

Chapter 31

Physician–Patient Relationship

Matthew L. Howard, MD, JD

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Physician–patient relationships (PPRs) have existed since some forgotten ancestor claimed special talent as a healer. The Hippocratic oath¹ is an early codification of rules governing the PPR, while the sanctions² of the Code of Hammurabi are an early expression of physician liability for harm to patients.³

Modern professional negligence law applies elements of the English common law of contracts and torts to the same concerns expressed by Hippocrates and Hammurabi.⁴ Structural change in the medical profession, propelled by Medicare legislation, rising costs, an aging population, technological change, and pressure from legislative mandates and corporate initiatives, is modifying the traditional approach. This chapter is intended to provide an overview of the issues, generally stating the majority view. Case law varies between jurisdictions; both case law and statutes should be examined for variance before taking any action with potential legal consequences.

The PPR traditionally has been considered contractual. Written contracts are the exception; the contract is implied by the actions of the parties in seeking and providing advice and care.⁵ The physician is deemed to have promised that professionally acceptable care will be provided. Unless a specific warranty has been made, courts will not infer that a physician has guaranteed treatment success. The fact that a patient does not pay for services does not affect the existence of the contract nor lessen the physician's duties, obligations, responsibilities, or liabilities.⁶

For a person to be professionally liable to another, four conditions must be met. The first of these is to demonstrate the existence of a relationship between the physician and the person claiming to have been harmed, which establishes the existence of a duty of due care. This is the prerequisite of every medical malpractice action.⁷ The law applied to physicians or other health care professionals is fundamentally the same as that applied to architects, engineers, and attorneys.

Duties may arise under some statutes from hospital–patient relationships, which, once established in accordance with the terms of the law, impose duties on the physician. When a physician becomes involved in a legal problem that stems from a hospital–patient relationship, it is usually because of a special relationship between the hospital

and physician. Managed care and telemedicine are further altering the traditional analysis.

NATURE AND CREATION

This chapter discusses the question of the physician–patient relationship entirely in the context of traditional American jurisprudence, which arises out of an Anglo-European tradition. From a legal point of view, that is entirely appropriate as the parameters of the PPR, especially when problems lead to court action, will be defined in that context. The PPR has a cultural aspect also, however. Although space limitations prevent a review of the differences that exist throughout the world, a brief commentary on the issues that arise from immigration to the United States, in a textbook of legal medicine directed at an American audience, is worthwhile. American medical literature has referred with increasing frequency to the Japanese tradition that a patient should not be told of a terminal prognosis. The current American view of the PPR, which is based on a contract entered into by two autonomous and competent adults, requires that the patient be affirmatively told of their prognosis. Many persons do not put their affairs in order until they know the end is approaching. At least one suit has been based on a physician's failure to apprise his patient of the patient's preterminal condition.⁸ But many cultures have been reported to believe that such information should be withheld.⁹ In all cases, of course, no assumption should ever be made about a person's beliefs based on their ethnicity. For each patient, at the onset of the PPR, the physician should ascertain the level of autonomy and information desired by the individual at hand. The physician should not be surprised to find many Japanese-Americans wanting full disclosure and persons of other ethnic backgrounds preferring to be kept in ignorance. The important point is to be aware of the possibilities and act to obtain necessary information so that the PPR can be satisfactory for both parties. In some instances, requests may be made for services appropriate to the culture but illegal in the United States, as for example when female genital excision (female circumcision) or "female cutting" is requested.¹⁰

In the absence of a PPR or some other special relationship, physicians are not legally compelled to treat strangers,

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even during an emergency, in almost all states.¹¹ When a person seeks the services of a physician for the purposes of medical or surgical treatment, that person becomes a patient and the traditional PPR is established.¹² A contract is implied by the mutuality of the relationship.¹³ The physician is not an employee of the patient.¹⁴ The mutuality of the standard consensual relationship is independent of who solicits the relationship or who pays for the services provided.¹⁵ Problems arise in situations where the physician is held to a duty to a person for whom he or she has not consciously agreed to provide care.

Creation of the PPR usually requires some form of physical contact with the patient. It may be created by a single telephone conversation.¹⁶ Pathologists¹⁷ and radiologists,¹⁸ however, have a duty to the patient to exercise reasonable and ordinary skill and care while rendering their services even though they generally have no personal contact with the patient.

Whether a PPR legally exists is a factual determination. For public policy reasons, courts give persons alleging injury from medical malpractice considerable latitude as to the evidence required to establish the existence of the relationship.¹⁹ Courts will determine whether the patient entrusted care to the physician and whether the physician indicated acceptance of the duty to render care. If the circumstances of the contact caused the patient to have a reasonable expectation of treatment or if the physician undertook to render treatment, then the courts will infer the existence of a relationship.²⁰

Treatment has been broadly defined as “the broad term covering all steps taken to effect a cure of an injury or disease. The word includes examination and diagnosis as well as application of remedies.”²¹ Courts may thus interpret minimal actions as an undertaking-to-treat resulting in a PPR that the physician did not intend to create.

LIMITING THE DUTIES IMPOSED

Once established, unless limited or conditioned by agreement, the relationship continues until the services are no longer needed or are properly terminated. Once the relationship has been terminated, the physician is generally not obligated to follow the patient’s progress.²²

Courts are quick to find a PPR yet generally recognize the physician’s ability to qualify or limit the relationship.²³ Agreements to treat may be limited to one particular treatment or procedure.²⁴ Physician availability may be restricted, if clearly understood and accepted by the patient, to certain times and places.²⁵

Physicians are free to choose their patients²⁶ and are not obligated to treat anyone with whom they have no special relationship.²⁷ Absent statutorily imposed requirements, physicians are not compelled to practice, to practice under terms other than those the physician may choose to accept, or to provide care to any or all prospective patients. This principle is recognized by the Principles of Medical Ethics of the American Medical Association and supported by case law.²⁸

An established relationship renders the physician liable for damages legally caused by any breach of the resulting duty.

