Medical Malpractice Liability for Consulting Physicians: A Case Law Survey

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I. Introduction

The healthcare field is an ever-changing landscape shaped by technological innovation and evolving care models designed to enhance the quality, efficacy, and provision of medical care. One way in which healthcare providers have recently sought to improve primary care is by transitioning to team-based primary care practices.[2] Team-based care involves "…the provision of health services…by at least two health providers who work collaboratively with patients and their caregivers… to achieve coordinated, high-quality care."[3] Dartmouth-Hitchcock Medical Center, for example, offers a team-based approach to primary care for the hospital's employees, which gives patients access to a team of providers consisting of primary care physicians, behavioral/mental health providers, nurses, and care coordinators.[4]

While this team-based model has potential to improve care, physicians who are members of these teams may try to disclaim malpractice liability—if those physicians did not meet the patient—by denying the existence of a physician-patient relationship. Medical malpractice defendants routinely argue that medical consultations can never give rise to a duty of care owed by the physician because the physician did not directly interact with the patient. If this were the case, however, any physician consulting on a patient's care could escape liability if they never met the patient, regardless of the nature of the consultation. In other words, a duty would not be owed by a radiologist interpreting films, a pathologist interpreting slides, a laboratory worker testing blood, a physician providing telephonic consultation, or by a physician participating in the diagnosis and treatment of a patient as a member of a team-based care model.

This theory is inconsistent with the law in New Hampshire and the nationwide trend that is shifting away from the traditional view that personal interaction is required to establish a physician-patient relationship. This article will discuss the law in New Hampshire and the various approaches taken by courts across the country in their determination of whether a physician-patient relationship arose between a consulting physician and a patient. Moreover, this article will demonstrate that the absence of personal interaction between a

patient and a physician consulting on his or her care does not necessarily absolve the consultant of malpractice liability.

II. Physician-Patient Relationship

One way to create medical malpractice liability is to prove the existence of a physician-patient relationship, which can be expressly created by the parties or implied by their conduct.[5] Whether a physician-patient relationship exists is a question of fact specific to each individual case.[6] Increasingly, courts are conducting "a qualitative analysis of the consultative physician's actions in relation" to the patient in deciding whether a physician-patient relationship existed.[7]

A. Affirmative Conduct

A physician-patient relationship can be expressly created by the parties or it can be implied by their conduct.[8] Face-to-face meetings between the physician and the patient are not required to give rise to a physician-patient relationship.[9] In the absence of a prior contractual relationship between the doctor and a hospital, a physician may establish a relationship with a patient by taking some affirmative action to treat the patient.[10]

Indeed, "an on-call physician to an emergency room consulted by telephone renders medical services by evaluating the information provided and making a medical decision."[11] Other jurisdictions have employed this approach and have found that a physician-patient relationship can be implied between an emergency room patient and an on-call physician they have never met when that physician actively participates in the diagnosis of the patient, actively participates in or prescribes the treatment plan for a patient, or owes a duty to the hospital or patient for whose benefit he is on-call.[12]

Other courts have looked at the extent to which the consultant exercised his independent professional judgment in a matter directly relating to the patient and the extent to which the consultant knows the exercise of his judgment will be relied upon and determine the ultimate course of care for the patient.[13] At least one court has found that "[a]n implied physician-patient relationship may arise when a physician gives advice to a patient, even if that advice is communicated through another health care professional."[14] In short, when a physician takes some affirmative act to participate in the care and treatment of a patient, a physician-patient relationship exists.[15] This is especially true when a physician listens to a description of a patient and then essentially directs the course of that patient's treatment.[16]

