Bovara v. St. Francis Hosp., 700 N.E.2d 143, 148 (Ill. App. Ct. 1998), *and* Irvin v. Smith, 31 P.3d 934, 940 (Kan. 2001), *and* Hill *ex rel.* Burston v. Kokosky, 463 N.W.2d 265, 266 (Mich. Ct. App. 1990), *and* Corbet v. McKinney, 980 S.W.2d 166, 169 (Mo. Ct. App. 1998), *with* Talavera *ex rel.* Gonzalez v. Wiley, 725 F.3d 1262, 1270 (10th Cir. 2013) (showing how courts analyze the duty question when a physician is on call), *and* Millard v. Corrado, 14 S.W.3d 42, 48 (Mo. Ct. App. 1999), *and* Mozingo *ex rel.* Thomas v. Pitt Cnty. Mem'l Hosp., Inc., 415 S.E.2d 341, 346 (N.C. 1992), *and* Lownsbury v. VanBuren, 762 N.E.2d 354, 360 (Ohio 2002), *and* Mead v. Legacy Health Sys., 283 P.3d 904, 911 (Or. 2012), *and* St. John v. Pope, 901 S.W.2d 420, 424 (Tex. 1995), *and* Prosise v. Foster, 544 S.E.2d 331, 332 (Va. 2001).
272. *See* cases cited *infra* note 274.
273. *See* cases cited *supra* note 271.
274. *See, e.g.*, *Talavera*, 725 F.3d at 1270; *Lownsbury*, 762 N.E.2d at 360; *Mead*, 283 P.3d at 911; *St. John*, 901 S.W.2d at 424; *Prosise*, 544 S.E.2d at 332.
275. *See Talavera*, 725 F.3d at 1270; *Millard*, 14 S.W.3d at 48; *Mozingo*, 415 S.E.2d at 346; *Lownsbury*, 762 N.E.2d at 360; *Mead*, 283 P.3d at 911; *St. John*, 901 S.W.2d at 424; *Prosise*, 544 S.E.2d at 332.
276. *See supra* note 271 and accompanying text.

whether there is a sufficient affiliation between the primary treating physician and the other on-call physician.[277]

1. Qualification: Degree of Affiliation

Many courts analyze the duty question in on-call cases by investigating whether a physician-patient relationship can be established.[278] This includes determining whether the on-call physician acted affirmatively, whether the on-call physician was supervising residents, and what the physician's contractual obligations to the hospital included.[279] However, courts have come to inconsistent conclusions because they weigh and define the factors differently.[280]

a. An Affirmative Act

Similar to curbside consultation cases, many courts determine whether an on-call physician provided a service or affirmatively acted in the patient's case.[281] For on-call cases, the analysis turns on whether the physician provided an initial diagnosis or treatment plan such that they became affiliated with the treating physician's care of the patient.[282]

In *St. John v. Pope*,[283] the plaintiffs sued the treating and on-call physicians, claiming that their negligence caused permanent and severe injuries.[284] After having back surgery and epidural injections, the patient came to the emergency room complaining of back pain and a fever.[285] His white blood cell count was also extremely high.[286] The emergency room physician, Dr. Suarez, examined the patient and initially diagnosed him with lower back pain and acute psychosis.[287] The patient's wife wanted him transferred to a hospital closer to their home.[288] Dr. Suarez called Dr. St. John, an internist who was on call for the hospital.[289] Dr. Suarez gave Dr. St. John the patient's history of recent back surgery and explained that the patient came in because of his fever and back pain.[290] Given that he was not a neurologist or neurosurgeon and the health facility was not able to handle such cases, Dr. St. John recommended that the patient be referred to a

277. *See supra* note 274 and accompanying text.
278. *See supra* note 271 and accompanying text.
279. *See infra* Parts II.B.1.a–c.
280. *See infra* Parts II.B.1.a–c.
281. *See supra* note 271 and accompanying text.
282. *See generally* Talavera *ex rel.* Gonzalez v. Wiley, 725 F.3d 1262 (10th Cir. 2013); Kelley v. Middle Tenn. Emergency Physicians, 133 S.W.3d 587 (Tenn. 2004).
283. 901 S.W.2d 420 (Tex. 1995).
284. *Id.* at 421.
285. *Id.*
286. *Id.*
287. *Id.*
288. *Id.*
289. *Id.*
290. *Id.* at 421–22.

hospital which had a neurosurgeon.[291] Dr. Suarez agreed with this recommendation and began to arrange for the patient's transfer by calling another emergency room.[292] However, the proposed hospital refused to accept the transfer, so the patient's wife then took him home.[293] The next day, Mr. Pope went to another hospital near his home, where physicians discovered that he had a lumbar puncture that led to meningitis.[294] Mr. Pope suffered several permanent disabilities from the disease.[295]

