Hurley, Administrator, v. Eddingfield.

SUPREME COURT OF INDIANA

156 Ind. 416; *59 N.E. 1058*

April 4, 1901, Filed

Appellant sued appellee for $ 10,000 damages for wrongfully causing the death of his intestate. The court sustained appellee's demurrer to the complaint; and this ruling is assigned as error.

The material facts alleged may be summarized thus: At and for years before decedent's death appellee was a practicing physician at Mace in Montgomery county, duly licensed under the laws of the State. He held himself out to the public as a general practitioner of medicine. He had been decedent's family physician. Decedent became dangerously ill and sent for appellee. The messenger informed appellee of decedent's violent sickness, tendered him his fees for his services, and stated to him that no other physician was procurable in time and that decedent relied on him for attention. No other physician was procurable in time to be of any use, and decedent did rely on appellee for medical assistance. Without any reason whatever, appellee refused to render aid to decedent. No other patients were requiring appellee's immediate service, and he could have gone to the relief of decedent if he had been willing to do so. Death ensued, without decedent's fault, and wholly from appellee's wrongful act.

The alleged wrongful act was appellee's refusal to enter into a contract of employment. Counsel do not contend that, before the enactment of the law regulating the practice of medicine, physicians were bound to render professional service to every one who applied. Wharton on Neg., ß 731. The act regulating the practice of medicine provides for a board of examiners, standards of qualification, examinations, licenses to those found qualified, and penalties for practicing without license. Acts 1897, p. 255; Acts 1899, p. 247. The act is a preventive, not a compulsive, measure. In obtaining the State's license (permission) to practice medicine, the State does not require, and the licensee does not engage, that he will practice at all or on other terms than he may choose to accept. Counsel's analogies, drawn from the obligations to the public on the part of innkeepers, common carriers, and the like, are beside the mark.

Judgment affirmed.

REYNOLDS v. DECATUR MEMORIAL HOSPITAL

APPELLATE COURT OF ILLINOIS, FOURTH DISTRICT

277 Ill. App. 3d 80*; *660 N.E.2d 235

January 4, 1996, FILED

Plaintiffs Kevin Thomas Reynolds, a minor (born July 14, 1988), by Barbara Reynolds, his mother and next friend, and Charles W. and Barbara Reynolds, individually, appeal from a summary judgment entered by the circuit court of Macon County in favor of defendant Dr. Thomas Fulbright in this medical malpractice action based on a negligence theory. * * *

The only issue is whether, as a matter of law, a telephone conference between treating pediatrician Dr. Sharon Bonds and Fulbright concerning Kevin's condition created a physician-patient relationship between Kevin and Fulbright so as to raise a duty which is enforceable in a medical malpractice action in light of the standards of protocol of the hospital at which Kevin was being treated and in which both physicians were allowed to practice. The trial court found there was no physician-patient relationship and, therefore, no duty was owed by Fulbright to plaintiffs. We affirm. * * *

Plaintiffs claim Kevin's quadriplegia resulted from the medical malpractice of defendants. The facts relevant to this appeal appear undisputed, although the legal consequences of those facts are in dispute.

At about 10:45 p.m. on November 29, 1990, Kevin was seen in the emergency room of Decatur Memorial Hospital by Dr. Terry Balagna. The history given indicated he was injured at 8:30 or 9 p.m. by falling while jumping on the couch in the family living room. Upon examination, an abnormal breathing pattern was observed. Tests were conducted to discover the possibility of an infection or an electrolyte or metabolic problem. Cervical spine X rays were taken at about 1:05 a.m. which appeared normal. Nevertheless, Kevin was admitted to the hospital. Balagna called Bonds, a pediatrician, to examine him.