The fundamental duty is to exercise the same degree of knowledge, skill, diligence, and care that an ordinary competent physician would exercise under the same or similar circumstances. There is a concomitant duty to suggest a referral if the physician knows or should know that he or she does not possess the requisite knowledge or skill to properly treat the patient.²⁹ Failure to make a referral is negligence.³⁰

The patient’s obligation includes following reasonable instructions for further evaluation and treatment.³¹ A patient’s failure to do so may preclude holding the physician solely liable for any resulting injuries.³² The physician, however, must provide the patient with information necessary to explain why physician recommendations ought to be followed.³³ The physician’s relative liability will be determined by the finder of fact from the facts and circumstances of the case. A patient’s failure to follow instructions does not, of itself, terminate the relationship or relieve the physician of obligations, nor does failure to pay the physician’s fees relieve the physician from further responsibility.³⁴

BREACH OF CONTRACT

Because the relationship is contractual in nature, an injured party may allege a breach of contract.^{35,36} As a general rule, when the presumptive patient declines the contract, no physician duty exists.³⁷ Some courts have come to opposing conclusions.³⁸ In the medical setting, this claim arises where the physician is alleged to have guaranteed a particular result or has promised to perform in a certain manner.³⁹ If the physician does not reasonably live up to the guarantee, then a valid action for breach of contract may exist, even if the physician’s performance was not negligent or deficient under the measure of meeting usual professional standards.⁴⁰

Claims arising in breach of contract are rare because the law allows only compensation for actual damages caused by the breach of contract, meaning tort damages are far more lucrative for the patient, and because most physicians understand the risks of offering guarantees and do not make statements that could be interpreted as a guarantee. Guarantees of physician availability, especially in the obstetrical context, where the services are deemed more personal, have been a source of litigation.

SPECIAL SITUATIONS

Once outside the traditional confines of a patient voluntarily approaching a physician at the physician’s office or clinic, innumerable variations on the theme occur, some of which lead to unexpected results.

“Curbstone” and “Sidewalk” Consultation

Physicians are not obligated to give gratuitous advice.⁴¹ Having given advice, however, physicians owe a duty of due care to anyone who might reasonably rely on such advice. If the gratuitous advice causes injury, the physician

may be liable for the injury.⁴² The degree of contact may be determinative.⁴³ Where a consultant offered advice to the treating physician but charged no fee and never examined the patient, no duty to the patient was created.^{44,45}

“Second Opinion” Programs

When a physician receives a referral from a third party for the purposes of a “second opinion,” a claim against that physician grounded in medical malpractice can succeed if the patient can demonstrate that the physician either affirmatively treated or affirmatively advised how treatment should proceed and harm resulted.⁴⁶

Substitute and Covering Physicians

As a general rule, physicians may use substitute physicians if they are unavailable. The substitute physician must be competent⁴⁷ and qualified,⁴⁸ and the patient must be aware, especially where services are particularly personal, that a substitution may take place.⁴⁹ Without this understanding, a cause of action for breach of contract and for abandonment may exist. Because the fact that physicians share after-hours call duty is so widely known, in most instances the courts will impose constructive knowledge and consent on the patient, even in the absence of express consent. To be certain that the patient understands and agrees, written consent to on-call coverage arrangements and substitution should be obtained.

When called on to treat another physician’s patient, the substitute physician establishes a separate and independent PPR, which includes a duty to diagnose, treat, and manage any identifiable and detrimental condition that may have been negligently caused by the primary physician. Failure to do so may lead to an independent malpractice action against the substitute.⁵⁰ Merely signing a prescription form for another physician has been held insufficient to establish such an independent relationship.⁵¹ The attending physician will not be liable for the acts of the covering physician⁵² unless there is some control of the treatment by the attending physician, agency or concert of action between the two physicians, or negligence in the referral.⁵³

House Staff

Generally, interns, residents, and employed staff physicians are treated as employees of their hospital, and as such their liability is vicariously imputed to the hospital. Employees are essentially indemnified by the hospital for acts performed within the usual course of their duties.⁵⁴ The current trend is to place more liability on the hospital for negligent hiring, or, in the case of private physicians with staff privileges, for negligent credentialing. Physicians working as fellows may not enjoy the hospital’s indemnification; their status depends on their contractual agreement with the hospital. Nevertheless they have duties to all hospital patients with whom they establish a relationship.

Part-Time, Volunteer, and Clinical Faculty

Clinical faculty not employed by the hospital, functioning in an educational capacity for students and house staff, may be liable to patients who serve as teaching examples. In determining whether a PPR was created during contact with a patient seen during a teaching session or on rounds, courts look at the nature of the physician’s contact with the patient and whether the patient had a reasonable expectation that the teaching physician’s role included treatment.⁵⁵

As a general rule, the court will determine whether the physician had actual contact with the patient and whether any examination or treatment of the patient was done for the patient’s benefit.⁵⁶ If an examination causes the patient to reasonably believe that the examination was made for treatment purposes, the court may infer a relationship.⁵⁷ In contrast, if a physician conducting a lecture merely discusses a patient’s case and recommends a course of treatment that, when followed, results in injury, courts have found no PPR and insufficient contact.⁵⁸ A teaching physician supervising physicians-in-training may be held responsible for any negligent care that the instructor ordered and also may be held liable for negligent supervision of the trainee.

Emergency Department Physicians and Emergency Situations

Generally, physicians are not under a duty to treat anyone with whom no relationship exists, even in emergencies where death or disability will result.⁵⁹ Public perception exists that fear of litigation prevents physicians from responding to emergencies. The public policy implications led to institution of “Good Samaritan” laws in many states, providing for immunity from professional liability for intervening physicians. Physicians often view these protections as deficient because immunity is predicated on physician abstention from seeking payment for care rendered and because protection exists against liability for “ordinary” negligence but not against “gross” negligence. Physicians understandably may be reluctant to risk a court determination as to whether an error committed in the heat of an emergency was ordinary or gross negligence.

Freedom to refuse treatment does not extend to hospitals, which have a duty to render reasonable emergency medical aid to the extent that hospital facilities will allow.⁶⁰ The Emergency Medical Treatment and Active Labor Act (EMTALA) codifies these rules for any hospital that receives federal funds, which is all hospitals for all intents and purposes. The law was enacted out of congressional concern that hospitals were refusing to provide care for uninsured patients, sending them instead to public or charity facilities that might be miles away, and thus it was characterized as an “antidumping” law.

As enacted, EMTALA provides for fines and suits against hospitals, but only for fines against physicians. Because the law characterizes the fines as civil penalties, trial by jury is not required. Proof of negligence is not required.

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Each violation may cost a physician \$50,000, and this fine may not be covered by medical malpractice insurance policies.