The court held there was no physician-patient relationship between Dr. St. John and the patient because Dr. St. John had not examined or treated him.[296] Although Dr. St. John listened to the treater's description of the patient's symptoms and came to a conclusion about the patient's condition, he did so for the purpose of evaluating whether he should take the case, not to diagnosis or treat the patient.[297] Because the on-call physician did not come up with the initial diagnosis or contemplate a treatment plan that Dr. Suarez was obligated to follow, there was no physician-patient relationship.[298] The on-call physician simply provided a recommendation that could be followed per the treater's discretion.[299]

In *Mead v. Legacy Health System*,[300] the court analyzed whether the physician knew or reasonably should have known that they were diagnosing a patient's condition or treating the patient.[301] Here, the on-call physician received a phone call from a resident asking for advice about a patient in the emergency room.[302] The next day, a nurse called the on-call physician to ask if he would see the patient, but the nurse did not say the request was urgent.[303]

The patient argued a relationship was implied because the physician, in response to the resident's initial telephone call, offered his opinion that the patient should be admitted to the hospital.[304] By offering such an opinion, the patient argued, he was acting in his capacity as the on-call neurosurgeon.[305] The court, however, determined that a jury could infer that a physician-patient relationship did not exist because, inter alia, the on-call physician did not directly examine, treat, or create a treatment plan for the patient.[306]

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291. *Id.* at 422.
292. *Id.*
293. *Id.*
294. *Id.*
295. *Id.*
296. *Id.* at 424.
297. *Id.*
298. *Id.*
299. *Id.*
300. 283 P.3d 904 (Or. 2012).
301. *Id.* at 911.
302. *Id.*
303. *Id.*
304. *Id.*
305. *Id.*
306. *See id.* at 913.

Additionally, the court fleshed out the meaning of "diagnosis" and "treatment" to sort physicians' actions into these two categories.[307] The court recognized that

> whether a physician's expression of an opinion constitutes a diagnosis will vary depending on, among other things, the customary practice within the relevant medical community, the degree and the level of formality with which one physician has assumed (or the other physician has ceded) responsibility for the diagnosis or treatment, the relative expertise of the two physicians, and the reasonable expectations, if any, of the patient under the circumstances.[308]

Based on these factors, the appropriate standard should be "whether a physician who has not personally seen a patient either knows or reasonably should know that he or she is diagnosing a patient's condition or treating the patient."[309]

The above cases show that courts determine the degree of affiliation between the primary treating physician and the on-call physician based on the actions or inactions of the on-call physician.[310] Through this lens, the actions themselves, as well as the physicians' perception of whether they knew or reasonably should have known that they were diagnosing or treating the patients, are significant to finding a relationship.[311] This latter question incorporates principles of undertaking and reliance in determining the degree of affiliation and the presence of an implied relationship.[312]

b. Unique Expertise: Foreseeability of Reliance

Similar to curbside consultations, courts also investigate whether a relationship exists between an on-call physician and a patient on the basis of foreseeability, reliance, and undertaking.[313] Specifically, they analyze whether it is foreseeable that, given the expertise of the on-call physician as a supervisor or specialist, the treating physician would rely heavily on an opinion or recommendation.[314] An on-call physician's degree of affiliation with the treating physician may be informed by whether the on-call physician is in a supervisory role where interns, residents, and nurses might rely on their expertise and knowledge.

In *Lownsbury v. VanBuren*,[315] a patient sued a supervising physician after her baby sustained severe brain damage due to the prenatal care and treatment she received.[316] The physician administered a nonstress test and an amniotic

307. *Id.* at 910.
308. *Id.*
309. *Id.*
310. *See id. See generally* St. John v. Pope, 901 S.W.2d 420 (Tex. 1995).
311. *See* cases cited *supra* note 310.
312. *See Mead*, 283 P.3d at 910.
313. *See* cases cited *supra* note 274.
314. *See generally* Lownsbury v. VanBuren, 762 N.E.2d 354 (Ohio 2002); Prosise v. Foster, 544 S.E.2d 331 (Va. 2001).
315. 762 N.E.2d 354 (Ohio 2002).
316. *Id.* at 355.

fluid index test to the patient.[317] Based on the results, the physician ordered that the mother be sent to the labor and delivery unit to induce labor.[318] Rather than following these instructions, the obstetrics residents administered a contraction stress test[319] and discharged the mother.[320] The baby was then born with permanent brain damage.[321] The patient's family sued the supervising physician, Dr. Stover, alleging he was negligent in failing to supervise the obstetrics residents who had cared for the mother, leading to the baby's permanent brain damage.[322]

Here, the issue was not whether the supervising physician had any contact with the patient or the treating residents; rather, it was "whether and to what extent Dr. Stover assumed the obligation to supervise the residents."[323] Did the supervising physician "assume only a limited and passive duty to remain in his call room until consulted by a resident with a problem, or did he assume an active duty to gauge the performance of the residents or familiarize himself with the condition of the patients at [the hospital]?"[324] The court found there was sufficient evidence that the jury could use to decide these questions.[325] Specifically, the consent form that was presented to the patient was substantial evidence that the on-call physician was required to take an active role in supervising the hospital's residents and caring for the hospital's patients.[326]