Telephonic consultations between emergency department physicians and on call specialists about the care and treatment of emergency room patients can establish a physician-patient relationship. For example, in Kelley

v. Middle Tennessee Emergency Physicians,[17] the plaintiff presented to an emergency room complaining of chest pain similar to that she had suffered from several months earlier when she had a heart attack.[18] The emergency room physician spoke with a cardiologist on call who listened to the presentation and history and advised that the patient could be treated as an outpatient.[19] The patient was discharged and subsequently died of a cardiopulmonary arrest days later.[20] The Kelley court found that there was sufficient evidence to show that this was more than an informal consultation because the call was made to the appropriate specialist, who was on call for the treating physician, and it was made specifically for direction in the management and care of the patient.[21] The court found that there were issues of material fact in dispute about the extent of affirmative involvement in the patient's care by the on-call physician, thereby precluding summary judgment.[22]

Similarly, in Wheeler v. Kersting Memorial Hospital,[23] the court held, as a matter of law, that a physician who evaluated the status of a pregnant woman's labor and approved her transfer to another hospital for treatment on the basis of information received over the phone by a nurse was liable as a treating physician.[24]

Likewise, in Lection v. Dyll,[25] the plaintiff presented to an emergency room with symptoms of hemiparesis, slurred speech, headache and dizziness.[26] The emergency room physician ordered several tests and called the on-call neurologist for guidance in whether additional treatment was warranted.[27] The neurologist diagnosed the patient with a hemiplegic migraine and advised that no further treatment was warranted, so discharge would be proper with appropriate follow up and instructions.[28] The Lection court found that genuine issues of material fact were in dispute as to whether a physician-patient relationship existed based on the neurologist's affirmative participation in the diagnosis and treatment plan for this patient. The court explained that the neurologist's affirmative conduct amounted to "an evaluation of the information provided and a medical decision concerning [plaintiff's] need for treatment."[29] Furthermore, the Lection court found that a physician-patient relationship arose by contract because the neurologist was required under the hospital bylaws to take call from the emergency room.[30]

In McKinney v. Schlatter,[31] a patient presented to an emergency room with chest pain and, after ordering several tests, the emergency room physician called the cardiologist on call for assistance in the treatment plan for the patient.[32] The emergency room physician described the patient and test results and the cardiologist told him that the complaints did not sound cardiac in nature and instructed the emergency room physician to do a few

more tests, ultimately recommending discharge of the patient with follow up with the patient's personal physician.[33] The McKinney court found that there were genuine issues of material fact in dispute as to the extent of the physician's affirmative involvement in the diagnosis and treatment plan of the patient.[34]

B. Foreseeable Reliance

Other courts frame the inquiry as whether it was reasonable and foreseeable that the patient would rely on the physician's advice or whether the physician's actions created a reasonable expectation of care.[35] For example, in Cogswell v. Chapman,[36] the court found that a doctor-patient relationship can be established by a telephone call where 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.[37] The consultant ophthalmologist discussed the patient's eye injury with the treating physician, asked if the patient's eye pressure had been checked, and discussed treatment management.[38] The court held that the defendant's conduct demonstrated "more than an informal interest and involvement in plaintiff's condition," and presented an issue of fact for the jury, "especially in light of defendant's expertise in ophthalmology."[39]

In Gilinsky v. Indelicato,[40] the patient began suffering from neurologic symptoms while receiving chiropractic treatment.[41] The chiropractor called a neurologist several times to discuss his patient's symptoms and course of treatment. Over the course of seven phone calls, the neurologist never advised the chiropractor to get the patient emergent neurologic care.[42] As a result, the patient suffered permanent deficits from a stroke. The court found the following circumstances to be highly probative in its evaluation of whether a physician-patient relationship came into existence: (1) the extent to which the consultative physician exercised his professional judgment in a matter bearing directly upon the plaintiff, and (2) the foreseeability to the consultant that his exercise of judgment ultimately would determine the precise nature of the medical services to be rendered to the plaintiff.[43] The court found that a reasonable jury could find that the neurologist became a part of the physician-patient relationship with the patient and there were genuine issues of material fact in dispute, precluding summary judgment.[44]