EMTALA's scope is being broadened by case law beyond the inappropriate transfer out of emergency departments of indigent patients or women in labor. It is reasonable to assume that increased physician liability will follow. EMTALA has been superimposed on the preexisting rule that the private physician who has agreed to be on-call for the emergency department is presumed to have a relationship with the patient based on the public's reasonable expectation of emergency care.⁶¹

Telephone Contacts

Although physical contact is usually required, a relationship may be established even from a telephone call if the court interprets the physician's comments as treatment. Where a covering physician's contact with the patient was limited to informing the patient that his or her admission could be arranged only by the family physician and commenting that the family physician's earlier diagnosis seemed reasonable, the court ruled that no relationship had been established.⁶² Where a physician questioned a caller and advised hospital admission, a relationship was considered established.⁶³ Similarly, where a patient made an appointment after talking to a physician but was then refused care when she arrived for her appointment, the appointment made for the specific purpose of treating the condition that had been discussed over the telephone was deemed sufficient to establish a PPR.⁶⁴

Where a physician had not seen a patient for more than two years and seven months, a telephone call to discuss treatment options was deemed sufficient to reestablish a PPR, precluding a statute of limitations defense against a subsequent negligence suit.⁶⁵

Sexual Contacts

A sexual component to the PPR is universally condemned.⁶⁶ Numerous states have passed laws providing for disciplinary action against physicians who engage in such relationships.⁶⁷ Although the American Medical Association's standard states flatly that all sexual contact between physicians and patients is misconduct, some courts have declined to adopt this view, holding that the sexual relationship must arise out of the PPR to fall within the purview of the statute.⁶⁸ In other instances, suits grounded in medical malpractice because of sexual conduct have been brought by patients, with conflicting results.^{69,70} The increasing social pressure to end such contacts should suggest to the prudent physician that social relationships should be strictly confined to nonpractice situations.

Managed Care Relationships

Additional complications have been introduced by the increased role of third-party payors in determining the care provided. Where a third-party payor did not approve

a physician's plan of treatment and declined to pay for continued hospitalization, the court held that the third-party payor could be held liable when medically incorrect decisions resulted from institutional obstacles present because of attempts to reduce costs. However, the third-party payor escaped liability in the particular case because the physician failed to press the patient's case with the payor.⁷¹ In a similar situation, a patient committed suicide after being discharged when the insurer declined to pay for further hospitalization.⁷² The appellate court reversed a summary judgment for the hospital and remanded for trial on the issue of whether the actions of the insurer led to the death.

Telemedicine

Extensive case law is developing around liability imposed by various forms of telemedicine. For details, see Chapter 40.

Relationships Imposed by Statute

In addition to EMTALA, an increased duty to treat is being imposed by some states as a condition of licensure. For example, physicians have been forbidden to refuse care to patients who have tested positive for human immunodeficiency virus.⁷³

LIABILITY FOR INJURY TO THIRD PARTIES

Nonpatient Relationships with Physicians

Not every patient contact results in the creation of a PPR. Traditionally, when a physician performs an examination at the request of a third party for sole use by the third party (e.g., to determine eligibility for employment or for the issuance of life insurance), liability has not existed where physicians fail to inform the patient of results of tests or x-rays. If a physician is employed to perform preemployment examinations, then the physician's duty is owed to his or her employer; no PPR is implied. Absence of therapeutic intent is often the key issue.⁷⁴ Courts have said that the employed physician owes no duty to the examinee other than to avoid causing an injury⁷⁵ and is under a duty to use reasonable care to avoid same.⁷⁶ Failure to do so may lead to a claim based on ordinary negligence rather than medical malpractice. In Michigan, a PPR was assumed to exist here also, when an IME was found liable for an injury caused during examination.⁷⁷ Another court assumes no duty unless advice is offered.⁷⁸ No liability exists for a negligently performed examination, but the employer may be liable to the examinee for the negligent acts of a physician-employee under the doctrine of *respondeat superior*.⁷⁹ The physician may in turn be liable to the company under a contract theory for any resulting damages.

Contrary results have been reached. As a general rule, a third-party employed physician is not bound to disclose abnormal findings to an examinee. Exception to this rule

applies if the physician conducts an examination on a person with whom he or she has a prior existing PPR or if the physician completes an attending physician's statement for an insurance company and is paid a fee for doing so (contrast with physician as salaried employee).⁸⁰ Under such circumstances, the physician might have a duty to disclose significant findings to the examinee. This traditional rule was explicitly abandoned and physician liability expanded in a case in which a preemployment physical included a chest x-ray examination. The physician, failing to detect what later proved to be a lung carcinoma, reported to the employer that the person was employable. This court ignored traditional intent to treat and patient expectation rules in finding the physician liable.⁸¹

If a physician gratuitously elects to discuss findings with the examinee, he or she must not misrepresent the examinee's medical condition. If the physician recommends treatment, liability may result if substandard advice causes injury to the examinee.⁸² Third parties other than employers may employ physicians to examine or treat a patient. The courts distinguish between liability to the third party (for the examination itself) and liability to the patient (for the treatment once it has begun).⁸³

Indirect Relationships with Physicians

Recognizing the fundamental principle that all must use ordinary care not to injure others, violations of that duty occur when an injury results that is reasonably avoidable and is a foreseeable consequence of a person's actions. All physicians have a duty to warn patients about aspects of their medical condition or treatment that could injure others.⁸⁴ The physician treating a seizure patient, for example, may be liable for injury to a nonpatient if the injury is indirectly caused by negligent treatment, failure to diagnose the condition, or failure to advise the patient of the risks of engaging in dangerous activities.⁸⁵

Although the courts reject creating a PPR with the third-party victim, they freely apply ordinary negligence principles and hold that the injury to the nonpatient was a foreseeable consequence of the patient's condition, which imposed on the physician a duty to avoid injury to foreseeable victims.⁸⁶ Lack of foreseeability was at issue where a physician treated a police officer for a pituitary gland tumor. A citizen later shot by the officer was not permitted to maintain an action either under malpractice or negligence theories against the treating physician.⁸⁷

Liability has resulted in some cases when physicians have failed to advise patients of the danger of performing certain acts while taking medications, such as driving while using sedatives or decongestants,⁸⁸ but there has been no liability in similar circumstances in other courts.⁸⁹ Liability has resulted when the physician failed to properly caution patients with communicable diseases to avoid transmitting the disease to third parties.⁹⁰ The Court of Appeals considered a suit against a physician brought by the family of a motorist killed in an automobile accident with the physician's patient. The patient had received a sedating medication by injection and was given no warning against driving.