The physician-patient relationship and subsequent duty of care arises from circumstances that show a physician's consent to act for the patient's medical benefit.[327] The court in *Lownsbury* recognized that physicians working in an institutional environment may assume a duty of supervisory care due to the environment's "myriad of complex and attenuated relationships."[328] These relationships include the responsibility of either an individual physician or a group of physicians to supervise residents, interns, and the like.[329] This supervision creates a level of skill and competence that ensures adequate patient care.[330] Thus, an on-call physician becomes affiliated, through acts and duties of supervision, with the treating physician's care of a patient.[331]

317. *Id.*
318. *Id.*
319. *Id.*
320. *Id.*
321. *Id.*
322. *Id.*
323. *Id.* at 363.
324. *Id.*
325. *Id.* Because the defendant's motion for summary judgment was on appeal, the question here was whether there was sufficient evidence to raise a genuine dispute of material fact as to the existence of a physician-patient relationship between the supervising physician and the patient's mother. *Id.* at 357.
326. *Id.* at 363.
327. *See id.* at 360.
328. *See id.*
329. *See id.*
330. *See id.*
331. *See id.*

The treating physician is almost mandated to rely on the expertise provided by the supervising physician.[332]

Unlike *Lownsbury*, in *Prosise v. Foster*,[333] the Supreme Court of Virginia found that an attending physician did not have a duty of care in the absence of direct contact with or consultation concerning the patient, even in the environment of a teaching hospital.[334] The on-call physician, Dr. Foster, was not physically present in the emergency room but was available to answer any questions from the treating residents and interns.[335] During this time, a four-year-old girl came to the hospital and was placed under the care of a first-year resident.[336] The patient had chicken pox lesions in her mouth, was lethargic, and could not eat or drink.[337] Earlier that month, the patient had been treated for asthma with intravenous corticosteroids as an inpatient at another hospital.[338] The first-year resident consulted with a third-year resident regarding the patient's condition and prior treatment, then examined the patient without reading her chart or learning that she had been treated with corticosteroids.[339] Neither resident called the on-call attending physician regarding the patient's condition or treatment.[340] The residents treated the patient for dehydration and released her with instructions to see her pediatrician.[341]

The next day, the patient returned to the hospital and Dr. Foster saw her for the first time.[342] Dr. Foster diagnosed her with a condition in which the chicken pox virus affects the body's entire system.[343] The treating team placed the patient on an antiviral medication, but she died as a result of the infection.[344] The patient's mother sued Dr. Foster, alleging she had a duty to supervise the medical care rendered by the residents working at the hospital.[345]

The court held that there were no facts that supported a finding that the attending physician accepted responsibility for the patient.[346] Dr. Foster did not treat the patient or participate in any treatment decisions with the residents during the initial visit.[347] Neither the residents nor the hospital staff consulted with Dr. Foster.[348] Thus, simply agreeing to act as an on-call attending physician in a teaching hospital was considered, on its own,

332. *See id.* at 358.
333. 544 S.E.2d 331 (Va. 2001).
334. *Id.*
335. *Id.* at 332.
336. *Id.*
337. *Id.*
338. *Id.*
339. *Id.*
340. *Id.*
341. *Id.*
342. *Id.*
343. *Id.*
344. *Id.*
345. *Id.*
346. *Id.* at 334.
347. *Id.*
348. *Id.*

insufficient evidence to prove Dr. Foster assumed responsibility for the patient's case.[349]

c. Contractual Obligation: Undertaking

In determining the degree of affiliation between the treating physician and the on-call physician, some courts consider the physician's contractual obligations.[350] Courts have recognized that the obligations that flow from a physician's on-call status are not uniform.[351] The obligations vary from one institution to another, depending on their policies, contractual terms, and agreements with on-call physicians, as well as the customary practices in the relevant medical community.[352] Thus, a physician's degree of affiliation with a particular patient may be informed by these unique policies and obligations.

In *Talavera ex rel. Gonzalez v. Wiley*,[353] a patient alleged that a physician-patient relationship was formed based on the physician's agreement with the hospital.[354] After fainting in a store bathroom, the patient arrived at the hospital.[355] She was seen by a nurse and complained of general weakness, a sore throat and ear, and a headache.[356] However, before Dr. Wiley, the on-call emergency room physician, could examine her, she left the hospital.[357] The patient returned to the hospital that night, where she was seen by Dr. Wiley, who ultimately discovered that the patient had suffered a stroke.[358] The patient sued Dr. Wiley, claiming that he owed her a duty of care and negligently prevented her from receiving the appropriate treatment, which resulted in permanent physical and mental injuries.[359]

The patient argued that the terms of Dr. Wiley's contract required him to examine and treat patients within twenty minutes of their arrival at the hospital.[360] Thus, the contract allegedly created a physician-patient relationship and established a duty of care to the patient.[361] The court found that no prior case in the state had explicitly held that a tort duty for a physician

349. *Id.*

350. *See* Millard v. Corrado, 14 S.W.3d 42, 50 (Mo. Ct. App. 1999); Corbet v. McKinney, 980 S.W.2d 166, 169 (Mo. Ct. App. 1998) ("Where the consultant physician does not physically examine or bill the patient, a physician-patient relationship can still arise where the physician is contractually obligated to provide assistance in the patient's diagnosis or treatment and does so.").