The court in Diggs v. Arizona Cardiologists[45] held that a cardiologist, by virtue of professional expertise, could be found to have a duty of care when it was foreseeable that the patient's treating physician would rely on his advice.[46] The defendant in Diggs consulted with an emergency room physician about a patient who had presented with severe chest pain.[47] The two physicians discussed the patient's clinical history and the results of her physical examination.[48] The cardiologist also reviewed the patient's EKG.[49] Following

the cardiologist's diagnosis of pericarditis, they agreed that the patient should be given a nonsteroidal anti- inflammatory medication and discharged.[50] Three hours later, the patient died of cardiopulmonary arrest.[51] The court noted that the defendant cardiologist was in a "unique position" to prevent future harm to the patient because the emergency room doctor was not fully qualified to interpret the EKG, relying on the cardiologist's interpretation and curbside diagnosis of pericarditis.[52] Under these circumstances, the court concluded that the absence of a contractual relationship between the patient and the defendant cardiologist did not preclude liability.[53]

C. "Invisible" Specialists

Another group of cases involve "invisible" specialists such as radiologists and pathologists who regularly perform services but rarely see or speak to the patient.[54] In such cases, "[a] consensual relationship between a physician and a patient may exist where others have contracted with the physician on the patient's behalf."[55] The courts in these cases found that the important fact in determining whether the relationship is a consensual one is not who contracted for the service, but whether it was contracted for with the express or implied consent of the patient or for his benefit.

III. Physician-Patient Relationship By Contractual Obligation

Some courts consider whether a pre-existing contractual obligation between the consultant and the hospital give rise to a physician-patient relationship. Indeed, a physician "may agree in advance with a hospital to the creation of a physician-patient relationship that leaves him no discretion to decline treatment of the hospital's clients."[56] For example, In Lection v. Dyll,[57] the court found that a physician-patient relationship arose out of the on-call physician's contractual obligation because the hospital by-laws required the on-call physician to provide medical care to patients in the emergency room in order to maintain active staff privileges.[58]

In Oja v. Kin,[59] however, the plaintiff argued that "[the defendant consultant's] contractual relationship with the hospital, combined with the hospital by-laws, imposed a duty on [the consultant] to come to the hospital when he was called, or to arrange for coverage."[60] The court noted that while the consultant may have owed such a duty to the hospital, a contract between a consultant and the hospital does not necessarily create rights in third parties such as the plaintiff.[61] Thus, the plaintiff would have to prove that he was an intended third-party beneficiary before he could enforce the contract against the defendant consultant.[62]

In Hand v. Tavera,[63] the court recognized a physician-patient relationship where a "health-care plan's insured show[ed] up at a participating hospital emergency room, and the plan's doctor on call [was] consulted about treatment or admission."[64] The court found that the on-call doctor's contract requiring the physician "provide enrollees with medical services" brought the patient and physician together "just as surely as though they had met directly and entered into the physician patient relationship."[65] The court also noted that the patient paid the plan insurance premiums, the plan in turn paid physicians to be on call for its patients in need of services.[66]

In other cases, courts have found that contracts to provide supervisory call services for residents at a teaching hospital can give rise to a duty of care to a patient being treated by those residents.[67] In Lownsbury v. VanBuren and Mozingo v. Pitt County Memorial Hospital, the defendant physicians had no direct contact with the patient, but rather were telephonically available to provide medical advice to the residents treating the patients at the teaching institutions. Those cases relied on the duties that the physician contracted for in their employment relationship.[68] Specifically noting that physicians are free to limit the extent and scope of employment, these courts found that the defendant physicians undertook by contract to provide on call supervision or consultation for their residents.[69]

Similarly, in Schendel v. Hennepin County Medical Center,[70] the court found that a doctor-patient relationship existed between a patient and a group of staff neurosurgeons even though the staff physicians claimed they did not interact with the patient during his hospital stay and did not recommend the care delivered to the patient.[71] In denying the defendants' judgment notwithstanding the verdict, the court found that a jury could have reasonably concluded that the physicians' contractual obligations to provide "guidance and direction" to residents gave rise to a duty to evaluate the residents' patients.[72]