Bonds arrived at the hospital at about 1:45 a.m. on November 30, 1990. At that time, Kevin's temperature was 102 degrees Fahrenheit. Bonds made a quick assessment of plaintiff and took a history from Barbara, which indicated Kevin had jumped off the couch, landed on his arm, walked to his mother, and gradually become limp after that. Bond noticed the child's breathing difficulties and that he was flaccid. She reviewed the emergency room records and X-ray reports, conducted reflex tests, and noticed he was moving his head. His neck was not tender. Among the possible reasons for his condition which Bonds considered were neurologic, traumatic, metabolic, infectious, or post-infectious problem. Because of the fever, she was leaning toward the infectious process diagnosis, and she did not consider a spinal cord injury. A history of a two-foot fall with a normal 2 1/2-year-old child did not indicate to her the existence of a cervical cord injury from trauma.

At 2:05 a.m., Bonds telephoned Fulbright at his home. She advised Fulbright that Kevin walked following the fall, he had an elevated temperature and was flaccid and responsive, and the cervical spine X rays were negative. She probably told him the child was flaccid from the neck down, including all four extremities. Fulbright inquired if the child had a stiff neck. Bonds said she did not know, went to check Kevin's neck, and returned to inform Fulbright that his neck was stiff. At the end of the conversation, Fulbright suggested a spinal tap to determine whether meningitis, encephalitis, or something similar was involved. Bonds did not ask Fulbright to treat Kevin, nor did Fulbright commit himself to further involvement with Kevin. Bonds was under the impression that Fulbright would see Kevin if she contacted him and requested that he treat Kevin.

Fulbright's recollection of his telephone conversation was as follows:

> "Dr. Bonds called me regarding Kevin Reynolds. She related to me that the patient had presented with a history of a fall, I believe from a couch. The height estimated to be less than two feet. She related that the child was listless, and that the child was febrile with a fever of -- on the order of 102 degrees Fahrenheit.
>
> I questioned Dr. Bonds regarding the history. My first concern was the veracity of the history. My major concern here was the question of child abuse. There was some report on her part that the history had been somewhat inconsistent. That in itself is a hallmark of abuse. I questioned her specifically as to whether or not she felt abuse was operative in this case. She stated relatively emphatically that she did not think that it was.
>
> She did not think that the fall was overly significant because of it's [*sic*] apparently benign nature, that is, a fall from a low height of a young child as happens to every young child.
>
> The question of the cause of the fever and the possible neurological causes of the fever was raised. The question of meningitis was discussed. The question of an ascending neuritis was discussed. The performance of a lumbar puncture was discussed. The conclusion was that Dr. Bonds would perform the lumbar puncture and let me know if she wanted me to see the child thereafter. I offered to make myself physically available if she wished. We elected to proceed with the plan of her performing the lumbar puncture and letting me know if she needed me there."

Fulbright often received informal inquiries from other doctors asking questions and seeking suggestions. These inquiries do not include a request to see a patient, review a patient, or render an opinion, but only to discuss the case. He considered this a courtesy service for which he did not bill. He offered to make himself available because the other physician may be inhibited about asking him to see the patient due to the late hour or the marginal neurosurgical nature of the case.

At 3:30 a.m. on November 30, 1990, Bonds performed the spinal tap. Before leaving the hospital, she told a nurse to write an order in Kevin's chart "to consult with Fulbright to see in early a.m." That note was posted to the chart, and the message was taken off the chart at 4:05 a.m. The usual practice was for the ward clerk or nurse to notify the operator, who would place the message in the appropriate area. The message was never received by Fulbright. At 8 a.m., Bonds realized Fulbright had not received the message, attempted to locate him, and was told he was in surgery performing a very long procedure. Fulbright stated he did not receive another call from Bonds or anyone else at the hospital with regard to Kevin's condition or treatment. Kevin's family never asked

Fulbright to treat Kevin, and he never saw, examined, or came to a diagnosis as to Kevin's condition. Fulbright did not bill for any services to Kevin.

When Kevin was transferred to St. John's Hospital (St. John's) at 12 p.m. on November 30, 1990, Bonds' diagnosis was an infectious process called Guillain-Barre syndrome. At St. John's, a spinal cord injury was diagnosed.