351. *See* Mead v. Legacy Health Sys., 283 P.3d 904, 911 (Or. 2012).

352. *See id.*

353. 725 F.3d 1262 (10th Cir. 2013).

354. *Id.* at 1265.

355. *Id.*

356. *Id.*

357. *Id.* The patient left the hospital against medical advice because she was not sure how to pay for her care and felt well enough to leave. *Id.*

358. *Id.* at 1266–67.

359. *Id.* at 1267. The parties agreed that the onset of the stroke occurred when she was found unconscious and the three-hour window to receive preventative treatment began to run only at that time. *Id.* at 1269.

360. *Id.* at 1271.

361. *Id.*

can arise through the physician's contract with a hospital and refused to do so here.[362] Even if the court were to accept such a theory, the terms of Dr. Wiley's contract did not give rise to any duty.[363] Reading the specific terms of the contract, the on-call physician is only required to give a response within twenty minutes, not to "see, examine, or treat" the patient specifically.[364] The time frame also could not be a condition that automatically creates a relationship, as it would create a relationship with every emergency room patient whose arrival the physician is notified of within twenty minutes.[365] Consequently, the court found no relationship between the patient and Dr. Wiley on the basis of the contract and its obligations.[366]

2. Exceptions to the Rule: A Duty of Care Despite No Relationship

Many courts assert that where there is an implied relationship, the physician assumed a duty of care.[367] However, some courts find an undertaking even if there was no physician-patient relationship.[368] Other courts have emphasized whether or not it was foreseeable that the patient and subsequent healthcare professional would rely on the physician's actions or expertise to prevent harm.[369]

a. Undertaking to Provide Care

Some courts have found an undertaking, regardless of the presence of a physician-patient relationship, based on an on-call physician affirmatively agreeing to supervise residents who the on-call physician knows are actually treating patients.[370] This involves the on-call physician knowing that residents and interns will be relying on them for supervision and advice in the actual treatment of patients given their expertise and the preset protocols of the hospital.

In *Mozingo ex rel. Thomas v. Pitt County Memorial Hospital, Inc.*,[371] the court found that the on-call physician owed the patient a duty of reasonable care in supervising the residents who actually cared for the patient.[372] Dr. Kazior, an employee of Eastern OB/GYN Associates, had an agreement with the East Carolina University Medical School to provide on-call supervision to the interns and residents in the obstetrics residency program.[373] The

362. *Id.* at 1270.
363. *Id.* at 1271.
364. *Id.*
365. *Id.*
366. *Id.*
367. *See* cases cited *supra* note 274.
368. *See generally* Mozingo *ex rel.* Thomas v. Pitt Cnty. Mem'l Hosp., Inc., 415 S.E.2d 341 (N.C. 1992).
369. *See infra* Part II.B.2.a.
370. *See Mozingo*, 415 S.E.2d at 345.
371. 415 S.E.2d 341 (N.C. 1992).
372. *Id.* at 342.
373. *Id.*

patient, Ms. Mozingo, was admitted for the delivery of her child.[374] Two residents in the program treated Mozingo.[375] That evening, Dr. Kazior began his assignment providing on-call services.[376] He remained at home and available to take calls from the residents.[377] That night, he received a phone call from a second-year resident informing him that she had encountered a problem with delivering the baby, who was now suffering from shoulder dystocia.[378] Dr. Kazior responded that he would be there immediately and left his home to go to the hospital.[379] By the time he arrived, the baby had been delivered.[380] Following the incident, the plaintiffs filed suit against Dr. Kazior, alleging that his negligent supervision of the residents performing the delivery caused the baby's injuries.[381]

The court held that, because Dr. Kazior knew the residents were actually treating patients when he undertook the duty to supervise them as an on-call physician, he owed the patients a duty of reasonable care in supervising the residents.[382] Additionally, the court found that Dr. Kazior's nontraditional physician-patient relationship with the plaintiffs did not diminish his duty of reasonable care when supervising the residents.[383] Here, the undertaking was determined outside the scope of the physician-patient relationship and existed because an on-call physician affirmatively agreed to provide on-call supervision of residents who they knew were treating patients.[384]

b. Foreseeability of Harm and Reliance

Some courts find a duty of care when harm to the patient is foreseeable as a result of the patient and other healthcare practitioners relying on the expertise, decision-making, authority, and obligation of the other physician.[385] "If the harm is particularly foreseeable, a duty will be recognized as that is the touchstone for the creation of duty."[386] Thus, if, under the circumstances, a reasonably prudent person would have anticipated danger and provided against it, courts may recognize a duty to prevent harm.