IV. New Hampshire Law

In New Hampshire, "one who contractually provides services 'may be liable to third parties for a foreseeable harm resulting from the breach of a duty of care.'"[73] In Seymour v. Gill et al,[74] Judge Houran relied on the Restatement of Torts to determine the situations in which a party under contract to provide services will be liable to the third party for a breach of a duty. The Restatement provides:

> 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

(b) he has undertaken to perform a duty owed by the other to the third person, or

(c) the harm is suffered because of reliance of the other or the third person upon the undertaking.[75]

Furthermore, a physician-patient relationship as defined in N.H. RSA 329:1-c may not be required for a duty to exist between a physician and a patient.[76] In Bachman et al v. Hou, M.D., et al,[77] Judge Temple recognized that a duty may arise between a physician and a non-patient even in the absence of this defined relationship. In Bachman, the defendant moved for summary judgment, arguing that the defendant doctor did not owe a duty to the wife of his patient because he and the patient's wife did not have a physician-patient relationship as defined in 329:1-c.[78]

In denying the defendant's motion, the court, citing Edwards v. Lamb,[79] explained "that when a physician provides advice to non-patient family members, he undertakes an affirmative act that gives rise to a duty to carry out that act with care."[80] The Edwards court emphasized that a duty arose in that case solely from the fact that the physician had engaged in "positive action."[81] The Bachman court also cited Fruiterman v. Granata,[82] for the proposition that "a physician can, in certain circumstances, affirmatively undertake to provide health care to an individual, who prior to that moment was not the physician's patient, and thereby assume the duty to comply with the applicable standard of care."[83] Additionally, the court was persuaded by the holding in Jenkins v. Best,[84] which provided that in order to find that the defendant owed an independent duty to the patient under the "undertaker's doctrine"—the restatement approach outlined in Seymour—the court must find that the defendant consultant "personally engaged in some affirmative act amounting to a rendering of services" to the patient, treating physician, or the hospital.[85]

In light of this case law, Judge Temple found that that "although…a [329:1-c] physician-patient relationship *may have been sufficient* to give rise to such duties, *it was not necessary*."[86] Accordingly, a physician-patient relationship as defined in 329:1-c is not required for a duty to arise in New Hampshire where the physician has engaged in some affirmative act or "positive action."[87]

V. Conclusion

Whether a physician-patient relationship existed between a consulting physician and a patient is a question of fact based on whether there is a contractual obligation that gave rise to a duty to the patient or whether the consultant physician affirmatively acts to participate in the diagnosis and

treatment plan for the patient. Consulting physicians should not be absolved from liability simply because they did not see the patient. This is not the law in New Hampshire and does not reflect the nationwide trend consisting of detailed analyses of the facts and circumstances surrounding how the patient received medical care.

