Formation of the Physician-Patient Relationship:

Contract-Based and Tort-Based Approaches

Compiled at the Request of

The Honorable Justice Marian P. Opala,

Oklahoma Supreme Court

By S. Sandy Sanbar, MD, PhD, JD

Questions

- When is the physician-patient relationship formed in the modern era of telephonic consults and remote records review?
- Can a relationship be formed with a physician who has never even met the patient?
- Should a duty of care and a physician-patient relationship exist where a physician has undertaken to diagnose, treat or prescribe?
- When may a physician reasonably sever ties with his or her patient?
- What may a physician do to avoid the formation of a physician-patient relationship or a claim of abandonment?

Introduction

Historically, the provider/patient relationship arose under a theory of express or implied contract.[1] A person would seek treatment from a physician, and the physician would accept the person as a patient by initially examining the patient, rendering a diagnosis or treatment; mutual consent was required. That ***contract-based approach***, however, while still one way to assess formation of the physician-patient

[1] *See* 61 Am Jur 2d *Physicians, Surgeons and Other Healers* §130 (2008) ("The relationship of physician and patient is [formed] if the professional services of a physician are accepted by another person for the purposes of medical or surgical treatment. Because this relationship may result from an express or implied contract, the voluntary acceptance of the physician-patient relationship by the affected parties creates a prima facie presumption of a contractual relationship between them.").

relationship, has essentially been overtaken by a ***tort-based approach*** focusing on the existence of a special relationship or status arising from the physician's actions – even in the absence of mutual consent, a meeting of the minds or other traditional indicia of a contract.

Is a Physician-Patient Relationship Formed When a Physician Merely Issues an Order or Prescription without Personally Seeing the Patient?

A developing area of the law is when a physician-patient relationship may be established even where the physician does not personally see the patient. Many jurisdictions have ruled that, if a physician is "on-call," a physician-patient relationship may exist between a patient seeking services in a hospital Emergency Department and the on-call physician. Indeed, that status or ***"special relationship"*** may exist even when the on-call physician refused to see the patient or was unavailable to attend the patient.[2] Other, more fleeting physician contacts, however, may still give rise to a physician-patient relationship, as exemplified nationally in the following jurisdictions. However, there is no "majority rule" on these issues, and the Florida case below probably sets the lowest bar for the formation of a physician-patient relationship.

Florida

In ***Giallanza v. Sands***, (Fla App Div 4 1975), a Florida Physician who was on inactive courtesy staff, home sick at the time, merely permitted an acquaintance to use his name to seek admission to the hospital for emergency treatment. The Court found a triable issue of fact as to whether the physician "accepted" the decedent as a patient, and reversed summary judgment in favor of defendant physician.[3]

Georgia

In ***Walker v. Jack Eckerd Corp***., *cert den* (1993), a Georgia defendant physician placed prescriptions by phone as an accommodation to plaintiff, an extended family member who subsequently developed glaucoma. The plaintiff testified that he inquired of physician concerning the eye drops and drug in

[2] *Hiser v. Randolph*, 126 Ariz. 608 (Az Ct App 1980). In *Hiser,* Plaintiff's decedent entered the ED in a diabetic coma and the defendant on-call physician in the ED refused to treat her, stating that she should be treated by her regular physician who had seen her in the ED the previous night. The patient died the next day. The Arizona court found that the defendant physician, by assenting to the hospital bylaws, and accepting payment from the hospital to act as the on-call emergency room doctor, personally became bound to insure that all patients treated in the emergency room receive the best possible care. *Id*. at 777.
[3] *Giallanza v. Sands*, 316 So. 2d 77 (Fla App Div 4 1975).

question; he sought out physician's counsel and physician gave him certain advice regarding diet and fat intake. The physician testified that during his first conversation, he warned plaintiff that he did not like plaintiff using the drug and advised him to see his ophthalmologist. The appeals court found a triable question of fact as to whether a physician-patient relationship existed, which precluded summary judgment. The appeals court denied the defendant physician's petition for reconsideration and the Georgia Supreme Court denied *certiorari*. There is no further history in the public record, and we assume the matter was settled after remand.[4]

In another case in Georgia, ***Clanton v. Von Haam*** (1986), a physician-patient relationship was ***not*** created where the plaintiff telephoned defendant physician, who had treated her previously for an unrelated condition, physician listened late at night to her recital of symptoms, told her she would have to wait to see him in the morning, and recommended she continue the immediate course of treatment prescribed by another physician.[5]

Pennsylvania

In ***Fabian v. Matzko*** (1975), a Pennsylvania case, the sole contact between patient and physician was a telephone call in which the physician informed patient's husband of the hospital's admission policies. In accordance with the hospital's standard procedure, the physician, after ascertaining that the woman had a private physician and the private physician's diagnosis, informed the husband that she could not be admitted unless arrangements were made for admission by the private physician. The husband was then unable to re-contact the private physician or, following that attempt, to re-contact the hospital physician. The woman subsequently suffered another attack, sustaining a cerebral hemorrhage. Court affirmed summary judgment for the hospital physician and hospital, finding that ***no*** physician-patient relationship had been formed because the hospital physician did not undertake to render medical service.[6]