For instance, in *Warren v. Dinter*,[387] discussed above, the Minnesota Supreme Court held that "a physician has . . . a legal duty of care based on the foreseeability of harm."[388] The court emphasized that "when there is no

374. *Id.*
375. *Id.*
376. *Id.*
377. *Id.*
378. Shoulder dystocia is a condition in which the baby's shoulder becomes wedged in the mother's pelvic cavity during delivery. *Id.*
379. *Id.*
380. *Id.*
381. *Id.* at 343.
382. *Id.* at 344–45.
383. *Id.* at 345.
384. *See id.*
385. *See generally* Warren v. Dinter, 926 N.W.2d 370 (Minn. 2019).
386. Millard v. Corrado, 14 S.W.3d 42, 47 (Mo. Ct. App. 1999).
387. 926 N.W.2d 370 (Minn. 2019).
388. *Id.* at 377; *see supra* notes 1–5 and accompanying text.

express physician-patient relationship, we have turned to the traditional inquiry of whether a tort duty has been created by foreseeability of harm."[389] Thus, the court inquired "whether it was foreseeable that Dinter's decision not to admit Warren, if made negligently, would be relied on by Warren, through [the nurse], and cause her harm."[390] Specifically, was the relevant danger objectively reasonable to expect?[391]

The court found that it was reasonable to conclude that the danger was foreseeable to Dr. Dinter that the patient would rely on his actions and would be harmed as a result of them.[392] Because the nurse practitioner could not admit the patient on her own, Dr. Dinter was tasked with making this admission decision.[393] As the gatekeeper, Dr. Dinter made a medical decision not to open the gate to the patient, thereby impacting the subsequent treatment she received and the harm she incurred.[394] Further, "Dr. Dinter knew, or should have known, that his decision whether or not to admit a prospective patient, based on his own medical judgment, would be relied on by [the nurse] and her patient."[395] Additionally, the court believed Dr. Dinter also "knew, or should have known, that [such] a breach . . . could result in serious harm."[396]

The above case demonstrates the importance of foreseeability and reliance in finding a duty of care.[397] The court's analysis did not include whether an implied physician-patient relationship existed.[398] Rather, the court found a duty of care existed, that it was foreseeable that the physician's medical judgment would be relied upon by the patient and other healthcare professionals, and that a breach of care would result in serious harm.[399]

c. Public Policy Considerations

Given the nuanced duty question, a few courts have determined that a physician owes a duty of care to a nontraditional patient because of public policy.[400] In *Millard v. Corrado*,[401] the patient was involved in a car crash and experienced serious trauma.[402] As a result, the patient suffered severe internal bleeding and developed hypovolemic shock.[403] The emergency medical technicians brought the patient to a hospital known to operate as a

389. *Warren*, 926 N.W.2d at 375.
390. *Id.* at 377–78.
391. *Id.* at 378 (citing Foss v. Kincade, 766 N.W.2d 317, 322 (Minn. 2009)).
392. *Id.*
393. *Id.*
394. *Id.*
395. *Id.*
396. *Id.*
397. *See id*.
398. *See id.*; Millard v. Corrado, 14 S.W.3d 42, 47 (Mo. App. Ct. 1999) (recognizing that foreseeability of harm can create a duty of care).
399. *See Warren*, 926 N.W.2d at 378.
400. *See generally* Millard v. Corrado, 14 S.W.3d 42 (Mo. App. Ct. 1999).
401. 14 S.W.3d 42 (Mo. App. Ct. 1999).
402. *Id.* at 44.
403. *Id.*

twenty-four-hour emergency department and thus, expected to have a general surgeon on call.[404]

Dr. Corrado, a general surgeon at this hospital, scheduled himself to be on call, even though he was preparing to attend a meeting in another city in the state.[405] Before leaving for his meeting, Dr. Corrado had asked Dr. Jolly, an orthopedic surgeon, to cover for him during the four-hour period that he would be out of town.[406] Dr. Jolly agreed to fill in for Dr. Corrado even though he did not have privileges to perform general surgery.[407] Dr. Corrado did not notify anyone else at the hospital that he would be out of town and unable to provide care to emergency room patients requiring a general surgeon.[408]

When the patient arrived at the hospital, the emergency medical technician paged Dr. Corrado because he was listed as the on-call general surgeon.[409] The page went unanswered.[410] An emergency room physician then examined the patient and diagnosed her with an intra-abdominal bleed.[411] Dr. Corrado was paged again but did not respond.[412] Ten minutes later, Dr. Jolly saw the patient and concurred with the previous diagnosis.[413] However, because he was not qualified as a general surgeon and did not have hospital privileges, Dr. Jolly could not perform surgery on the patient.[414] Around twenty minutes later, Dr. Corrado called the emergency room and advised that the patient be transferred to another hospital.[415] Approximately four hours after the accident, the patient underwent surgery.[416] The patient later sued Dr. Corrado, alleging that the delay in her treatment caused several injuries.[417]

The court held that Dr. Corrado owed the patient a duty of care for the patient's ordinary negligence claim on the basis of certain public policy factors.[418] In determining whether public policy supports the recognition of a duty of care, the court considered the following factors:

> (1) the social consensus that the interest is worth protecting, (2) the foreseeability of harm and the degree of certainty that the protected person suffered the injury, (3) the moral blame society attaches to the conduct, (4) the prevention of future harm, (5) the consideration of cost and ability to

404. *Id.* at 45.
405. *Id.* at 44.
406. *Id*.
407. *Id*.
408. *Id*.
409. *Id.* at 45.
410. *Id.*
411. *Id.*
412. *Id.*
413. *Id.*
414. *Id.*
415. *Id.*
416. *Id.*
417. *Id.* at 45–46.
418. *Id.* at 47.

