

Establishing the physician-patient relationship

by Lynne Dakers, RN, JD, Risk Management Representative

Physicians can no longer expect that direct face-to-face contact or a formal consultation is required to form the basis of a physician-patient relationship. What follows is a brief overview about the way the law in this area is headed with some risk management suggestions.

Ethical principles aside, legally the physician-patient relationship is primarily a contractual one. It is the relationship that establishes the physician's legal duty to provide competent medical care. In other words, the existence of a physician-patient relationship is a prerequisite for any medical malpractice claim. Thus, in a lawsuit for medical negligence, a patient must first prove that such a relationship existed.

While the requirements for termination of the physician-patient relationship are fairly straight forward,¹ what constitutes the establishment of such a relationship is not.

As will be seen below, courts are increasingly broadening the definition of the doctor-patient relationship, sometimes finding a relationship in situations where traditionally none existed.

Although based in contract and couched in terms of offer and acceptance (can be express, but is usually implied²), the law has evolved more into that of quasi-contract. The terms of the "contract" are fixed in advance of bargaining by standard and customary practices.³ Courts impute to both parties standard intentions and reasonable expectations.⁴ Perhaps most significantly, courts are stressing the fiduciary obligations of the physician⁵ and other public policy considerations, further obfuscating the issue. And while the patient may terminate the relationship at any time, the law of abandonment constrains the physician's withdrawal from care.⁶

Areas of concern

What physicians must be vigilant in guarding against are those situations in which the courts might construe that a physician has provided medical services that the "patient" subsequently relies on to his or her detriment.⁷ This can occur in the most innocuous of situations, such as in a conversation at a party or over the phone. While these types of cases are rare, the prudent physician should refrain from giving medical advice in informal situations.

Another less obvious source of potential liability would be where the physician maintains a professional web site and provides health information or links to other sites which the patient again relies on to his/her detriment. While this situation is even more unlikely, there are ways to limit your potential liability here as well.⁸

Office staff can also be a source of liability. While physicians would generally not have a duty to treat an unsolicited walk-in patient,⁹ once the patient is asked by the receptionist to wait to be seen, the "acceptance" of that patient's "offer" has occurred.¹⁰ Similarly, the act of scheduling an appointment or accepting a referral can constitute an establishment of the relationship.¹¹

Generally, courts have held that informal consultations¹² and the rendering of gratuitous emergency care¹³ do not create a doctor-patient relationship. This area of the law is also evolving, however, with courts more willing to find that a relationship exists in these situations.



Under traditional case law, physicians performing physical examinations for third parties, such as employers, insurance companies, or for workers' compensation, have not been held by courts to have established a physician-patient relationship.¹⁴ However, where the person being examined inquires about a particular issue and receives medical information from the physician, courts have held differently.¹⁵

Perhaps the most significant changes in this area of the law have come about in the area of managed care. Courts are now looking to the managed care contract as well as hospital policies and bylaws to find a relationship between physicians and patients who have never

physician-patient relationship (continued)

directly interacted with each other.^{16,17} Physicians must also be aware of the growing tendency to charge on call physicians who do not respond to emergency requests with violations of the Emergency Medical Treatment and Active Labor Act (EMTALA).¹⁸

Risk management suggestions

Since the courts are increasingly finding a physician-patient relationship in the above situations, it becomes necessary for physicians and their staffs to take steps and/or alter their practice to limit potential liability. As with many practice management suggestions, they are not foolproof, but rather may serve to manage your risk.

Physicians can limit their liability in the office environment by creating policies and procedures, ensuring that staff members adhere to them and that potential patients are informed of them. Educate staff as to the dangers of attempting to accommodate walk-in patients.

In the hospital setting, understand your on call responsibilities under the hospital bylaws. If you see a patient in the emergency room or in-house, limit your obligation to the patient by agreement at the time services are rendered and document this in the medical record.¹⁹ Minimize curbside consultations. When asked for an informal consultation, keep it brief and simple. Avoid repeated conversations about the same patient. Ask if your opinion, advice, etc. will be formally noted in the patient's record. Offer the option of a formal consult. Keep notes: to whom you spoke, what was said, and the date (but avoid using the patient's name). Clearly determine and document if you agree to examine the patient.