According to the affidavit of Dr. John Oldershaw, a neurosurgeon, the medical staff rules of Decatur Memorial Hospital relating to consultations state:

> "4.1 Appropriate consultation shall be obtained by practitioners in cases in which the patient is not a good medical or surgical risk and in cases in which the diagnosis is obscure, where there is doubt as to the best therapeutic measure to be utilized, or where the treatment is difficult and especially in cases with probable disorders or complications lying within a field other than the one in which the attending physician is primarily qualified.
>
> 4.2 A consultant must be well qualified to give an opinion in the field where his opinion is sought. A satisfactory consultation must include the examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record. When operations are involved, the consultation note, except in emergency, shall be recorded prior to the operation."

According to Oldershaw, the failure of Fulbright to examine Kevin and the records before making a recommendation and failing to follow through after being consulted violated the hospital rules and generally accepted standards of practice in the medical community.

* * *

In a negligence action for medical malpractice, there must be a duty owed by defendant to the plaintiff, a breach of duty, an injury proximately caused by the breach, and resultant damages. The determination of whether the parties stood in such a relationship to one another that the law would impose on defendant a duty of reasonable conduct for the benefit of the plaintiff is a question of law. That policy determination is based on consideration of the likelihood of injury, the magnitude of the burden of guarding against it, and the consequences of placing that burden on the defendant. A physician's duty is limited to those situations in which a direct physician-patient relationship exists or there is a special relationship such as when an infant sues for prenatal injuries foreseeably caused by the physician's negligent care of the mother prior to conception. In this case, there was no special relationship as in *Renslow,* and there was no direct physician-patient relationship, and hence no duty owed to plaintiffs by Fulbright. This determination was properly made as a matter of law.

The relationship of physician and patient is one of trust and confidence. It is a consensual relationship in which the patient knowingly seeks the physician's assistance and the physician knowingly accepts the person as a patient. A consensual relationship can exist where other persons contact the physician on behalf of the patient, but this is not a case in which Fulbright was asked to provide a service for Kevin, conduct laboratory tests, or review test results. Fulbright did nothing more than answer an inquiry from a colleague. He was not contacted again and he charged no fee. A doctor who gives an informal opinion at the request of a treating physician does not owe a duty of care to the patient whose case was discussed. This is not a case in which Fulbright had accepted a

referral of the patient. Nor is this a case in which a physician undertook to direct the actions of hospital employees in a telephone conversation with an emergency room nurse.

The affidavit of Oldershaw does not help plaintiffs. Whether Fulbright owed a duty to Bonds, and ultimately to plaintiffs, is a question of law, not a question of medicine. The proffered opinion of plaintiffs' expert transcends the bounds of his competence and intrudes on the exclusive province of the court. Plaintiffs may not, in the guise of offering expert medical opinion, arrogate to themselves a judicial function and obviate a ruling on the existence of or extent of a legal duty which might be owed by a physician to a patient.

For the same reasons, the rules of Decatur Memorial Hospital are not dispositive of this case. Such rules are more appropriately considered in determining whether the standard of care was met. Such considerations only arise after a physician-patient relationship imposing a duty has been found to exist.

Plaintiffs also argue that, since the telephone conversation breached the hospital rules, Fulbright breached his contract with Decatur Memorial Hospital. Plaintiffs' complaint in this case did not present a theory of recovery on behalf of plaintiffs as third-party beneficiary of any contract between the hospital and Fulbright. This issue is not presented by the pleadings.

Distinguishable from this case is plaintiffs' cited case of *Hiser v. Randolph (App. 1980), 126 Ariz. 608, 617 P.2d 774*, which involved the question of whether a physician under contract to a hospital to render emergency room services had a duty to render care to anyone presenting themselves to the hospital for emergency care. In *Hiser,* the court found that the contractual relationship between a hospital and the doctor obligated the doctor to treat such patients. The rules of Decatur Memorial Hospital in this case cannot, as a matter of law, require a physician to enter into a physician-patient relationship with every person treated in the hospital whose treating physician might make an informal inquiry about that case.