The Michigan court permitted the suit to proceed not in negligence as described previously but as a medical malpractice action, ruling that dismissing the suit because of the absence of a PPR between the physician and the deceased would "exalt form over substance."⁹¹ West Virginia has come to a similar conclusion.⁹²

Where a patient's relative who was permitted to remain in an emergency department treatment area fainted at the sight of blood and sustained significant permanent sequelae from the resulting head injury, the physician was held to have no liability to the injured relative.⁹³

Courts have imposed liability on physicians who bear a special relationship to a dangerous person and a subsequent victim.⁹⁴ Such a relationship may support affirmative physician duties for the benefit of a nonpatient third party.⁹⁵ The duty to the nonpatient stems from the physician's special relationship with the patient, and the potential for harm to the third party is a result of the patient's behavior. The leading case is *Tarasoff*,⁹⁶ which imposed liability on a psychotherapist whose patient had repeatedly expressed hostile intent toward a specific person who was subsequently murdered. Most subsequent cases have limited that liability to the facts of the *Tarasoff* case, although the victim need not be a patient. Where hostile intent has not been limited to a specific, readily identifiable person, no liability has been found when harm subsequently resulted.⁹⁷ The duty to protect endangered third persons has been extended to the protection of endangered property.⁹⁸

RELATIONSHIPS FORMED BY CONTRACT WITH OTHERS

If a physician contracts with a third party to treat a patient, then the PPR is not established with the patient until there is some overt undertaking. If the physician does not treat the proposed patient, then no duty to the expectant patient is created. However, physician liability to the third party who relies on the physician's assurance to treat may exist.⁹⁹ When a third party contracts with a physician to treat a particular patient and the treatment is undertaken, the PPR is established and the physician's duty is now to the patient rather than the third party.¹⁰⁰ If the physician's agreement to provide care to a patient leads the third party to believe that the patient is being competently cared for, and because they are reasonably restrained by this belief the third party does not seek care elsewhere, then the physician could be liable to both patient and third party. Liability to the patient would be based on medical malpractice, and liability to the third party would be based on breach of contract. Such a situation could arise in the case of a minor student at college being treated at the request of a parent living elsewhere. A physician employed by a third party for the sole purpose of obtaining evidence to support the third party's challenge to a claim of injury is under no duty to the examinee.¹⁰¹ The physician is generally under no duty to inform the examinee of the results of the examination and is not liable to the examinee if a negligent examination or negligently prepared report of the examination later causes injury to

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the examinee, provided the report was not, as postulated, prepared for the use or benefit of the examinee.¹⁰²

TERMINATION

The duties imposed on the physician by the creation of a PPR continue until the relationship is terminated. This termination may occur through completion of the treatment by virtue of patient recovery,¹⁰³ dismissal of the physician by the patient, mutual consent, or formal physician withdrawal.¹⁰⁴ Like any other contract, the parties may terminate the agreement by mutual consent. The patient may unilaterally terminate the relationship for any reason and at any time. This termination may be express or implied by the patient's actions.¹⁰⁵ Even though dismissed, the physician is under a duty to warn the patient of any risk of discontinuing treatment. A prudent physician will carefully document the basis and circumstances of dismissal as protection against a later claim by the patient of abandonment. The relationship may be considered terminated once a patient's care has been properly and completely transferred to another physician so that the services of the transferring physician are no longer needed and the duty of continuing care ends.¹⁰⁶ Once services are terminated, the traditional rule has been that the physician is under no duty either to provide future care or to reestablish the relationship.¹⁰⁷ However, some courts have mandated such liability on the grounds that the physician is in a better position than the patient to keep abreast of changing knowledge.¹⁰⁸

If during the course of treatment a physician concludes that he or she lacks the requisite skill or knowledge to treat the patient competently or for other acceptable reasons determines that the patient would be more properly treated by another physician or at another facility, then the patient should be so informed. As a practical matter, patients readily accede to their physician's judgment in these circumstances and termination of the relationship by a mutually agreed-on transfer usually results. If transfer is declined, then the treating physician is required to inform the patient of the consequences of the refusal, to carefully document the refusal and appropriate counseling, and to continue care until a proper unilateral termination of the relationship has been accomplished.

Unilateral termination by the physician is permitted. The patient must be provided sufficient time to arrange for care to be provided by another physician. Written notice¹⁰⁹ should be provided, preferably by certified mail.¹¹⁰ The notice should provide an explanation of the patient's condition and the further services needed, as well as a description of the likely consequences of failure to obtain continuing care. The physician should continue to provide care for such time as it will reasonably take for the patient to secure further care, and this length of time should be specified in the notice letter.¹¹¹ Improper withdrawal¹¹² by physicians has resulted in suits for breach of contract,¹¹³ professional negligence, and abandonment.¹¹⁴

Abandonment

Abandonment is the unilateral severance of the PPR by the physician without reasonable notice to the patient at a

time when continued medical care is still necessary.¹¹⁵ If physician illness or disability is the cause of the withdrawal, then abandonment has not occurred. Liability for abandonment may be found where the physician intends to terminate the relationship without the patient's consent, as well as where the court finds physician failure to attend the patient as frequently as due care in treatment would demand. Such failure denies the patient the benefit of the PPR and is referred to as *constructive abandonment*.

Abandonment may give rise to an action for either negligence or breach of contract.¹¹⁶ If a patient is injured because the physician failed to see the patient often enough or if the physician improperly concluded that the patient's condition required no further treatment, the patient has a cause of action in negligence alone.¹¹⁷ In an action for negligence the patient must present expert testimony; such testimony is not required in an action for breach of contract. The remedies vary, however, and negligence is the action generally preferred. Because abandonment can occur only if there is a valid PPR, it does not result if a physician permissively refuses to enter into such a relationship with a particular person.¹¹⁸

EXPECTATIONS OF THE FUTURE: TRENDS

Society's perception of the PPR is generally reflected in the law. Change is constant, with a tendency to expand liability for physicians counterbalanced by a lesser trend to control expansion.

Expansion of liability is seen in a series of cases.^{119–122} A new source of litigation will be cases where physicians are held liable for inducing patients to accept surgery by exaggerating their experience and training.¹²³

Unwillingness to expand liability is seen where a deceased patient's family brought suit against treating physicians on the theory that the physicians' failure to inform the patient of his prognosis led him to engage optimistically in financial dealings that because of his subsequent early death harmed his heirs.¹²⁴ The court declined to hold the physicians liable. Further supporting a view that courts wish to restrain liability was the decision of the Pennsylvania Supreme Court to reverse the decision in *Duttry* on the grounds that misrepresentation is a contract issue, and not a malpractice issue.¹²⁵ However, this result was reversed by the Pennsylvania legislature, which specifically added misrepresentation to the list of unprofessional actions that could support suit or discipline.¹²⁶

CONCLUSION

Physician liability depends on the existence of a PPR. Such a relationship may be explicit, implicit, or statutorily imposed. Numerous situations arise in our complex society in which physician, patient, government, and third-party payor interact in ill-defined ways, such that PPRs can arise by implication and without conscious physician intent. Physicians should be cautious in their statements and in their behavior to avoid creating a relationship that contrary to their intentions imposes legal obligations.