Texas

In ***Rampel v. Wascher***, 845 SW2d 918 (Tex App 1992), *writ den* (1993), a Texas Doctor husband did ***not*** have physician-patient relationship with his wife on the night she died, even though he had been treating his wife for stress and anxiety for four years and had prescribed medications as recently as two

[4] *Walker v. Jack Eckerd Corp.*, 209 Ga App 517, *cert den* (1993).
[5] *Clanton v. Von Haam*, 177 Ga App 694 (1986).
[6] *Fabian v. Matzko*, 236 Pa Super 267 (1975).

months before, where wife did not seek medical care or advice or medication from her husband on the actual night of death; doctor testified that he was ***not*** acting as her physician but as her husband that night. He did not see her take any medication, and any medication she took that night was without input from him. Plaintiff estate's take-nothing judgment in negligence action against doctor husband was affirmed.[7]

Oregon

Until 2009, Oregon law did not address the question of when a physician-patient relationship was formed. Indeed, ORS Chapter 677 [8] and the OARs make no reference at all to the formation of the physician-patient relationship. Early case law only hinted at it.

In ***Dowell v. Mossberg*** (1961), the Oregon Supreme Court noted in dicta: "Failure to exercise due care in the treatment of a patient is a breach of a legal duty ***which arises, not out of contract, but out of the relationship of physician and patient.***"[9]

Probably the closest approach to articulating the elements of a physician-patient relationship in Oregon tort law was in 1985, in ***Sullenger v. SETCO Northwest, Inc***.[10] In *Sullenger*, a minor child was cared for and admitted to the hospital by the patient's attending physician, who testified that he did not seek the defendant pediatrician's opinion, did not seek the defendant's consultation, and did not seek the defendant's approval of treatments being rendered.[11] Rather, the facts were that while exiting the patient's room the attending physician asked the defendant pediatrician if he would take the child's case, and the defendant pediatrician declined. These facts were unchallenged by the plaintiff. The facts showed that the defendant pediatrician did not examine the patient, review charts, review nurses notes, x-rays, or any other tests results. On this basis, the Oregon Supreme Court affirmed the defendant physician's motion for summary judgment, finding that no physician-patient relationship existed which could give rise to a duty of care.[12]

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[7] *Rampel v. Wascher*, 845 SW2d 918 (Tex App 1992), *writ den* (1993).
[8] Of note, Oregon's Good Samaritan statute provides that emergency medical assistance does not, by itself, create a physician-patient relationship. ORS 30.800(3).
[9] 226 Or 173, 190 (1961) (emphasis added).
[10] 74 Or App 345 (Or 1985).
[11] *Id*. at 347.
[12] *Id*. at 348-49 ("The duty to aid another person arises out of a relationship between the actor and the other").

A recent Oregon Court of Appeals case decided on October 28, 2009, ***Mead v. Adler,***[13] goes to the heart of the formation question. This is Oregon's first reported case on the formation of "on-call" physician-patient relationships.

Mead decided whether a neurosurgeon formed a physician-patient relationship with the injured plaintiff when an ER physician telephoned the defendant neurosurgeon for a consult on plaintiff's low back pain. The emergency physician had ordered an MRI, the results of which led her to believe that the plaintiff was developing *cauda equina*, a very serious neurological condition related to a herniated lumbar disk. The ER physician and defendant disagreed about the contents of the phone conversation, but the court found the following facts undisputed:

(1) The defendant was the on-call neurosurgeon;
(2) The neurosurgeon took the ER physician's call and listened to a description of plaintiff's symptoms;
(3) The defendant neurosurgeon felt that plaintiff did not need neurosurgical treatment; and
(4) The defendant neurosurgeon thought that the plaintiff should be admitted by her primary physician for observation and pain management.

The plaintiff's condition deteriorated over the ensuing four days, until the defendant ultimately performed surgery. The plaintiff did, indeed, have *cauda equina*, and suffered permanent impairment.[14]

The plaintiff filed suit against the hospital, a consulting neurologist and the neurosurgeon for medical malpractice. At trial, the plaintiff moved for a directed verdict on the issue of whether by undertaking to evaluate and diagnose, even by phone, the defendant impliedly consented to the formation of a physician-patient relationship, which thereby created a duty of due care. The trial court denied the plaintiff's motion for directed verdict and permitted the question of whether a physician-patient relationship existed to go to the jury, which then issued a verdict in favor of the defendant neurosurgeon. On appeal, the Court of Appeals reversed and remanded for a peremptory instruction to the jury that a physician-patient relationship existed as a matter of law.[15]

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[13] 321 Or App 451 (2009).
[14] 321 Or App at 456.
[15] *Id*. at 456-57.