Plaintiffs suggest that what needs to be done is to find a physician-patient relationship to result from every such conversation. The consequence of such a rule would be significant. It would have a chilling effect upon practice of medicine. It would stifle communication, education and professional association, all to the detriment of the patient. The likely effect in adopting plaintiffs' argument also would be that such informal conferences would no longer occur. To reiterate, this would inhibit the exchange of information and expertise among physicians and would not benefit the medical profession or persons seeking treatment. * * *

DIGGS v. ARIZONA CARDIOLOGISTS, LTD.

COURT OF APPEALS OF ARIZONA, DIVISION ONE, DEPARTMENT C

198 Ariz. 198*; *8 P.3d 386

August 8, 2000, Filed

After conferring with cardiologist, Dr. Rubin S. Valdez, the St. Luke's Medical Center emergency room physician, Dr. Paul Johnson, treated Cynthia Diggs' severe chest pain and released her. Three hours later, she died of a heart attack. Her husband, Vainus Diggs, Sr., her children, and her parents filed a medical malpractice suit against, among others, Dr. Valdez, Arizona Cardiologists, Ltd., and Arizona Cardiology Group, P.C. ("the Valdez defendants"). The trial court granted summary judgment to the Valdez defendants reasoning that, without an express or implied physician-patient relationship, Dr. Valdez owed no duty of care to Mrs. Diggs.

The issue is whether Dr. Valdez's brief discussion with Dr. Johnson, during which Dr. Valdez reviewed Mrs. Diggs' clinical records and rendered advice on the diagnosis and treatment of her medical condition, is sufficient to create a duty from Dr. Valdez to Mrs. Diggs. We hold that when Dr. Valdez undertook to give advice to Dr. Johnson regarding Mrs. Diggs' care and treatment, knowing that Dr. Johnson would rely on this advice, Dr. Valdez owed a duty of reasonable care to Mrs. Diggs. We also hold that an express physician-patient relationship is not a requisite for finding a duty of reasonable care under these circumstances. We therefore do not determine whether an express physician-patient relationship existed between Dr. Valdez and Mrs. Diggs. Because summary judgment was inappropriate, we reverse and remand.

BACKGROUND

On the morning of July 17, 1996, Mrs. Diggs was stricken with severe chest pain. Paramedics took her to the St. Luke's Medical Center Emergency Department where she was seen by Dr. Johnson. Dr. Johnson took her medical history, examined her, and ordered an electrocardiogram ("EKG") and an echocardiogram. Although the EKG machine indicated that Mrs. Diggs was suffering from myocardial infarction, Dr. Johnson thought that her physical symptoms were indicative of pericarditis, inflammation of the sac around the heart.

Dr. Johnson had treated pericarditis in the past but before he could be certain that Mrs. Diggs was suffering from pericarditis he had to rule out myocardial infarction as a possible diagnosis. He was, however, untrained in the interpretation of echocardiograms and thus was unable to use the results of this test to make a differential diagnosis. Furthermore, because the computer interpretation generated by the EKG machine conflicted with Dr. Johnson's interpretation of the EKG, he needed confirmation from a cardiologist that the EKG demonstrated pericarditis, rather than myocardial infarction.

Dr. Johnson saw Dr. Valdez visiting another patient in the Emergency Department. Although Dr. Valdez was not the on-call cardiologist at that time, Dr. Johnson and Dr. Valdez

briefly discussed Mrs. Diggs' case. Dr. Johnson presented Dr. Valdez with Mrs. Diggs' clinical history and the results of his physical examination. Dr. Valdez also reviewed the EKG results.

Dr. Valdez agreed with Dr. Johnson that Mrs. Diggs should be discharged. They concluded that Mrs. Diggs' pericarditis should be treated with Indocin, a nonsteroidal anti-inflammatory medication, and that she follow up with her family practice physician immediately. Dr. Valdez also offered to see Mrs. Diggs in ten days for follow-up care.