When asked for a consultation, be aware that if you and the referring physician are part of the same managed care plan, a court may infer that a relationship exists. Managed care contracts must be thoroughly reviewed, preferably with the advice of an attorney.

If you contract with third parties to provide services such as physical exams, avoid further direct contact with the patient. If the patient does inquire about test results, be aware that by giving this information you may be creating a relationship with the patient that might not otherwise be inferred.

Finally, if you provide emergency care under the Good Samaritan Statute, do not subsequently charge the patient for those services if you want to benefit from the protection afforded by the statute.

Conclusion

While this area of the law is far from clear and court decisions are often not favorable to physicians, we hope that the suggestions above serve to elucidate some of the judicial reasoning behind the current trend and may help physicians to accommodate their practice accordingly.

Notes

1. In order to avoid being sued for the tort of abandonment once a relationship has been established, the physician who wants to terminate the relationship must provide the patient notice and a reasonable opportunity to obtain medical services elsewhere while continuing to provide necessary medical care in the interim.

2. See *Childs v Weiss*, 440 S.W.2d 104 (Tex Civ App-Dallas 1969, no writ).

3. *Health Law: Cases, Materials and Problems*. Second Edition.

4. Id.

5. Id.

6. Id. See above FN1.

7. An element of a malpractice case being that the plaintiff suffers damages.

8. See *the Reporter*, May/June 2000

9. See *Salas v. Gamboa*, 760 S.W.2d 838 (Tex App-San Antonio, 1988)

10. See James E. Schutte, *A Handbook for Doctors and Those Who Work With Them*, H&H Publishers, 1995.

11. See *Davis v. Weiskopf*, 439 N.E. 2nd 60.

12. See *Ranier v. Grossman*, Ct. of App 2nd Dist., 31 Cal App. 3rd 539, April 11, 1973.

13. See Tex Civ Prac & Rem Code Ann s. 74.001 (Vernon 1986).

14. See *Wilson v. Winsett*, 828 S.W.2d 135 (Tex App-San Antonio, 1992)

15. See *Caldwell v. Overton*, 554 S.W.2d 832 (1977).

16. See *Hand v. Tavera*, 864 S.W.2d 678 (Tex App-San Antonio, 1993), see also *Fought v. Solce*, 821 S.W.2d 218 (Tex App-Houston, 1991, writ denied).

17. For a more in-depth discussion on emerging areas of liability, visit the TMLT web site CME program "Streetwise," module 1.

18. See *EMTALA Charges Against Physicians Increase*, Medical Malpractice Law & Strategy, August 1999.

19. *The Physician-Patient Relationship — Creation and Termination*, Medicine and the Law, Vol. 81, March 1985.

Closed claim study: office protocols help physician prevail

by Barbara Rose, Managing Editor

Stephen P. Kelly, MD, one of TMLT's insured physicians, was recently vindicated in a claim with a jury verdict in favor of his practice. He has agreed to share his experience in *the Reporter* for the benefit of TMLT policyholders. This summary will include information from Dr. Kelly, the defense attorney and the TMLT claim department.

On referral from an optometrist, the patient was determined to need cataract surgery, which was performed by Dr. Kelly with a result of 20/20 vision without glasses. The patient was discharged from Dr. Kelly's care in seven weeks. Three months later, the patient called for an appointment to discuss a YAG laser posterior capsulotomy. He indicated no symptoms of concern or an emergency. At the scheduled appointment, the patient again did not describe flashes or floaters. However, upon examination he was found to have a retinal detachment. Dr. Kelly immediately referred the patient to a retinal specialist for treatment. The patient later developed a macular hole.

When the patient filed suit against Dr. Kelly and the practice, the allegation included a statement that during his call three months after cataract surgery, the patient did report symptoms of flashes and floaters to the office staff. In deposition, the patient had many inconsistencies in his testimony. During the plaintiff's office visit, the plaintiff stated that he did not have any flashes and floaters. In spite of this, the plaintiff's attorney offered a settlement in

the hope that a busy physician would not want the inconvenience of losing time and money from his practice.

Dr. Kelly and his TMLT claim team and attorney went to trial and prevailed with a unanimous favorable jury verdict. Even though the patient was 75 years of age, had lost most of his sight in one eye, and could no longer do master woodworking or play golf, the jury did not accept the allegations against Dr. Kelly and his staff. The records from his primary physician stated that the plaintiff was having problems with woodworking before he first saw Dr. Kelly. Forty-nine inconsistencies were noted in the plaintiff's deposition.