The legal obligation imposed is the requirement to exercise ordinary professional care in the discharge of professional duties. The plaintiff patient alleging malpractice must establish the existence of the PPR, a breach of the duty created by that relationship, and the existence of an injury caused by the breach. Reasonable differences of opinion as to these elements may subject the physician to all the financial and emotional stress of a lawsuit and its aftermath. Proof of the elements stated, which requires a mere preponderance of the evidence, will subject the physician to liability, will trigger National Practitioner Data Bank reports, and may precipitate disciplinary action.

Endnotes

1. Attributed to Hippocrates, Greek physician, fourth century B.C.E.
2. A physician whose patient loses an eye under treatment has his own eye put out.
3. Hammurabi, Babylonian king, lived in the twenty-seventh century B.C.E., roughly 4700 years before the publication of this work.
4. *Thomas v. Corso*, 265 Md. 84, 288 A. 2d 379 (1972) (abandonment is a contract issue, no expert required).
5. *Pike v. Honsinger*, 155 N.Y. 201, 49 N.E. 760 (1898); *Greenstein v. Fornell*, 275 N.Y.S. 673 (1932).
6. *Vitta v. Dolan*, 155 N.W. 1077 (Minn. 1916) (patient need not pay; physician duty remains).
7. *Kennedy v. Parrot*, 243 N.C. 355, 90 S.E. 2d 754 (1956) (preference for tort law over contract law in "due care" situations).
8. *Arato v. Avedon*, 5 Cal. 4th 1172, 858 P. 2d 598, 23 Cal. Rptr. 2d 131 (1993) (physician's duty does not extend to liability for inaccurate prognosis as to life expectancy).
9. B. Freedman, *Offering Truth*, 153 Arch. Intern. Med. 572-76 (1993) and L.J. Blackhall, S.T. Murphy, G. Frank, et al., *Ethnicity and Attitudes Toward Patient Autonomy*, 274 J.A.M.A. 820-25 (1995).
10. N.D. Cent. Code 12.1-36-01; 1999 Tex. Gen. Laws 3213 (female genital mutilation prohibited).
11. *Childs v. Weis*, 440 S.W. 2d 104 (Tex. 1969) (physician may arbitrarily refuse to render care to a nonpatient).
12. *Traveler's Ins. Co. v. Bergeron*, 25 F. 2d 680, 49 S.Ct. 33 (1928) (relationship established when professional services are accepted by another person for purposes of medical or surgical treatment).
13. *Findly v. Board of Supervisors*, 230 P. 2d 526 (Ariz. 1951) (consensual relationship); *Brumalov v. Fritz*, 183 Ga. App. 231, 358 S.E. 2d 872 (1987) (patient refused advised admission, then was injured while leaving emergency department; suit against physician dismissed).
14. *In re Estate of Bridges*, 41 Wash. 2d 916, 253 P. 2d 394 (1953) (physician not employee).
15. *Hoover v. Williamson*, 236 Md. 258, 203 A. 2d 861 (1964) (services paid for by employer but duty to employee).
16. *Vitta*, *supra* note 6 (not necessary for patient to know physician, engage his or her services, or pay for them in ordinary way).
17. *Walters v. Rinker*, 520 N.E. 2d 468 (Ind. Ct. App. 1988) (examination of tumor removed from patient establishes PPR).
18. *Rule v. Cheeseman*, 181 Kan. 957, 317 P. 2d 472 (1957) (radiologist's duty of care).
19. *Vitta*, *supra* note 6.
20. *Betesh v. United States*, 400 F. Supp. 238 (D.C. 1974) (in the context of a preinduction physical, physician's recall of rejected examinee to check on progression of disease was sufficient act to indicate treatment).
21. *Kirschner v. Equitable Life Assurance Soc.*, 284 N.Y.S. 506 (1935) (defines "treatment").
22. *Fleischman v. Richardson-Merrell, Inc.*, 266 A. 2d 639, 558 N.Y.S. 2d 688 (1990) (no duty to follow patient's progress once relationship is terminated).
23. *Osborne v. Frazor*, 425 S.W. 2d 768 (Tenn. 1968) (relationship by its terms may be limited); *Mozingo v. Pitt County Memorial Hosp., Inc.*, 415 S.E. 2d 134 (N.C. 1992).
24. *Markley v. Albany Medical Center*, 163 A. 2d 539, 558 N.Y.S. 2d 688 (1990) (duty may be limited to those medical functions undertaken by physician and relied on by patient).
25. *Sendjar v. Gonzales*, 520 S.W. 2d 478 (Texas 1975) (physician had right to refuse hospital calls).
26. *Hoover*, *supra* note 15 (no duty to nonpatient unless physician affirmatively acts).
27. *Hiser v. Randolph*, 617 P. 2d 774 (Ariz. 1980), *overruled on other grounds*, 688 P. 2d 605 (1988) (may refuse to treat patient). The author must distinguish between duty for professional liability purposes, discussed here, and duties imposed as a condition of licensure. In various states, duties as a condition of continued licensure have been imposed that restrict a physician's right to freely choose those for whom he or she will provide care. Included are abstention from balance billing of Medicare patients, acceptance of Medicaid patients, and acceptance of HIV-positive patients. Additional restrictions are created by federal civil rights laws and the Americans with Disabilities Act.
28. *Childs*, *supra* note 11 (right of physician to refuse intoxicated patient); *Childers v. Frye*, 158 S.E. 744 (N.C. 1931) (may refuse to treat nonpatient); *Coss v. Spaulding*, 126 P. 468 (Utah 1912) (physician employed by third party to examine also gratuitously advised, thereby establishing a relationship).
29. Malpractice: Physician's Failure to Advise Patient to Consult Specialist or One Qualified in a Method of Treatment which Physician Is Not Qualified to Give, 35 A.L.R. 3d 349 (failure to get consultation).
30. *Shoemaker v. Crawford*, 78 Ohio App. 3d 53, 603 N.E. 2d 1114 (1991), *appeal denied*, 64 Ohio 3d 1434, 595 N.E. 2d 943 (1992) (physician's admitted lack of experience in managing postoperative patient establishes negligence where that lack of experience was proximate cause of patient's injury).
31. Malpractice: What Constitutes Physician-Patient Relationship for Malpractice Purposes, 17 A.L.R. 4th 132 (PPR for malpractice purposes).
32. Medical Malpractice: Patient's Failure to Return, as Directed, for Examination or Treatment as Contributory Negligence, 100 A.L.R. 3d 723 (patient contributorily negligent for failure to return).
33. *Truman v. Thomas*, 27 Cal. 3d 285, 611 P. 2d 902, 165 Cal. Rptr. 208 (1980) (physician liable for failure to warn of consequences of refusing Pap smear).
34. *Rule*, *supra* note 18.
35. *Osborne*, *supra* note 23 (contractual relationship between patient and physician).
36. *Alexandridis v. Jewett*, 388 F. 2d 829 (1968) (obstetrician breached contract when he did not deliver infant).
37. *Thor v. Superior Court*, 5 Cal. 4th 725, 855 P. 2d 375, 21 Cal. Rptr. 357 (1993) (physician has no duty toward quadriplegic who refuses medically necessary feeding tube).
38. *Laurie v. Senecal*, 666 A. 2d 806, 808 (1995) (physician's duty persists despite refusal).
39. *Guilmet v. Campbell*, 385 Mich. 57, 188 N.W. 2d 601 (1971) (physician's representations interpreted as guarantees); *Stewart v. Rudner*, 349 Mich. 459, 84 N.W. 2d 815 (1957) (family practitioner breached contract by promising cesarean section that was not performed). N.B. Michigan law was later amended to require such contracts to be in writing.