The Court of Appeals' reasoning is based in part on a review of Oregon case law discussing the duties arising from "special relationships," with the court concluding:

> A special relationship arises out of the responsibility of one person to act on behalf of and in the best interests of the other. An implicit aspect of the special relationship is that it is consensual--the party to whom the duty is owed authorizes the party who owes that duty to exercise independent judgment on the former party's behalf, and the party who owes the duty voluntarily assumes that responsibility.[16]

Following this reasoning, and citing to a Kansas case, the ***Mead*** court found that: "In the absence of an express agreement by the physician to treat a patient, a physician's assent to a physician-patient relationship can be inferred ***when the physician takes affirmative action with regard to care of the patient.***"[17]

The Court went on to discuss the novel question under Oregon law of whether an on-call physician's advice to an emergency room physician over the telephone concerning a specific patient will give rise to a physician-patient relationship. After much review of case law from other states, the Court held:

> In summary, the consensus of the jurisdictions that have considered the question is that a physician-patient relationship can arise by implied consent of the physician based on indirect contact between the physician and patient through telephone communication between a hospital emergency room physician and an on-call physician concerning the care of an emergency room patient; ***the pivotal inquiry is whether the on-call physician affirmatively participates in the care of the patient***. That affirmative participation exists if the on-call physician undertakes to diagnose or treat the patient. *** ***[W]e also conclude that an on-call physician who affirmatively undertakes to diagnose or treat an emergency room patient over the telephone has impliedly consented to a physician-patient relationship for purposes of negligence liability***.[18]

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[16] *Id*. at 458.
[17] *Id*., citing to *Adams v. Via Christi Regional Medical Center*, 270 Kan 824, 837, 19 P3d 132, 140 (2001).
[18] *Id*. at 461-62 (emphasis added).

The advice rendered by the defendant was not "merely casual or informal advice to a colleague."[19] The defendant neurosurgeon was contacted by the ER physician because of his ***on-call status*** and the defendant rendered an opinion on the appropriate course of care. The court found the ***Mead*** facts distinguishable from the casual ***"curbside consult"*** that one physician may provide to another as a professional courtesy.[20]

In light of these cases, and expanding on the ruling in ***Mead***, a reasonably coherent – and fairly conservative – rule might be stated as follows:

> ***If a physician affirmatively undertakes to diagnose, treat or prescribe, his or her responsibility for failure to possess and use the skill and care of an ordinary physician is not dependent upon an express agreement of employment or a promise to pay for services. A duty of care and a physician-patient relationship exist where a physician has undertaken either gratuitously or for a consideration to render a medical service, no matter how slight. Mere contact with a patient or the administrative facilitation of services by another provider, however, is not enough to form a physician-patient relationship.***

Oklahoma

Date: 02-09-2010

Case Style: Shannon Jennings v. Blake Allen Badgett, M.D.

Case Number: 2010 OK 7

Judge: Taylor

Court: Supreme Court of Oklahoma on appeal from the District Court for Oklahoma County

Plaintiff's Attorney: Benjamin Butts, Butts & Marrs, P.L.L.C., Oklahoma City, Oklahoma, for the appellants.

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[19] *Id*. at 464.
[20] *Id*.

Defendant's Attorney: John Wiggins and Erin Renegar, Wiggins Sewell & Ogletree, Oklahoma City, Oklahoma, for the appellee.

Description: ¶1 Two questions are presented for our review. The first question, one of first impression, is whether a physician-patient relationship is an indispensable element of a medical malpractice claim against a physician. The second question is whether a physician-patient relationship between the plaintiffs and the appellee doctor exists as a matter of law. We answer the first question in the affirmative and the second question in the negative.

I. PROCEDURAL HISTORY

¶2 On April 25, 2007, Shannon Jennings and Brandy Crawford (Crawford), individually and as parents and natural guardians of Shelby Jennings (Shelby), filed a petition in the District Court of Oklahoma County against Blade Allen Badgett, M.D. (Dr. Badgett); Stephen D. Schlinke, M.D. (Dr. Schlinke); and Integris Baptist Medical Center, Inc., for the alleged negligent delivery, care, and treatment of Shelby on November 21, 2003. Dr. Schlinke moved for summary judgment. The plaintiffs objected to the motion, and Dr. Schlinke replied.

¶3 On December 26, 2007, the district court granted summary judgment in Dr. Schlinke's favor.1 In conformity with Title 12, Section 994(A) of the Oklahoma Statutes, on March 14, 2008, the district court declared its December 26, 2007 order to be final, found that there was no just reason for delay, and expressly directed the filing of the final order. On April 7, 2008, the plaintiffs filed a petition in error appealing the district court's judgment in Dr. Schlinke's favor. On May 6, 2009, the Court of Civil Appeals affirmed the district court. On May 26, 2009, the plaintiffs filed their petition for certiorari. This Court granted certiorari.