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[2] Lisa Schottenfeld, M.P.H. et al., *Creating Patient-Centered Team-Based Primary Care*, AHRQ Pub. No. 16-0002-EF (March 2016) (explaining team-based care has potential to improve comprehensiveness, coordination, efficiency, effectiveness, and value of care").
[3] *Id.* (citing the National Academy of Medicine's definition of team-based care).
[4] *See* https://employees.dartmouth-hitchcock.org/livewellworkwell/live_well_work_well_primary_care.html, (outlining benefits of Dartmouth's Live Well/Work Well Primary Care).
[5] *See Kelley v. Middle Tennessee Emergency Physicians*, 133 S.W.3d 587, 593 (Tenn. 2004*); St. John v. Pope*, 901 S.W.2d 420 (Tex. 1995); *Gilinksy v. Indelicato*, 894 F. Supp. 86 (N.Y. 1995).
[6] *See, e.g.*, *Wilson v. Teng*, 786 So.2d 485, 499 (Ala. 2000); *Diggs v. Arizona Cardiologists, Ltd.*, 8 P.3d 386, 391 (Ariz. 2000); *Millard v. Corrado*, 14 S.W.3d 42, 52 (Mo.App. E.D. 1999); *Cogswell v. Chapman*, 249 A.D.2d 865, 866 (NY AD 3 Dept. 1998); *Mozingo v. Pitt County Memorial Hospital*, 415 S.E.2d 341, 346 (N.C. 1992); *Lowensbury v. VanBuren*, 762 N.E.2d 354, 364 (Ohio 2002); *Kelley v. Middle Tennessee Emergency Physicians*, 133 S.W.3d 587, 597 (Tenn. 2004) (collecting cases); *Lection v. Dyll*, 65 S.W.3d 696, 715 (Tex.App. - Dallas 2001).
[7] *Gilinsky v. Indelicato*, 894 F.Supp. 86, 92 (E.D.N.Y. 1995).
[8] *See Kelley v. Middle Tennessee Emergency Physicians*, 133 S.W.3d 587, 593 (Tenn. 2004*).*
[9] *See Lection*, 65 S.W.3d at 704; *McKinney v. Schlatter*, 692 N.E.2d 1045, 1050 (Ohio 1997) (rejecting the notion that direct contact between patient and physician is required to establish a physician patient relationship because it "would allow on-call cardiologists and kindred specialists who, with a duty to do so, provide what one could term 'indirect medical care,' to escape all liability even after rendering a diagnosis and prescribing a course of treatment").
[10] *See id.* at 705; *see also Seymour v. Gill et al*, Carroll Cty. Super. Ct. No 07-C-0037 (2008).
[10] *Lection v. Dyll*, 65 S.W.3d 696, 704 (Tex. App. 2001) (noting that if a contract "does not imply a physician-patient relationship in and of itself" whether the consulting physician agreed to the physician-patient relationship depends on "whether he did or said something that agreed to the relationship").
[11] *Lection,* 65 S.W.3d at 705.
[12] *See McKinney*, 692 N.E.2d at 1050.
[13] *See Gilinsky v. Indelicato*, 894 F.Supp. 86, 92 (E.D.N.Y. 1995).
[14] *Campbell v. Haber*, 710 N.Y.S.2d 495 (App. Div. 2000).
[15] *See Kelley*, 133 S.W.3d at 594.
[16] *See id.*
[17] 133 S.W.3d 587 (Tenn. 2004).
[18] *See id.* at 590-591.
[19] *See id.*
[20] *See id.*
[21] *See Kelly,* 133 S.W.3d at 598.
[22] *See id.*
[23] 866 S.W.2d 32 (Tex. App. 1993).
[24] *See id.* at 39-40.