> spread the risk of loss, and (6) the economic burden upon the actor and the community.[419]

The court found that these public policy factors weighed in favor of finding that Dr. Corrado owed a duty of care to the patient.[420] Based on a Missouri General Assembly regulation that requires on-call emergency room physicians to arrive at the hospital within thirty minutes, the court found evidence of a social consensus that emergency room physicians should attend to their patients within a reasonable amount of time.[421] It was also foreseeable that the hospital would be presented with a patient requiring the care of a general surgeon during Dr. Corrado's absence.[422] The court found that "[i]mposing such a duty on 'on-call' physicians to notify appropriate hospital personnel of their unavailability does not place an unreasonable burden on the medical profession."[423] Given that a single phone call would have reduced the period between the patient's accident and surgery, a slight inconvenience to the physician is trivial in comparison to the risk to patients.[424] Lastly, the court found that if on-call physicians had a duty to give notice when they could not fulfill their responsibilities, it would prevent future harm and reduce the number of such incidents.[425]

The court extended a duty of care to Dr. Corrado on the basis of public policy and firmly held that this duty "will not have a detrimental impact on the ability of hospitals to attract physicians to accept 'on-call' assignments."[426] By considering public policy, the court was able to balance the public interest and address the duty question outside of any physician-patient relationship.[427]

III. THE CREATION OF A CLEAR LEGAL STANDARD

Based on the above analysis, this Note argues for the creation of a clear legal standard that would address the nuances of the duty question in cases involving either a curbside consultation or an on-call physician. Part III.A summarizes the case law for both curbside consultations and on-call physicians and emphasizes the need to create a clear legal rule to address the imperative duty question. Part III.B proposes a specific rule that includes a step-by-step analysis for courts to apply when faced with a case involving either a curbside consultation or an on-call physician.

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419. *Id.* (citing Hoover's Dairy, Inc. v. Mid-Am. Dairymen, Inc., 700 S.W.2d 426, 432 (Mo. 1985) (en banc)).

420. *Id.* The court determined that on-call "physicians owe a duty to reasonably foreseeable emergency patients to provide reasonable notice to appropriate hospital personnel when they will be unavailable to respond to calls." *Id.* at 48.

421. *Id.* at 47.

422. *Id.* at 47–48.

423. *Id.* at 47.

424. *Id.*

425. *Id.*

426. *See id.* at 48.

427. *See id.*

A. The Need for Clarity

Courts consider each case in the realm of curbside consultations and on-call physicians on their respective facts but have failed to provide a clear legal standard.[428] When determining liability, courts consider the confines and scope of the physician-patient relationship but also consider when physicians may owe a duty of care to these nontraditional patients in the absence of such a relationship.[429]

In curbside consultation cases, most courts analyze the duty question by determining whether there is an implied physician-patient relationship.[430] Specifically, they analyze whether an affirmative act exists or not.[431] Most courts do not find that providing advice alone is a sufficient affirmative act.[432] However, most courts have also not formally defined what a sufficient affirmative act is in such situations, nor have they formalized what actions, in conjunction with providing advice, establish an implied physician-patient relationship.[433]

While courts' analyses often center around this act "requirement," courts also consider other factors, such as the length, duration, and detail of the consult.[434] Many have also analyzed whether it is reasonably foreseeable that a patient may be injured as a result of the consulting physician's actions or whether the consulting physician undertook to advise the treating physician in such a way that the treating physician would rely on the recommendation.[435] Foreseeability, undertaking, and reliance are embedded in many courts' approaches in considering both whether a physician-patient relationship exists and whether a duty of care exists notwithstanding the lack of such a relationship.[436] In some ways, these principles act as guideposts for courts grappling with the duty question.[437]

With on-call cases, courts are more willing to recognize a duty of care even in the absence of a physician-patient relationship.[438] The focal point of their analyses is the degree of affiliation between the on-call physician and the treating physician or healthcare facility. To determine this degree of affiliation, some courts consider an on-call physician's affirmative actions, their unique expertise that may make reliance foreseeable, and contractual obligations that create an undertaking.[439] Regardless of whether a relationship is found, some courts still consider whether there was an undertaking to provide medical care, whether it was reasonably foreseeable