Dr. Johnson discharged Mrs. Diggs around 1 p.m. with the above instructions. She died about three hours later of cardiopulmonary arrest. After her death, another cardiologist at St. Luke's reviewed Mrs. Diggs' EKG and echocardiogram pursuant to the hospital's practice to have a cardiologist review all such tests for an "official" interpretation. The tests confirmed that Mrs. Diggs was suffering from an acute myocardial infarction while she was in the emergency department earlier in the day.

Plaintiffs filed this medical malpractice action against Dr. Johnson, the three corporate entities doing business as St. Luke's, and the Valdez defendants, requesting damages for wrongful death. The Valdez defendants moved for summary judgment, arguing that Dr. Valdez only informally consulted with Dr. Johnson regarding Mrs. Diggs and owed her no duty of care. Plaintiffs filed a cross-motion for summary judgment on the issue, arguing that Dr. Valdez owed a duty of care to Mrs. Diggs because he: (a) formed a physician-patient relationship with Mrs. Diggs; (b) negligently performed voluntary undertakings according to Restatement (Second) of Torts (1965) ("Restatement") sections 323, 324, and 324A; and (c) was contractually obligated to treat Mrs. Diggs under St. Luke's Bylaws.

The trial court found no contractual physician-patient relationship between Dr. Valdez and Mrs. Diggs and relying on *Hafner v. Beck, 185 Ariz. 389, 916 P.2d 1105 (App. 1995)*, decided as a matter of law that Dr. Valdez did not owe a duty to Mrs. Diggs. The court concluded that Dr. Valdez's involvement was limited to an informal consultation that did not give rise to a duty of due care. It further rejected plaintiffs' argument based on the Bylaws because they presumed a physician-patient relationship that did not exist. The court did not address plaintiffs' Restatement arguments.

After the court granted summary judgment for the Valdez defendants, plaintiffs settled their claims against the remaining defendants. The court entered an order dismissing the claims against Dr. Johnson and the St. Luke's entities and entered judgment in favor of the Valdez defendants. Plaintiffs timely filed this appeal of the summary judgment in favor of the Valdez defendants.

DISCUSSION

* * * We observe that courts have reached differing conclusions when considering whether a consulting physician owes a duty of care to the patient. The cases range from a doctor simply answering a colleague's casual telephone inquiry about a course of treatment to an on-call doctor examining and essentially directing the course of the patient's treatment. Generally, where a physician has been informally consulted, the courts deny recovery for negligence, theorizing that a duty cannot exist absent a contractual relationship.

But the employment contract rationale is unsatisfactory when, for example, diagnostic medical services are provided by a pathologist. No express physician-patient relationship exists yet many courts have concluded that the physician who provides consulting services to a treating doctor for the benefit of an unknown patient has an "implied" contract of employment that gives rise to a duty.

In the instant case, we decline to apply this rationale. Although an express contractual physician-patient relationship clearly gives rise to a duty to the patient, the absence of such a relationship does not necessarily exclude a duty to the patient. Nor, in our view, is it necessary for the court to "imply" a contractual relationship between physician and patient in order to find a duty of reasonable care. Rather, we follow our supreme court's traditional approach to duty and determine whether a sufficient relationship existed between Dr. Valdez and Mrs. Diggs such that, as a matter of policy, Dr. Valdez owed her a duty of reasonable care.

Because the trial court relied on *Hafner* for the proposition that a contractual physician-patient relationship must exist to establish a duty in a medical malpractice action, we first examine that case. There, a workers' compensation claimant sued a psychologist who performed an independent medical examination for the insurance carrier. The claimant alleged that the psychologist's examination fell below the standard of care and that he "'negligently reported incorrect information' about her to the [carrier]." The court reasoned that because the psychologist was hired by the carrier to evaluate the claimant and not to treat her, his duty of care ran only to the carrier.