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40. *Greenwald v. Grayson*, 189 S. 2d 204 (Fla. 1976) (ability to recover in contract even though no negligence shown).
41. *Oliver v. Brock*, 342 S. 2d 1 (Ala. 1976) (no obligation to practice or to accept professional employment).
42. *Osborne*, *supra* note 23.
43. *Ingber v. Kandler*, 128 A.D. 2d 591, 513 N.Y.S. 2d 11 (1987) (informal opinion offered without review of records or even knowledge of patient's name does not establish relationship); *Grassis v. Retik*, 25 Mass. App. Ct. 595, 521 N.E. 2d 411 (1988) (admitting resident not responsible for later negligence of treating physicians where resident had no further contact with patient).
44. *Irvin v. Smith*, 31 P. 2d 934, 939 (Kan. 2001) (physician agreement to provide care in the future does not create a PPR).
45. *NDB Bank v. Barry*, 223 Mich. App. 370, 372–73, 566 N.W. 2d 47 (1997) (multiple telephone conversations between attending physician and consultant do not create a PPR where consultant never examined patient and never accepted decision-making responsibility).
46. *Hickey v. Travelers Ins. Co.*, 158 A.D. 2d 112, 558 N.Y.S. 2d 554 (1990) (cause remanded for trial to determine whether physician was guilty of “negligent omission” for which apparently no liability would be imposed, or “negligent commission” for which liability would be imposed).
47. *Reed v. Gershweir*, 160 Ariz. 203, 772 P. 2d 26 (Ct. App. 1989) (physician not liable for malpractice of covering physician where reasonable care in selecting coverage was exercised).
48. *Blackshear v. Calis*, L-01240-93 (N.J. Super. Ct. Middlesex Cnty., July 16, 1996) (obstetricians left inexperienced resident to do difficult forceps delivery).
49. *Alexandridis*, *supra* note 36 (obstetrician breached contract when resident delivered infant).
50. *Perna v. Pirozzi*, 457 A. 2d 431 (N.J. 1983) (patient should be informed of substitution in advance).
51. *Baird v. National Health Foundation*, 144 S.W. 2d 850 (Mo. 1940) (substitute physician cannot use other physician's negligence as excuse for own actions).
52. *Bass v. Barksdale*, 671 S.W. 2d 476 (Tenn. Ct. App. 1984) (covering physician signed prescription at request of primary physician).
53. *Steinberg v. Dunseth*, 631 N.E. 2d 809 (Ill. App., 4th Dist. 1994).
54. *McKenna v. Cedars of Lebanon Hosp.*, 93 Cal. App. 282, 155 Cal. Rptr. 631 (1979) (malpractice action against resident physician for emergency care rendered to inpatient with whom resident had no prior contract allowed protection of Good Samaritan statute); *Leathers v. Serrell*, 376 F. Supp. 983 (1979) (intern loses hospital's immunity because he did not function within strict interpretation of statute when he treated nonpatient).
55. *Smart v. Kansas City*, 105 S.W. 709 (1907), *overruled on other grounds*; *State ex. rel. McNutt v. Keet*, 432 S.W. 2d 597 (Mo. 1968) (where clinical professor examined patient on ward with patient's knowledge, consent, and belief the purpose was for treatment, a relationship was implied).
56. *Rogers v. Horvath*, 65 Mich. App. 644, 237 N.W. 2d 595 (1975) (no relationship because examination not conducted for patient's benefit and no advice offered). But *see also Lownsbury v. VanBuren*, 762 N.E. 2d 354 (Ohio 2002) (physician who agreed to supervise resident physicians at a teaching hospital has PPR with patient with whom he had minimal contact).
57. *Perna*, *supra* note 50.
58. *Rainer v. Grossmen*, 31 Cal. App. 3d 539 (1973) (lecturing physician gave advice in response to question; no attempt to treat; no relationship).
59. *Pearson v. Norman*, 106 P. 2d 361 (Colo. 1940) (license to practice does not require physician to accept all comers).
60. *Clough v. Lively*, 186 Ga. App. 415, 367 S.E. 2d 295 (1988) (emergency department nurse checked patient's vital signs and drew blood at police request; patient dies after transfer to jail; PPR established by consent to draw blood).
61. *Hiser*, *supra* note 27; *Thompson v. Sun City Comm. Hosp.*, 141 Ariz. 597, 688 P. 2d 605 (1984) (assenting to hospital bylaws, which required participation in emergency room call, altered physicians' right to refuse to treat a patient).
62. *Wilmington General Hosp. v. Manlove*, 54 Del. 15, 174 A. 2d 135 (1961) (more than public reliance on hospitals to provide care is required to establish PPR); *Weaver v. University of Michigan Board of Regents*, 506 N.W. 2d 264 (Mich. App. 1993) (telephone call to make appointment does not create PPR).
63. *Fabran v. Matzko*, 236 Pa. Super. 267, 344 A. 2d 569 (1975) (telephone contact insufficient to establish relationship); *St. John v. Pope*, 901 S.W. 2d 420 (Tex. Sup. Ct. 1995) (telephone discussion about postoperative fever, followed by physician advice to seek care from surgeon who performed surgery, insufficient to establish relationship).
64. *Hamil v. Bashline*, 224 Pa. Super. 407, 305 A. 2d 57 (1973) (telephone contact constituted advice and treatment); *Lyons v. Grether*, 218 Va. 630, 239 S.E. 2d 103 (1977) (appointment arranged by telephone to treat created duty where patient was not permitted to enter with guide dog).
65. *Swift v. Coleman*, No. 68488 (N.Y. App. Div., 3d Dept., Mar 10, 1994) (anticipation of future treatment created by single telephone call sufficient to establish a “continuous relationship of trust and confidence”); *Cogswell v. Chapmen*, 672 N.Y.S. 2d 460 (App. Div. 1998) (giving medical advice in response to query from patient is sufficient to establish PPR).
66. Council on Ethical and Judicial Affairs, American Medical Association, *Sexual Misconduct in the Practice of Medicine*, 266 J.A.M.A. 2741 (1991).
67. *See, e.g.*, Colo. Rev. Stat. Ann. 12-36-117(1)(r); Fla. Stat. Ann. 458.331(1)(j); Ariz. Rev. Stat. Ann. 32-1401(21)(z); Doering's Calif. Bus. and Prof. Code §756.
68. *Gromus v. Medical Board of California*, 8 Cal. App. 4th 589, 10 Cal. Rptr. 452 (1992) (sexual interaction must breach professional duty in a way “substantially related to the qualifications, functions, or duties of the occupation for which a license was issued.”); *Larsen v. Comm. on Medical Competency*, 585 N.W. 2d 801 (N.D. 1998) (consensual relationship for 3 months grounds for revocation of license).
69. *New Mexico Physicians Mutual Liability Co. v. LaMure*, 116 N.M. 92, 860 P. 2d 734 (1993) (insurance company not required to indemnify physician found liable in medical malpractice by jury for sexual misconduct with patient); *Patricia C. v. Mark D.*, 12 Cal. App. 4th 1211, 16 Cal. Rptr. 2d 71 (1993) (psychotherapist not liable in malpractice for sexual misconduct with patient).
70. *Benavidez v. United States*, 177 F. 3d 927 (10th Cir. 1997) (homosexual relations between therapist and patient under the influence of drugs and alcohol is malpractice); *St. Paul Fire and Marine Insurance v. Engelmann*, 2000 WL 33674542 (S.D.) (where physician was acquitted of rape charges, despite admitting to sexual contact, the insurer was required to defend the resulting civil action and may have to pay whatever portion of the judgment is attributable to noncriminal conduct; case remanded for trial for jury to apportion damages between covered negligence and noncovered criminal behavior).
71. *Wickline v. State*, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986) (physician has duty to advocate for his or her patient and to challenge inappropriate payor decisions).
72. *Wilson v. Blue Cross*, 222 Cal. App. 3d 660, 271 Cal. Rptr. 876 (1990) (insurer may be liable if refusal to pay for continued hospitalization was clearly contrary to informed medical opinion).
73. *Cahil v. Rosa*, 89 N.Y. 214, 674 N.E. 2d 274 (1997) and *Lasser v. Rosa*, 237 A.D. 361 (N.Y. 1997) (New York State human rights law forbids a dentist from turning away patients because of positive HIV tests).