II. SUMMARY JUDGMENT AND STANDARD OF REVIEW

¶4 Under Rule 13(a) of the Rules of District Courts, 12 O.S.2001, ch. 2, app. (Rules of District Courts), a party may move for summary judgment or summary disposition of any issue when the evidentiary materials filed in support of the motion show that there is no genuine issue of any material fact. The moving party must support the motion by attaching and referencing evidentiary materials supporting the

party's statement of undisputed facts. Id. The opposing party must state the material facts which the party contends are disputed and attach supporting evidentiary materials. Id. The court shall grant judgment to one of the parties if it appears that there is no substantial controversy as to any material fact and that one party is entitled to judgment as a matter of law. Id. at Rule 13(e). All reasonable inferences are taken in favor of the opposing party. Wittenberg v. Fid. Bank, N.A., 1992 OK 165, ¶ 2, 844 P.2d 155, 156. The party opposing the motion cannot, on appeal, rely on any fact or evidentiary material not included or referenced in its statement of disputed facts. Rules of District Courts at Rule 13(b).

¶5 Summary judgment settles only questions of law. Rox Petrol., L.L.C. v. New Dominion, L.L.C., 2008 OK 13, ¶ 2, 184 P.3d 502, 504. We review rulings on issues of law by a de novo standard pursuant to the plenary power of the appellate courts without deference to the trial court. Glasco v. State ex rel. Okla. Dept. of Corrections., 2008 OK 65, ¶ 8, 188 P.3d 177, 181. Thus, summary judgments are reviewed de novo. Id.

III. PARTIES' ALLEGATIONS AND CONTENTIONS

¶6 The plaintiffs alleged in the petition filed in Oklahoma County District Court that Shelby was born on November 21, 2003. Drs. Badgett and Schlinke negligently caused Shelby to be delivered prematurely resulting in respiratory distress syndrome and in hospitalization in Integris Baptist Medical Center's neonatal intensive care unit. While in the intensive care unit, the hospital's employees negligently caused Shelby to develop vertebral osteomoyelitis. Because of the vertebral osteomyelitis, Shelby has required numerous surgeries and suffers severe, permanent spinal deformity.

¶7 The plaintiffs contend that Dr. Badgett contacted Dr. Schlinke for an opinion concerning Crawford's care. Based on Dr. Schlinke's opinion, Dr. Badgett caused Shelby to be delivered prematurely and, but for Dr. Schlinke's opinion, Shelby would not have been prematurely delivered. Dr. Schlinke knew or should have known that Dr. Badgett would rely on his opinion. Dr. Schlinke's negligence caused or contributed to Shelby' injuries and, thus, Dr. Schlinke is also liable for the injuries.

¶8 Dr. Schlinke's position is that in order to maintain a medical malpractice action against a physician, there must be a physician-patient relationship. He contends that under the facts no physician-patient relationship was formed. Thus, he had no duty to the plaintiffs and cannot be held liable for Shelby's

injuries.

IV. UNDISPUTED FACTS

¶9 The undisputed facts presented in the evidentiary materials on summary judgment and viewed in the light most favorable to the plaintiffs are as follows. Dr. Badgett called Dr. Schlinke seeking an opinion which Dr. Badgett incorporated into his decision on how to care for Crawford. Dr. Badgett made it clear to Dr. Schlinke, and Dr. Schlinke knew, that Dr. Badgett would be relying on the opinion in determining Crawford's care. Dr. Badgett gave Dr. Schlinke an appropriate history and report on Crawford's then current complications. But for Dr. Schlinke's advice, Dr. Badgett would not have delivered Shelby on November 21, 2003, but would have "pushed to term." However, it was Dr. Badgett's sole decision regarding Shelby's delivery. Although Dr. Badgett sometimes refers patients to Dr. Schlinke, he did not refer Crawford to Dr. Schlinke.

¶10 Further undisputed facts in the evidentiary materials are as follows. Dr. Badgett never asked Dr. Schlinke to enter into a physician-patient relationship with any of the plaintiffs and did not request Dr. Schlinke to co-manage Crawford or Shelby's case. Dr. Schlinke never talked to or saw any of the plaintiffs, did not charge them for professional services, did not provide or attempt to provide them medical care or treatment, was not asked to provide them with medical care or treatment, and did not agree to provide them with medical care or treatment. Dr. Schlinke did not examine any of the plaintiffs, consult with any of the plaintiffs, and did not have access to or look at Crawford's medical chart or records. Dr. Schlinke recognizes that his "informal" opinions may be relied upon by other doctors, that his advice could result in harm to a patient, and that he wants to give the best information that he can to other physicians, but the other physicians have to combine his opinion with the clinical scenario and make the final decision.