We conclude that the trial court read *Hafner* too broadly when it relied on the statement that "[a] medical malpractice suit *such as this* will lie only when there was a doctor patient relationship creating a duty to act for the patient's benefit." The defendant in *Hafner* was an independent psychologist who had no therapeutic relationship with the patient. The court emphasized the narrow basis for its holding by stating that a doctor who conducts an independent medical examination and does not "'intend to treat, care for or otherwise benefit the employee'" has no duty to that person.

Duty is, after all, merely "an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection." *Hafner* correctly notes that the question is whether there is a "'relation between individuals which imposes upon one a legal obligation for the benefit of the other.'" As we read *Hafner*, it states that because the defendant rendered no treatment, the relationship between the parties was so attenuated that, for policy reasons, the plaintiff was not entitled to protection.

We find support for our analysis of *Hafner* in *Ornelas,* a case on which the *Hafner* court relied to support its holding. There, an organ donor sued the donee's anesthesiologist for the unnecessary loss of a donated kidney. The *Ornelas* court found that the anesthesiologist did not owe the donor a duty because the donor "failed to allege or prove the existence of a physician/patient relationship [between the donor and the anesthesiologist] *or any other legal theory which would give rise to any legal duty* on the part of [the anesthesiologist]."

In examining whether any legal theory exists here that would, in the words of *Ornelas*, "give rise to any legal duty," we are guided by *Ontiveros*. There, our supreme court extended the duty a

tavern keeper owes to his patrons to include the "obligation to help control the conduct of his patron in order to prevent that patron from injuring someone else." The court based this extension on the policy of placing duties on those most capable of preventing the harm caused by the intervening negligence of others. This policy is guided by one of the underlying principles of our system of tort law: the prevention of future harm.

Returning to the facts in this case, we note that Dr. Valdez was in a unique position to prevent future harm to Mrs. Diggs. Dr. Johnson approached Dr. Valdez, the head of St. Luke's cardiology department, for assistance in making certain determinations about Cynthia Diggs' medical care that Dr. Johnson was not fully qualified to make on his own. As between Dr. Johnson and Dr. Valdez, only Dr. Valdez had the expertise to interpret the echocardiogram, rule out myocardial infarction on the basis of the EKG, and admit Cynthia Diggs to the hospital for further treatment. Dr. Valdez, with his superior knowledge and experience, was in the best position to correct any error in Dr. Johnson's diagnosis.

Furthermore, the Restatement section 324A, which we previously adopted in *Tollenaar v. Chino Valley School District, 190 Ariz. 179, 181, 945 P.2d 1310, 1312 (App. 1997)*, provides that:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of a third person or his things, is subject to liability to the third person for physical harm resulting from his failure to exercise reasonable care to protect his undertaking, if (a) his failure to exercise reasonable care increases the risk of such harm, or . . . (c) the harm is suffered because of reliance of the other or third person upon the undertaking. [1]

Thus, if an actor's negligent undertaking "results in increasing the risk of harm to a third person, the fact that he is acting under a . . . gratuitous agreement with another will not prevent his liability to the third person." Additionally, "where the reliance of the other, or of the third person, has induced him to forgo other remedies or precautions against such risk, the harm results from the negligence as fully as if the actor had created the risk."

Taking the undisputed facts and all inferences therefrom in a light most favorable to Mrs. Diggs, we find that Dr. Valdez voluntarily undertook to provide his expertise to Dr. Johnson, knowing that it was necessary for the protection of Mrs. Diggs and that Dr. Johnson would rely on it. Dr. Valdez knew that the computer interpretation generated by the EKG indicated an acute myocardial infarction and that proper interpretation of the EKG required a cardiologist. In his deposition, Dr. Valdez agreed that he confirmed Dr. Johnson's pericarditis diagnosis, that he recommended Mrs. Diggs be treated with Indocin, and that by ordering Mrs. Diggs to follow-up with him in ten days, he implied to Dxr. Johnson that it was safe to discharge her.