74. *Lotspeich v. Chance Vought Aircraft*, 369 S.W. 2d 705 (Tex. App. 1963) (employer has liability under *respondeat superior* to employee for physician's negligence; no PPR); *Mracheck v. Sunshine Biscuit*, 308 N.Y. 116, 123 N.E. 2d 801 (1954) (employer liability for acts of negligent physician; no PPR).
75. *Lotspeich*, *supra* note 74 (no duty to employee except not to injure); *Mero v. Sadoff*, 31 Cal. App. 4th 1466, 37 Cal. Rptr. 2d 769 (1995) (physician who injures patient during worker's compensation examination is liable in malpractice even in absence of PPR).
76. *Beadling v. Sirotta*, 41 N.J. 555, 197 A. 2d 857 (1964) (preemployment examination, duty of reasonable care; not entitled to results of examination, but entitled to not be injured during examination).
77. *Fleishman*, *supra* note 22.
78. *Wilmington General Hosp.*, *supra* note 62.
79. *Dowling v. Mutual Life Ins. Co. of N.Y.*, 168 So. 2d 107 (La. 1964) (prior relationship may impose duty).
80. *Green v. Walker*, 910 F. 2d 291 (1990) (physician has responsibility "to the extent of the tests conducted").
81. *Keene v. Wiggins*, 69 Cal. App. 3d 308, 138 Cal. Rptr. 3 (1977) (no duty where examination is for report to employer but voluntary care or attempt to treat or benefit worker creates a duty).
82. *Maltempo v. Cuthbert*, 504 F. 2d 325 (5th Cir. 1974) (promise to parents to treat imprisoned son).
83. *Myers v. Quisenberry*, 144 Cal. App. 3d 888, 193 Cal. Rptr. 733 (1983) (failure to warn diabetic patient of driving risk).
84. *Lemmon v. Freese*, 210 N.W. 2d 576 (Ia. 1973) (liable for foreseeable injury to third party resulting from failure to warn patient of dangers of seizures).
85. *New Mexico Physicians*, *supra* note 69.
86. *Joseph v. Shafey*, 580 So. 2d 160 (Fla. 1991) (no duty or privity of contract between citizen shot by officer and officer's physician).
87. *Wilschinsky v. Medina*, 108 N.M. 511, 775 P. 2d 713 (1989) (physician's duty extends to members of the public who may be injured by sedated driver; the duty is met by warning the patient not to drive); *Zavalas v. State of Oregon*, 861 P. 2d 1026, 124 Or. App. 166 (1993) (physician liable in negligence to people injured by patient driving under the influence of drug prescribed by physician); *Kaiser v. Suburban Transportation System*, 398 P. 2d 14 (Wash. 1965) (failure to warn bus driver of sedating effect of decongestant).
88. *Johnson v. Fine*, 45 P. 3d 441 (Okla. Ct. App. 2002) (physician did not owe a duty to the mother of two children who were injured in an automobile accident caused by a patient to whom the physician had prescribed Xanax).
89. *DiMarco v. Lynch Homes Chester County, Inc.*, 559 A. 2d 530 (Pa. 1989) (injured third party relied on incorrect advice provided by physician to patient regarding communicability of hepatitis); *Nold v. Binyon*, 31 P. 3d 274, 278 (Kan. 2001) (physician has PPR with unborn fetus that contracted hepatitis B after failure of attending physician to appropriately treat mother with gammaglobulin to protect fetus).
90. *Welke v. Kuzilla*, 144 Mich. App. 245, 375 N.W. 2d 403 (1985) (malpractice action allowed despite absence of PPR).
91. *Osborne v. United States of America*, No. 30115 (S.Ct. W.Va. July 3, 2002) ("the legislature intended to allow individuals generally to recover damages attributable to medical professional liability regardless of whether they are actually patients") (on a question of state law certified from U.S. District Court).
92. *McElwain v. Van Beek*, 447 N.W. 2d 442 (Minn. Ct. App. 1989) (duty to warn third parties applies only to dangers arising from the patient).
93. *Duvall v. Goldin*, 363 N.W. 2d 275 (Mich. 1984) (special relationship imposes duty on physician that benefits third party).
94. *Id.* (special relationship with dangerous person imposes a duty to warn public).
95. *Tarasoff v. Regents of the University of Calif.*, 17 Cal. 3d 425, 551 P. 2d 344, 131 Cal. Rptr. 14 (1976) (failure to warn third party of known threat presented by patient).
96. *Thompson v. County of Alameda*, 27 Cal. 3d 741, 614 P. 2d 728, 167 Cal. Rptr. 70 (1980) (endangered third party not readily identifiable; no duty to warn); *Sellers v. United States*, 870 F. 2d 1098 (6th Cir. 1989) (no duty to injured third party where inpatient psychiatric service had no knowledge of patient's harmful intent to a particular person).
97. *Peck v. Counseling Service of Addison County, Inc.*, 499 A. 2d 422 (Vt. 1985) (duty to warn nonpatient third party of possible property damage).
98. *Maltempo*, *supra* note 8.
99. *Hoover*, *supra* note 15, at 250 (relationship between physician and patient no matter who pays).
100. *Davis v. Tirrell*, 443 N.Y.S. 2d 136 (1981) (psychiatrist employed by school district to examine student and advise district about handicap; no PPR).
101. Council on Ethical and Judicial Affairs, *supra* note 66.
102. *Thiele v. Ortiz*, 165 Ill. App. 3d 983, 520 N.E. 2d 881 (1988) (duty to evaluate possible complication of surgery 2 weeks postoperatively exists despite presence of other treating physicians).
103. *Peterson v. Phelps*, 123 Minn. 319, 143 N.W. 793 (1913) (termination of duties).
104. *Millbaugh v. Gilmore*, 30 Ohio St. 2d 319, 285 N.E. 2d 19 (1972) (patient's conduct terminated relationship).
105. *Brandt v. Grubin*, 131 N.J. Super. 182, 329 A. 2d 82 (1972) (referral of psychiatric patient terminates care).
106. *Hoemke v. New York Blood Center*, 720 F. Supp. 45 (S.D.N.Y. 1989) (physician had no duty to contact past recipients of blood transfusions to warn them that they could be HIV infected and that they could spread the virus to others); *Boyer v. Smith*, 345 Pa. Super. 66, 497 A. 2d 646 (1985) (no duty to contact past recipient of medications when new risks discovered).
107. *Tresemar v. Burke*, 86 Cal. App. 3d 656, 150 Cal. Rptr. 384 (1978) (physician required to notify patients of risks of Dalkon shield once such risks became known).
108. *Burnett v. Laymon*, 181 S.W. 157 (Tenn. 1915) (definition of reasonable notice dictated by circumstances of case).
109. *Groce v. Myers*, 224 N.C. 165, 29 S.E. 2d 553 (1944) (reasonableness of notice).
110. *Miller v. Dore*, 154 Me. 363, 148 A. 2d 692 (1959) (must notify with sufficient time for patient to find substitute).
111. *Collins v. Meeker*, 198 Kan. 390, 424 P. 2d 488 (1967) (improper withdrawal from case).
112. See Measure and Elements of Damages in Action Against Physician to Achieve Particular Result or Cure, 99 A.L.R. 3d 303 (breach of contract).
113. See Liability of Physician Who Abandons Case, 57 A.L.R. 2d 432.
114. *Stohlman v. Davis*, 220 N.W. 247 (Neb. 1928); *Mucci v. Houghton*, 57 N.W. 305 (Iowa 1894); *Groce v. Myers*, 224 N.C. 165, 29 S.E. 2d 553 (1944) (abandonment defined).
115. *Chase v. Clinton County*, 217 N.W. 565 (Mich. 1928); *Alexandridis*, *supra* note 36 (causes of action in abandonment).
116. *Thomas v. Corso*, 265 Md. 84, 288 A. 2d 379 (1972) (negligent care distinguished from abandonment).
117. *Easter v. Lexington Memorial Hosp.*, 303 N.C. 303, 278 S.E. 2d 253 (1984) (PPR required).
118. *State v. Warden*, 813 P. 2d 1146 (Utah 1991) (conviction for negligent homicide of infant upheld); *People v. Holvey*, 205 Cal. App. 3d 51, 252 Cal. Rptr. 335 (1988) (statute providing for criminal prosecution for "contributing to death of elderly