V. NECESSITY OF PHYSICIAN-PATIENT RELATIONSHIP

¶11 Medical malpractice involves matters of medical science and occurs when "those engag[ed] in the practice of the healing arts," 76 O.S.2001, § 20.1, fail to "exercise ordinary care in delivery of professional services" when a duty is owed the plaintiff. Franklin v. Toal, 2000 OK 79, ¶ 14, 19 P.3d 834, 837. Plaintiffs' have alleged that Dr. Schlinke was negligent in rendering professional services and,

in so doing, have brought a medical malpractice action against Dr. Schlinke.

¶12 The elements of a medical malpractice action, as with other negligence actions, are (1) a duty of care owed by the defendant to the plaintiff, (2) a breach of that duty, (3) an injury, and (4) causation. Franklin, 2000 OK 79 at ¶ 14, 19 P.3d at 837. In other words, the plaintiff must show that the defendant breached a duty owed the plaintiff which caused the plaintiff's injuries. The issue of the existence of duty is a question of law for the court. Lowery v. Echostar Satellite Corp., 2007 OK 38, ¶ 12, 160 P.3d 959, 964. This Court has not directly confronted the issue of whether a physician-patient relationship is essential for imposition of a duty in a medical malpractice action.

¶13 An action for malpractice is based on an employment contract. Funnell v. Jones, 1985 OK 73, ¶ 5, 737 P.2d 105, 107, cert. denied, 484 U.S. 853 (1987). To receive the professional services, the patient agrees to be treated, Scott v. Bradford, 1979 OK 165, ¶ 8-12, 606 P.2d 554, 556-557, and if the patient is unable to give consent, the consent may be implied. Rolater v. Strain, 1913 OK 634, 137 P. 96. Otherwise, a physician may be liable for assault and battery. Scott, 1979 OK 165 at ¶ 8-12, 606 P.2d at 556-557. Because in Oklahoma a physician is not under a general duty to provide professional services to others, see Jackson v. Mercy Health Ctr., Inc., 1993 OK 155, ¶ 5, 864 P.2d 839, 842, the physician must consent to provide the services. The agreement of the physician to treat and the patient to receive treatment is the basis of the employment contract.

¶14 Unless the contract expresses otherwise, the law will imply as a contractual term that the physician possesses "that reasonable degree of learning, skill, and experience which is ordinarily possessed by others of [the] profession, that [the physician] will use reasonable and ordinary care and diligence in the treatment of the case which [the physician] undertakes, and that [the physician] will use his [or her] best judgment in all cases of doubt as to the proper course of treatment." Muckleroy v. McHenry, 1932 OK 671, ¶¶ 0, 14, 16 P.2d 123 (Syllabus by the Court). Thus, "the law imposes a duty in the context of a relationship born of a contract [for which] a person injured by substandard performance of [the] duty may bring an action" for medical malpractice and a claim for breach of contract. Great Plains Fed. Sav. and Loan Ass'n v. Dabney, 1993 OK 4, ¶ 2, 846 P.2d 1088, 1095 (Opala, J. concurring). Because the duty in a medical malpractice action is born out of a physician-patient contract, the relationship is essential to an action for a breach of the duty giving rise to the malpractice action.

¶15 Most courts addressing the issue have likewise required a physician-patient relationship as a prerequisite to medical malpractice liability. Oliver v. Brock, 342 So.2d 1, 3-4 (Ala. 1977); Chatman v. Millis, 517 S.W.2d 504, 506 (Ark. 1975) (but would not say that the relationship must be predicated upon a contractual agreement); Bradley Center, Inc. v. Wessner, 296 S.E.2d 693, 695 (Ga. 1982); Flynn v. Bausch, M.D., 469 N.W.2d 125, 128 (Neb. 1991); Easter v. Lexington Memorial Hospital, Inc., 278 S.E.2d 253, 255 (N.C. 1981); Lownsbury v. Van Buren, 762 N.E.2d 354, 357-358 (Ohio 2002); Roberts v. Hunter, 426 S.E.2d 797, 799 (S.C. 1993); Kelley v. Middle Tenn. Emergency Physicians, P.C., 133 S.W.3d 587, 593-594 (Tenn. 2004); St. John v. Pope, 901 S.W.2d 420,423 (Tex. 1995); Didato v. Strehler, M.D., 554 S.E.2d 42, 47 (Va. 2001); Rand v. Miller, 408 S.E.2d 655, 656 (W.Va. 1991); James L. Rigelhaupt, Jr., Annotation, What Constitutes Physician-Patient Relationship for Malpractice Purposes, 17 A.L.R.4th 132 (1982 & Supp. 2009), cases cited therein (hereinafter 17 A.L.R.4th). But see Stanley v. McCarver, 92 P.3d 849 (Ariz. 2004) (imposing on physician, who was employed by business to conduct a pre-employment tuberculosis screening, a duty to make known other medical abnormalities based on it being foreseeable that the plaintiff would want to know).