Dr. Kelly attributed the outcome of this case to several processes he has developed in the 20 years of his practice. They include an investment in the education, training, competence and experience of his staff; a policy and procedure manual covering standard operating procedures and contingencies that are followed consistently; regular staff meetings to address administrative and medical issues in order to remain current; and, last but certainly not least, a comprehensive medical record

to reflect the quality of physician and staff practice. The medical record includes all phone calls from patients and this policy played a critical role in defense of this case.

The attorney representing Dr. Kelly said "It is my belief that the single most important factor in the verdict was the precise manner in which his office is managed. It was very evident that he is a detail oriented physician with a well trained and competent staff."

The TMLT claim supervisor agreed the case was favorable for Dr. Kelly because of his detailed office protocols with particular attention to management of patient calls and their documentation. The plaintiff's expert agreed that if Dr. Kelly and his staff consistently followed his protocols, it then seemed unlikely the patient could call with symptoms of possible retinal detachment and not be seen immediately.

This physician and his staff reflect the daily, consistent practice of prudent risk management that should be routine in every physician's office. We at TMLT thank Dr. Kelly for his willingness to be featured in *the Reporter* and hope his experience will inspire all physicians to reflect on their practice and put into effect those principles necessary to optimize patient care and also increase the likelihood of a successful defense in the event of a claim.



An ounce of prevention

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Risk management hot topics

by Barbara Rose, Managing Editor

There are risk management issues that those of us who visit our insured physicians encounter on an almost routine basis. These “hot topics” encompass adoption of policies that may cause migraines or ulcers for physicians who plead lack of time as the reason **not** to implement. In a court of law where a physician is being defended against an allegation of malpractice, this “lack of time” does not constitute an effective defense. Developing written policies and procedures and consistent practice by staff and physicians is the main factor in the favorable verdict for the physician featured in this issue.

Current allegations that can be defended with written policies that are **always** followed by physician and staff include:

- an informed consent process for office procedures
- follow-up on referrals for lab, consultants, x-ray, etc.
- follow-up on patients who “no show” for a scheduled appointment.

The informed consent issue is one often cited in claims, applying not only to the procedures included in the Texas Medical Disclosure list. Minor procedures, such as laceration repair, excision of skin tags, removal of ingrown toenails, circumcision, incision and drainage, all carry some risk.

Without explanation of the risks, benefits and options of the procedure, acknowledgment of patient understanding, and consent to proceed, and the documentation in the record of this process, the physician has left himself/herself exposed should there be an unexpected outcome.

A separate consent form is not required by law for procedures not on the Medical Disclosure list. However, a protocol should be written to either use a consent form for minor procedures or document the discussion with the patient and the patient's consent to do the procedure.

Physicians are now defending themselves for issues related to patient follow-up for tests, specialist referrals, or no shows with allegations of “failure to diagnose in a timely manner.” The patient who takes little accountability for his/her health care can try to place blame on the physician, and without a policy and documentation in the record that reflects efforts to contact patients, can result in a verdict for the plaintiff or in a settlement because the record does not include contacts that were made.

Design a tickle file or a log of patients referred for tests, appointments with other physicians, etc. in order to identify those that are not completed in the time frame scheduled. Give patients a

return appointment as a method of determining that orders were followed. For “no show” patients, develop a protocol to contact that patient and **document** your conscientious efforts to determine why the appointment was not kept. Triage the patient condition, and if of a serious nature (e.g. referral to a surgeon due to an abnormal mammogram), call again, document again, and then send a certified letter with your concerns and place a copy of the letter in the patient record. A plaintiff's attorney reviewing a record with this detail may suggest to the patient that his/her accountability and compliance are in question and the allegation cannot be viewed as legitimate.

Physicians must do all that they can to be secure in knowing that their practice is a reflection of their commitment to “best practice” in management of the medical care of their patients. Written policies and procedures, an investment in staff development (remember the doctrine of vicarious liability), and an excellent medical record will do much to discount patient claims of lack of information or accusations of no effort to contact in a matter of serious consequence. Practice prudent risk management every minute of every day in the hope of never having a claim but to make yourself defensible in the event you do.