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- dependent” is constitutional and applies to physicians; case remanded for trial; subsequently modified with respect to nonphysicians by *People v. Heitzman*, 9 Cal. 4th 189, 886 P. 2d 1229 (1994)).
119. *People v. Anyakora*, 162 Misc. 2d 47, 616 N.Y.S. 2d 149 (1993), *summary affirmation*, 238 A.D. 2d 216, 656 N.Y.S. 2d 253 (1997) (chief obstetrical resident convicted for failure to admit and for falsifying records used to justify refusal; action brought by Committee of Interns and Residents to obtain malpractice defense dismissed), 86 N.Y. 2d 478, 657 N.E. 2d 1315, 634 N.Y.S. 2d 32 (1995).
120. *Aufrichtig v. Lowell*, 85 N.Y. 2d 540, 650 N.E. 2d 401, 626 N.Y.S. 2d 743 (1995) (PPR creates a fiduciary duty that implies requirement to offer truthful testimony); *see also Hammond v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793 N.D. Supp. 793 (1965).
121. *Safer v. Estate of Pack*, 291 N.J. Super. 619, 677 A. 2d 1188 (1996), *appeal denied*, 146 N.J. 568, 683 A. 2d 1163 (1996) (physician has duty to warn those at known risk of avoidable harm from genetically transmissible condition, and duty extends to patient, as well as to members of immediate family of patient who may be adversely affected by breach of duty).
122. *Duttry v. Patterson*, 741 A. 2d 199 (Penn. 1999); *Johnson v. Kokemoor*, 545 N.W. 2d 495 (Wis. 1996).
123. *Arato*, *supra* note 8.
124. *Duttry v. Patterson*, 565 Pa. 130, 771 A. 2d 1255 (2001).
125. MCare Act, 40 Pa. Stat. §1303.504(d)(2) (2001).