[25] 65 S.W.3d 696 (Tex. App. 2001).
[26] *See id.* at 699.
[27] *See id.*
[28] *See id.*
[29] *Lection*, 65 S.W.3d at 707.
[30] *See id.*
[31] 692 N.E.2d 1045 (Ohio 1997).
[32] *See id.* at 1050.
[33] *See id.*
[34] *See id.*
[35] *See Mead v. Legacy Healthy System*, 283 P.3d 904 (Or. 2012); *Cogswell v. Chapman* 249 A.D.2d 865 (NY. App. Div. 1998); *Gilinsky v. Indelicato*, 894 F.Supp. 86 (E.D.N.Y. 1995).
[36] 249 A.D.2d 865 (NY. App. Div. 1998).
[37] *Id.* at 866.
[38] *See id.*
[39] *Id.* at 866-67.
[40] 894 F.Supp. 86 (E.D.N.Y. 1995).
[41] *See id.* at 88.
[42] *See id.*
[43] *See id.* at 92.
[44] *See id.* at 93.
[45] 8 P.3d 386 (Ariz. 2000)
[46] *See Diggs*, 8 P.3d at 390-91 (adopting approach outlined in The Restatement (Second) of Torts § 324A).
[47] *See id.*
[48] *See id.*
[49] *See id.*
[50] *See Diggs*, 8 P.3d at 390-91.
[51] *See id.*
[52] *See id.*
[53] *See Diggs*, 8 P.3d at 391.
[54] *See e.g.*, *Walters v. Rinker*, 520 N.E.2d 468 (Ind. Ct. App. 1988); *Peterson v. St. Cloud Hosp.*, 460 N.W.2d 635 (Minn. Ct. App. 1990); *Dougherty v. Gifford*, 826 S.W.2d 668 (Tex. App. 1992).
[55] *See Walters v. Rinker*, 520 N.E.2d 468, 472 (Ind. Ct. App. 1988).
[56] *Lection v. Dyll*, 65 S.W.3d 696, 704 (Tex. App. 2001).
[57] 65 S.W.3d 696 (Tex. App. 2001).
[58] *See id.* at 707; *see also Hiser v. Randolph*, 617 P.2d 774 (Ariz. Ct. App. 1980) (finding "lack of consensual physician-patient relationship" did not insulate on-call physician where his assent to hospital's bylaws, rules, and regulations bound him to "insure that all patients…treated in the Emergency Room receive the best possible care").
[59] 581 N.W.2d 739 (Mich. Ct. App. 1997).
[60] *Id.* at 743-44.
[61] *See* i*d.*
[62] *See id.* at 744.
[63] 864 S.W.2d 678 (Tex.App. San Antonio 1993).
[64] *Id.* at 679.
[65] *Id.*
[66] *See id.*
[67] *See Lownsbury v. VanBuren*, 762 N.E.2d 354 (Ohio 2002)*; Mozingo v. Pitt County Memorial Hospital*, 415 S.E.2d 341 (N.C. 1992).
[68] *See Lownsbury* 762 N.E.2d at 363; *Mozingo*, 415 S.E.2d at 346-47.
[69] *See Lownsbury*, 762 N.E.2d at 362-63; *Mozingo*, 415 S.E.2d at 346-47.
[70] 484 N.W.2d 803 (Minn. Ct. App. 1992).
[71] *See id.*
[72] *Id.* at 808.

[73] *Carignan v. N.H. Int'l Speedway*, 151 N.H. 409, 413 (2004).
[74] *See* Carroll Cty. Super. Ct. No 07-C-0037 (2008); *Cf. Diggs v. Arizona Cardiologists* 8 P.3d 386, 391 (Ariz. 2000) (applying approach outlined in The Restatement (Second) of Torts § 324A (1965)).
[75] The Restatement (Second) of Torts § 324A (1965).
[76] *See* N.H. RSA §329:1-c (2015). RSA 329:1-c defines a physician-patient relationship as:

> [A] medical connection between a licensed physician and a patient that includes an in-person or face-to-face 2-way real-time interactive communication exam, a history, a diagnosis, a treatment plan appropriate for the licensee's medical specialty, and documentation of all prescription drugs including name and dosage. A licensee may prescribe for a patient whom the licensee does not have a physician-patient relationship under the following circumstances: writing admission orders for a newly hospitalized patient; for a patient of another licensee for whom the prescriber is taking call; for a patient examined by a physician assistant, nurse practitioner, or other licensed practitioner; or for medication on a short-term basis for a new patient prior to the patient's first appointment or when providing limited treatment to a family member in accordance with the American Medical Association Code of Medical Ethics. Prescribing drugs to individuals without a physician-patient relationship shall be unprofessional conduct subject to discipline under RSA 329:17, VI. The definition of a physician-patient relationship shall not apply to a physician licensed in another state who is consulting to a New Hampshire licensed physician with whom the patient has a relationship.

Id.
[77] Hillsborough Cty. Super. Ct. No. 226-2027-CV-0079 (2018) (denying defendants' motion for summary judgment).
[78] *See Id.*
[79] 69 N.H. 599 (N.H. 1899).
[80] *Bachman* at *10.
[81] *Edwards*, 69 N.H. 599.
[82] 276 Va. 629, 645 (2008)
[83] *Id.*
[84] 250 S.W.3d 680, 693-94 (Ky. Ct. App. 2007) (brackets and internal quotations omitted).
[85] *Id.*
[86] *Bachman et al v. Hou, M.D., et al*, Hillsborough Cty. Super. Ct. No. 226-2027-CV-0079 (2018) (denying defendants' motion for summary judgment) (emphasis added).
[87] *Id.*