Dr. Valdez admitted that his advice significantly affected Mrs. Diggs' treatment. When asked what Dr. Johnson did to rule out myocardial infarction as a diagnosis, Dr. Valdez answered: "He relied on the clinical history. He relied on my curbside consult, and he thought that the clinical history and all the findings most favored pericarditis." Dr. Valdez later conceded, however, that nothing about the EKG, the clinical history, or the physical examination ruled out myocardial infarction. We can reasonably infer from this testimony that the principal factor that led Dr. Johnson

to rule out myocardial infarction was his reliance on Dr. Valdez's "curbside" opinion that Mrs. Diggs suffered from pericarditis.

Dr. Valdez further testified that if he had considered Mrs. Diggs as his own patient, he would have ordered a cardiac enzyme test to rule out myocardial infarction. Mrs. Diggs was discharged, however, without the benefit of that additional test. Dr. Valdez's advice and implicit opinion that it was safe to discharge Mrs. Diggs consequently increased the risk of harm to her.

Dr. Valdez argues that if we find that he had a duty to Mrs. Diggs under these circumstances, "informal" exchange of information between medical professionals will be chilled. We are not persuaded. We are not dealing with the informal exchange of medical information between two physicians, one of whom merely serves as a resource such as a treatise or textbook. In that case, where the 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.

Here, Dr. Johnson was not free to accept or reject Dr. Valdez's advice. Dr. Johnson was not a cardiologist; he needed the specialized knowledge of someone such as Dr. Valdez to read the echocardiogram and to confirm his interpretation of Mrs. Diggs' EKG. Furthermore, because Dr. Johnson did not have admitting privileges, only Dr. Valdez could admit Cynthia Diggs to St. Luke's Medical Center.

The record and all reasonable inferences indicate that Dr. Johnson did not exercise independent judgment as to Cynthia Diggs' diagnosis; rather he subordinated his professional judgment to that of the specialist in cardiology, Dr. Valdez. Paraphrasing the Restatement, section 324A, comment e, Dr. Johnson's reliance on Dr. Valdez induced him to forgo other remedies or precautions against such risk. We conclude from this record that when Dr. Valdez rendered his opinions, he effectively became a provider of medical treatment to Mrs. Diggs. This relationship between Dr. Valdez and Mrs. Diggs gave rise to a duty of reasonable care from Dr. Valdez to Mrs. Diggs.

CONCLUSION

We conclude that even without a contractual relationship, Dr. Valdez owed Mrs. Diggs a duty of due care in rendering medical advice regarding her diagnosis and treatment. We reverse the grant of summary judgment to the Valdez defendants and remand this case for further proceedings consistent with this decision.

TIERNEY v UNIVERSITY OF MICHIGAN REGENTS

COURT OF APPEALS OF MICHIGAN

257 Mich. App. 681*; *669 N.W.2d 575

August 5, 2003, Decided

Plaintiff Mary Tierney appeals by leave granted an order of the trial court denying her motion for leave to file a fourth amended complaint alleging patient abandonment in this medical malpractice action. We reverse and remand.

I

The issue presented in this case is whether under Michigan law a doctor's abandonment of his patient is actionable, as either medical malpractice or as a separate cause of action for patient abandonment. We hold that a claim of patient abandonment as a form of medical malpractice is viable under Michigan law under the circumstances alleged in this case. The trial court erred in denying plaintiff leave to file a fourth amended complaint encompassing her claim of patient abandonment in the context of her medical malpractice action. We reverse and remand for further proceedings.

II

Plaintiff had high-risk pregnancies and was a patient under the care of doctors at the Obstetrics Clinic of the University of Michigan. She filed this action after she suffered two successive miscarriages, the first of which she alleged resulted from negligent treatment by Dr. Clark Nugent and Dr. Anthony Opipari in performing a cerclage,[1] and the second of which she alleged resulted from the abandonment of her as a patient by Dr. Cosmos van de Ven after he learned that plaintiff had filed a lawsuit against his office mate, Dr. Nugent.