¶16 While this issue is a matter of first impression in Oklahoma, our resolution is foreshadowed by our previous decisions addressing legal malpractice. We have continuously required that a plaintiff claiming legal malpractice prove an attorney-client relationship. Worsham v. Nix, 2006 OK 67, ¶ 31, 145 P.3d 1055, 1065 (citing Manley v. Brown, 1999 OK 79, 989 P.2d 448) (a plaintiff in a legal malpractice action must prove, among other things, an attorney-client relationship); Norton v. Hughes, 2000 OK 32, ¶ 11, 5 P.3d 588, 591 (A plaintiff claiming legal malpractice must prove "the existence of an attorney-client relationship."); Haney v. State, 1993 OK 41, 4, 850 P.2d 1087, 1089 ("One of the requisite elements of a legal malpractice claim is the existence of an attorney-client relationship."); Allred v. Rabon, 1977 OK 216, ¶ 11, 572 P.2d 979, 981 (A plaintiff claiming legal malpractice must prove "the existence of the relationship of attorney and client between himself and the defendant.").

¶17 By finding the element of duty in a medical malpractice action requires a physician-patient relationship, we are not disallowing a cause of action for medical malpractice by a third-party beneficiary, such as a child, based on negligent prenatal care or a negligent delivery. Part of the purpose of a contract for medical care of a pregnant female is to insure the health of the child. In Nealis v. Baird, 1999 OK 98, 996 P.2d 438, we recognized that the parents of a prematurely-born child could bring a wrongful death action on the child's behalf against the mother's treating physicians. In

Graham v. Keuchel, 1993 OK 6, 847 P.2d 342, we allowed that a wrongful death claim could be brought on behalf of an infant for a physician's failure to administer a drug after a previous delivery which would have prevented the mother's Rh-positive sensitization. In this regard, this Court allowed that the intended beneficiaries of a will could bring a legal malpractice claim or contract claim against the attorney drafting the will. Leak-Gilbert v. Fahle, 2002 OK 66, ¶ 27, 55 P.3d 1054, 1062.

VI. THE EXISTENCE OF A PHYSICIAN-PATIENT RELATIONSHIP

¶18 The next question is whether the undisputed facts were sufficient to prove the existence of a physician-patient relationship between Dr. Schlinke and Crawford. Although the question of duty is one for the courts, Lowery, 2007 OK 38 at ¶12, 160 P.3d at 964, the question of the formation of a physician-patient relationship "is a question of fact, turning upon a determination of whether the patient entrusted his treatment to the physician and the physician accepted the case." Fruiterman v. Granata, 668 S.E.2d 127, 135 (Va. 2008) (citing Lyons v. Grether, 239 S.E.2d 103, 105 (Va. 1977)) ; Irvin v. Smith, 31 P.3d 934, 940-941 (Kan. 2001). On a motion for summary judgment when the material facts are undisputed and the evidentiary materials and facts show one party is entitled to judgment, the court may decide the issue as a matter of law. See Glasco, 2008 OK 65 at ¶ 36, 188 P.3d at 188.

¶19 It is unquestioned in Oklahoma and other jurisdictions that an attending or treating physician has the requisite connections with the patient to create a physician-patient relationship. See Jackson v. Okla. Mem'l Hosp., 1995 OK 112, ¶ 12, 909 P.2d 765, 772. In Jackson, this Court set out evidence in that case which showed that the defendant doctor, a faculty physician at a teaching hospital, was the plaintiff's attending physician. Id. at ¶ 11, 909 P.2d at 771-772. This Court concluded that the defendant doctor was the attending physician and, as such, could be held liable for medical malpractice. In other medical malpractice cases previously decided by this Court, treating physicians were implicitly deemed to have the requisite relationship with a patient necessary to maintain a medical malpractice action against them. Franklin, 2000 OK 79, 19 P.3d 834; Smith v. Karen S. Reisig, M.D., Inc., 1984 OK 56, 686 P.2d 285. In the present case, the plaintiffs do not assert, and there is no evidentiary material supporting a finding, that Dr. Schlinke was the plaintiffs' attending or treating physician. Thus, we turn to other indicia of a physician-patient relationship.

¶20 **This Court has not addressed whether a physician-patient relationship exists when the**

physician has not examined, diagnosed, or treated the patient. However, courts generally agree that, under similar facts to those before us, a physician's discussion with a treating physician concerning a patient, without more, does not create a physician-patient relationship and, thus, does not create a duty on the part of the non-treating physician. Adams v. Via Christi Reg'l Med. Ctr., 19 P.3d 132, 139-140 (Kan. 2001), and cases cited therein; Flynn v. Bausch, 469 N.W.2d 125, 128 (Neb. 1991), and cases cited therein; Diggs v. Ariz. Cardiologists, LTD., 8 P.3d 386, 389, 391 ("Generally, where a physician has been informally consulted, the courts deny recovery for negligence[, and] where treating physician exercises independent judgment in determining whether to accept or reject such advice, few policy considerations favor imposing a duty on the advising physician.").