428. *See generally* Teresa Baird, Note, *Who Is Actually Calling the Shots?: Watch Out, They May Not Be Liable:* Irvin v. Smith, 22 ST. LOUIS U. PUB. L. REV. 185 (2003).
429. *See generally* Blake, *supra* note 30; Baird, *supra* note 428.
430. *See supra* Part II.A.1.
431. *See supra* notes 161–65 and accompanying text.
432. *See supra* Part II.A.1.b.2.
433. *See supra* Part II.A.1.b.
434. *See supra* note 208 and accompanying text.
435. *See* cases cited *supra* note 209.
436. *See* cases cited *supra* note 240.
437. *See* cases cited *supra* notes 209, 240.
438. *See* cases cited *supra* notes 271, 274–75.
439. *See* cases cited *supra* note 274.

that the physician would rely on the on-call physician, or if public policy would favor finding a duty of care.[440]

While the above summary and case law demonstrate general trends in the courts' approaches, it remains unclear what factors may be dispositive to their analysis. This Note argues that it is necessary for courts to develop a clear legal rule for determining whether a duty of care exists between a patient and either a consulting physician or an on-call physician.

Developing a clear legal standard will help to balance the interests of physicians in sharing information and expanding their knowledge base against the interests of patients who are negligently harmed. It would be unwise to discourage physicians from advising colleagues or signing up for on-call shifts—these practices are critical to the medical community and have positive impacts on patient care.[441] Thus, in light of evolving medical standards and the increase in nontraditional care interactions, courts must establish a more formalized rule to align physician expectations and patient interests.

B. A New Legal Standard: Uniform Analysis of the Duty Question

Based on the above analysis of the case law, this Note proposes a uniform framework that considers prominent trends in medical malpractice law, along with important considerations of traditional negligence law. As a general matter, courts' duty of care analyses begin by building off of their understanding of a traditional physician-patient interaction. However, with the ongoing changes in medicine, it will be increasingly important for courts to deviate from their understandings of traditional interactions and relationships. The analysis below accounts for this.

This Note's argument is specific to cases involving either a curbside consult or an on-call physician. Nonetheless, other types of cases may raise a similar duty question, such as when physicians serve as independent medical examiners.[442] This step-by-step analysis can be applied to other such situations but may lack appropriate guidance specific to facts or trends in those cases.

1. The Rule: Is There an Implied Physician-Patient Relationship?

To bring a viable claim for medical malpractice against any physician, most courts require a showing of a physician-patient relationship.[443] Therefore, the first step of a court's analysis should be to consider whether a physician-patient relationship—mainly an implied relationship—exists. Depending on whether the court is presented with a case involving a curbside consultation or an on-call physician, the dispositive factor in the analysis differs. In curbside consultation cases, the analysis should turn on whether

440. *See* cases cited *supra* note 275.
441. *See* Blake, *supra* note 30, at 613.
442. *See* cases cited *supra* notes 68, 70.
443. *See supra* note 38 and accompanying text.

there is an affirmative act. In on-call cases, on the other hand, the analysis should depend on the degree of affiliation between the on-call physician and the treating physician or facility. If a court finds there is no relationship, this will significantly reduce the viability of the medical malpractice claim as a matter of law. Even if there is no relationship, however, a court may consider applying a public policy approach to answer the duty question, but these cases will likely be in the minority.[444]

a. Curbside Consultations: Is There an Affirmative Act?

In curbside consultation cases, courts should find that providing advice alone is not a sufficient affirmative act and an implied physician-patient relationship cannot be formed without any other affirmative action.[445] To determine whether there is an implied relationship in the context of curbside consultations, a court must look for whether there was an affirmative act taken on the part of the consulting physician. Courts can consider other factors as well. However, if there is no affirmative act, there should be no implied relationship. Thus, this factor should dispositive. This rule should be steadfast.

The affirmative act requirement stems from the common-law notion of the consensual nature of the physician-patient relationship.[446] Courts can consider what actions suggest that a physician has expressly or impliedly consented to a relationship with the patient.[447] Thus, courts can confine the scope of an affirmative act to specific acts or services and, if those are not present, then there is no relationship. What constitutes an affirmative act should be defined as an act that involves either examining, diagnosing, or treating the patient.[448] Examples of such acts include physically examining the patient, reviewing the patient's chart, ordering tests, reviewing tests, preparing reports, or providing recommendations that cannot be ignored.[449] Given the ever-changing nature of medicine and healthcare delivery, this list of acceptable affirmative acts may change over time. Therefore, this question can be fleshed out by past and future case law.

b. On-Call Physicians: What Is the Degree of Affiliation?

Being on call alone is not sufficient to establish an implied physician-patient relationship.[450] But, unlike curbside consult cases, the key question to determining the existence of an implied physician-patient relationship is not whether the on-call physician acted affirmatively; instead, courts should consider the degree of affiliation between the on-call physician and the

444. *See* Millard v. Corrado, 14 S.W.3d 42, 47 (Mo. App. Ct. 1999).
445. *See supra* notes 55–56 and accompanying text.
446. Adams v. Via Christi Reg'l Med. Ctr., 19 P.3d 132, 140 (Kan. 2001); *see* Baker, *supra* note 39.
447. *See Adams*, 19 P.3d at 140.
448. *See* cases cited *supra* notes 164–66.
449. *See* cases cited *supra* notes 164–66.
450. *See* cases cited *supra* note 271.

treating physician or the healthcare facility. This should be the dispositive factor in these cases. Where there is a significant degree of affiliation, a court should find that an implied physician-patient relationship exists.