¶21 In Oliver v. Brock, 342 So.2d 1 (Ala. 1977), the Alabama Supreme Court addressed the question of the existence of a physician-patient relationship which would support a medial malpractice action. Id. at 3. The facts were (1) the defendant doctor had never seen the plaintiff, (2) neither the plaintiff's parents nor her treating doctor had ever requested or engaged the defendant to serve as a consultant in the plaintiff's treatment, (3) the treating doctor called the defendant about another patient; during the conversation, described the plaintiffs injuries and the type of treatment being administered; did not ask for advice about the treatment; and was told by the defendant that he was treating the injuries correctly, (4) the conversation was gratuitous, and (5) the attending doctor did not employ the defendant to treat the plaintiff. Id. The court found that there was no evidence from which it could conclude that the defendant had consented to treat the plaintiff. Id. at 4-5.

¶22 The evidence in Flynn v. Bausch, 469 N.W.2d 125 (Neb. 1991), is more compelling of the existence of a physician-patient relationship than the evidence before this Court here. Nonetheless, the Nebraska Supreme Court found that the record did not support a physician-patient relationship between the defendant doctor and the plaintiff. Id. at 129. In Flynn, the defendant doctor and the plaintiff's treating doctor had a conversation about the plaintiff in the hospital nursery where the plaintiff was at the time. Id. at 127. The two doctors agreed that additional tests on the plaintiff were needed. Id. The defendant did not look at the plaintiff's chart or any test results and was not aware of the plaintiff's name. Id. Although the defendant did look at the plaintiff in the nursery, he did not examine the plaintiff but noticed that he appeared jaundiced and had a rash. Id. The defendant advised the treating doctor to wait on test results before performing a blood-exchange transfusion. Id. The plaintiff alleged that he suffered brain damage and other injuries which could have been avoided had he received the transfusion earlier.

Id. at 128. The court concluded that summary judgment in the defendant's favor was proper notwithstanding he had looked at the plaintiff in the nursery and had advised the transfusion be delayed, which it was. The court reasoned that the inferences were too general to support a finding that the defendant had undertaken to participate in the plaintiff's care. Id. at 129.

¶23 In St. John v. Pope, 901 S.W.2d 420 (Tex. 1995), the Texas Supreme Court faced the question of whether a physician-patient relationship existed under the facts in that case. Id. at 421. The defendant doctor was on call at the hospital when the plaintiff was being treated in the emergency room. Id. at 421-422. When the emergency room doctor consulted the defendant by telephone, the defendant opined that the patient should be transferred to another facility. Id. at 422.

¶24 The plaintiff in St. John sued the defendant for medical malpractice. See id. The court surveyed the history of medical malpractice and concluded that a physician-patient relationship was necessary to maintain a medical malpractice action. Id. at 423. It did not dispute that a physician's agreement with a hospital might require an on-call physician to treat the hospital's patients, but the fact that a physician is on call does not in itself impose such a duty. Id. at 424. The court found that the defendant had established the lack of a physician-patient relationship in his motion for summary judgment as a matter of law. Id. The court further noted that after the defendant had submitted evidence that he never agreed to treat the plaintiff "it was incumbent on [the plaintiff] to present [evidence of an agreement] in order to preclude summary judgment for the doctor." Id.

¶25 Here , Dr. Schlinke did not render medical advice to the plaintiffs; did not provide services to the treating physician on behalf of Shelby or Crawford; took no affirmative action to treat Shelby or Crawford; spoke only with Dr. Badgett and not to the Crawford or Jennings; did not examine Shelby or Crawford; did not receive a referral of Shelby or Crawford for treatment or consultation; was not employed by Dr. Badgett and had not been asked or contracted by Dr. Badgett to provide medical treatment to Shelby or Crawford; and had not reviewed any work, conducted any laboratory tests, reviewed any test results, prepared any reports, or billed the plaintiffs. Further, none of the plaintiffs agreed that Dr. Schlinke could treat Crawford or Shelby. Even though Dr. Badgett chose to rely on Dr. Schlinke's opinion, Dr. Badgett was free to exercise his independent judgment.