The ultimate cornerstone of a significant degree of affiliation is whether the on-call physician has an obligation to respond to the patient's case.[451] Where there is a built-in relationship with someone who counts as a treating physician or some kind of legal connection that authorizes or obliges the on-call physician to respond to the treating healthcare professional, there is a powerful argument that there is a duty of care, no matter how many steps are between the on-call physician and the treating one.[452]

The degree of affiliation factor is not explicitly mentioned in any of the above cases. Rather, it appears as an unsaid consideration. To provide clarity on how to determine the degree of affiliation, courts should consider which factors may help their analysis, such as affirmative actions, supervision, or contractual obligations. Courts may also develop the meaning of affiliation over time through case law.

2. Qualification: Are There Other Considerations?

While the affirmative act or the degree of affiliation should be dispositive to the creation of an implied physician-patient relationship, depending on the kind of case, courts do not consider any one factor in a vacuum—other circumstances and considerations inform their determinations. Similarly, here, courts can turn to other factors—specifically, foreseeability and undertaking—to support whether an affirmative act occurred or to determine the degree of affiliation. However, these factors alone cannot establish an implied physician-patient relationship.[453] There must be an affirmative act or a significant degree of affiliation present.

In the case law for both curbside consultations and on-call physicians, courts consider whether it was reasonably foreseeable to the consulting or on-call physician that a patient may be injured as a result of their actions or obligations.[454] Therefore, in determining this, courts may consider "the likelihood of injury, the magnitude of the burden of guarding against it and the consequences of placing that burden upon the defendant."[455] Additionally, courts may also consider whether the consulting or on-call physician advised or provided medical care such that the treating physician was not free to accept or reject the recommendations given.[456] If the treating healthcare professional felt obligated to follow the recommendations of the on-call or consulting physician, where they felt they had no option but to

451. *See* cases cited *supra* note 271.
452. *See* cases cited *supra* note 271.
453. *See* Bovara v. St. Francis Hosp., 700 N.E.2d 143, 146 (Ill. App. Ct. 1998).
454. *See id.*; Reynolds v. Decatur Mem'l Hosp., 660 N.E.2d 235, 239 (Ill. App. Ct. 1996); Lownsbury v. VanBuren, 762 N.E.2d 354, 363 (Ohio 2002).
455. *Bovara*, 700 N.E.2d at 146 (citing Lance v. Senior, 224 N.E.2d 231, 233 (Ill. 1967)); *see also Reynolds*, 660 N.E.2d at 239.
456. *See supra* notes 235, 253 and accompanying text.

follow the opinion, a court should consider that to be an undertaking that can support the finding of an affirmative act or a significant degree of affiliation.

The above considerations, taken together, incorporate principles of reliance and foreseeability of harm, along with the creation of an undertaking. These principles are the very bedrock of the duty of care in negligence law.[457] Accordingly, courts can and should consider these subfactors alongside their analyses of the affirmative act and degree of affiliation inquiries. This determination—that reliance, foreseeability, and undertaking, on their own, do not create an implied relationship—should not apply when a court analyzes an ordinary negligence claim; rather, it should only apply to claims of medical malpractice.

3. Exception: Public Policy Considerations

If a court does not find that there is an implied physician-patient relationship, it may consider whether public policy supports the recognition of a duty of care. A sample set of public policy considerations comes from *Millard*.[458]

Public policy considerations should not be the first step in a court's analysis of the duty question. While policy considerations are important, the duty question is a legal one and should not be answered on the basis of policy alone. Further, if courts exclusively relied on public policy considerations, issues of unpredictability and nonuniformity in this area would continue largely unabated. Thus, public policy alone will not remedy the problem at hand in these cases.

As a result, in the context of curbside consultations or on-call physicians, courts should consider public policy only after they have analyzed the physician-patient relationship. Given the uniqueness of the duty question, there may be circumstances where addressing public policy is necessary for the most comprehensive analysis.[459] Therefore, this Note recognizes the importance of such an approach but argues that courts should employ it only after completing a physician-patient relationship analysis.

CONCLUSION

The duty question raised when a nontraditional patient sues a physician is a difficult one. While many state and federal courts have approached this question, none have created a uniform, predictable, or streamlined approach to analyzing a duty of care. Without a clear legal standard, physicians and patients alike remain uncertain about what the law is and when a viable claim may be brought against a physician. Thus, it is imperative for courts to develop a clear legal standard that creates a steadfast rule, with qualifications and exceptions, that balances physicians' expectations, modern practices in medicine, and the interests of patients seeking redress.

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457. *See* GOLDBERG ET AL., *supra* note 37, at 74–76.
458. *See supra* note 419 and accompanying text.
459. *See supra* note 419 and accompanying text.