¶26 Dr. Schlinke submitted evidentiary materials supporting a finding that he did not have a physician-

patient relationship with the plaintiffs. It was then incumbent on the plaintiffs to come forth with evidentiary materials to support the formation of the essential physician-patient relationship. The plaintiffs relied on the fact that Dr. Badgett would not have allowed Crawford to deliver early but for Dr. Schlinke's recommendation. This is insufficient to create a physician-patient relationship. The facts before us fail to show that Dr. Schlinke agreed to treat the plaintiffs or undertook treatment of any of the plaintiffs. Thus, there was not the physician-patient relationship necessary for a medical malpractice action. The district court correctly granted judgment in Dr. Schlinke's favor.

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See: http://www.oscn.net/applications/oscn/deliverdocument.asp?cite=2010+OK+7

Outcome: ¶27 A medical malpractice action is one of negligence wherein the duty is born from a contractual relationship. In a medical malpractice action, the plaintiff must prove a physician-patient relationship in order to establish a duty owed by the defendant. A telephone conversation between a non-treating physician and the treating physician concerning the patient, even when the treating physician relies on the non-treating physician's opinion, without more, is insufficient to establish a physician-patient relationship. Based on the record before us, we conclude that Dr. Schlinke did not agree to or undertake to treat Crawford or Shelby and did not form a physician-patient relationship with the plaintiffs as a matter of law.

¶28 We find that the district court correctly rendered summary judgment in favor of Dr. Schlinke. The Court of Civil Appeals' opinion is vacated, the trial court's order awarding summary judgment in favor of Dr. Schlinke is affirmed, and the cause is remanded for further proceeding.

COURT OF CIVIL APPEALS' OPINION VACATED; CERTIFIED INTERLOCUTORY ORDER AFFIRMED; CAUSE REMANDED FOR FURTHER PROCEEDINGS.

What constitutes patient abandonment?

A good distillation of the holdings concerning physician abandonment may be found in Am Jur 2d:

> A claim for "abandonment" involves the termination of the professional relationship between the physician and the patient at an unreasonable time or without affording the patient the opportunity to procure an equally qualified replacement. It is a corollary to the physician's right to withdraw from a case upon giving proper notice that he is under a duty to continue his attendance upon the patient until all the conditions for his rightful withdrawal are complied with, and that a breach of this duty may render him liable. *** Absent good cause to the contrary, where the doctor knows or should know that a condition exists that requires further medical attention to prevent injurious consequences, the doctor must render such attention or must see to it that some other competent person does so until the termination of the physician-patient relationship.[21]

Thus, patient abandonment would generally be characterized as the breach of a duty under tort law analysis.

In California, the Court of Appeals considered the matter of a physician's refusal to treat an indigent woman in labor while inquiring about her ability to pay. Because the defendant physician had initially admitted plaintiff patient to the ED and transferred her to the labor and delivery floor before inquiring on her ability to pay, he had accepted the patient for treatment and could not abandon her.[22]

In a Utah case, the defendant physician hospitalized and treated the plaintiff patient for an infected finger. Against the physician's advice, the patient left the hospital. The physician instructed the patient to return for further treatment if the infection worsened. When the infection worsened, the physician examined the patient and told him to return to the hospital. Once at the hospital, the physician refused to treat the patient because of a previously owed bill. The patient was operated on at another hospital and his finger was eventually amputated, leading to his suit for malpractice. The court found that the physician, upon undertaking the operation during the patient's second admission, was under a duty to continue his attention as long as the case required.[23]

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[21] 61 Am Jur 2d *Physicians, Surgeons, and Other Healers* § 218 (2008).

[22] *Hongsathavij v. Queen of Angels Etc. Medical Ctr.*, 62 Cal App 4th 1123, 1138 (1998) ("A physician cannot just walk away from a patient after accepting the patient for treatment. A physician cannot withdraw treatment from a patient without due notice and an ample opportunity afforded to secure the presence of another medical attendant. [Internal citation omitted]. In the absence of the patient's consent, the physician must notify the patient he is withdrawing and allow ample opportunity to secure the presence of another physician.").

[23] *See Ricks v. Budge*, 91 Utah 307, 314 (1937) ("The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship, or by the discharge of the physician by the patient, or by the

The court found the physician's duty is to provide continuing care until the physician has properly withdrawn from the relationship. The physician's ongoing duty of care may be terminated by:

(1) The cessation of the necessity which gave rise to the relationship;

(2) The discharge of the physician by the patient; or

(3) The withdrawal from the case by the physician *after giving the patient reasonable notice so as to enable the patient to secure other medical attention*.[24]

A physician has the right to withdraw from a case, but if the case requires further medical or surgical attention, the physician must either provide care or, before withdrawing from the case, give the patient sufficient notice so the patient can procure other medical attention if the patient so desires.[25]

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withdrawal from the case by the physician after giving the patient reasonable notice so as to enable the patient to secure other medical attention. A physician has the right to withdraw from a case, but if the case is such as to still require further medical or surgical attention, he must, before withdrawing from the case, give the patient sufficient notice so the patient can procure other medical attention if he desires.").

[24] *Id*.

[25] *Id*.