At issue is the trial court's dismissal of plaintiff's claim against Dr. van de Ven premised on patient abandonment. Although the specific details concerning the alleged abandonment are in dispute, the general circumstances are undisputed. After her first miscarriage, plaintiff became pregnant again [2] and began treating with Dr. van de Ven. As in her earlier pregnancy, plaintiff was scheduled for a cerclage. After she was admitted for surgery, Dr. van de Ven informed plaintiff that he would not be performing the procedure because plaintiff had filed a lawsuit against Dr. Nugent. Plaintiff obtained a referral to another obstetrician, who performed the cerclage four days later. Plaintiff subsequently suffered another miscarriage.

Plaintiff filed this action against defendant, alleging a claim of patient abandonment on the basis of Dr. van de Ven's actions. The trial court granted defendant's motion for partial summary disposition, dismissing plaintiff's claim of "patient abandonment" on the ground that Michigan law does not recognize a cause of action for patient abandonment unless it is made in the context of a medical malpractice claim against the physician. The trial court later denied plaintiff's motion to file a fourth amended complaint to include a claim of patient abandonment as a form of medical malpractice.

[1] A cerclage is a surgical procedure in which the cervix is sutured during pregnancy to prevent it from opening prematurely.

The court reiterated its previous ruling that there is no distinct cause of action for patient abandonment under Michigan law.

III

Generally speaking, a person who engages a physician to treat his case impliedly engages him to attend throughout the illness or until his services are dispensed with. Stated differently, the relation of physician and patient, once initiated, continues until it is ended by the consent of the parties or is revoked by the dismissal of the physician, or until the latter's services are no longer needed or he withdraws from the case. Thus, the physician has a definite right to withdraw from the case provided he gives the patient reasonable notice so as to enable him to secure other medical attendance. Such a withdrawal does not constitute an abandonment. It is but a corollary of the physician's right to withdraw from a case upon giving proper notice, that he is under a duty to continue attendance upon the patient until the conditions for his rightful withdrawal are complied with. Consequently, a physician who is generally engaged to attend a patient is liable for any damages caused by his abandoning the case without sufficient notice or adequate excuse, provided injury results from his action.

Although the trial court acknowledged that Michigan has recognized a patient abandonment claim, citing *Fortner v Koch, 272 Mich. 273; 261 N.W. 762 (1936)*, the court found *Fortner* distinguishable because in that case the Supreme Court only addressed the plaintiff's claim of patient abandonment in the context of his claim of medical malpractice. We find this distinction inconsequential.

In this case, plaintiff was under the care of Dr. van de Ven. The fact that he declined to perform a procedure and terminated his treatment of plaintiff is no less grounds for legal redress than the circumstances in *Fortner*, where the defendant doctor misdiagnosed the plaintiff's syphilis as cancer and therefore failed to pursue a course of proper treatment. The *Fortner* Court found no error in the trial court's separate instruction on the question of patient abandonment. The claim of abandonment in *Fortner* essentially was premised on the lack of treatment:

> "A physician is not chargeable with neglect in allowing intervals to elapse between his visits, where the patient needs no attention during the intervals, but he is negligent in doing so where the attention is needed * * * the frequency of the visits is a question for the physician to determine, if he uses ordinary judgment."

The general rule governing patient abandonment is, as stated in *Fortner*:

> When a physician takes charge of a case and is employed to attend a patient, the relation of physician and patient continues until ended by the mutual consent of the parties, or revoked by dismissal of the physician, or the physician determines that his services are no longer beneficial to the patient and then only upon giving to the patient a reasonable time in which to procure other medical attendance.

The circumstances in this case fall within the general rule enunciated in *Fortner*.

Further, contrary to the trial court's analysis, it seems evident that plaintiff's claim of patient abandonment was initially framed in the context of a medical malpractice claim. As defendant points out, in a medical malpractice action a physician's conduct is compared to the degree of skill,

care, and diligence exercised by a member of the same profession, practicing in the same or similar locality.

"Malpractice, in its ordinary sense, is the negligent performance by a physician or surgeon of the duties devolved and incumbent upon him on account of his contractual relations with his patient."

"'Medical malpractice * * * has been defined as the failure of a member of the medical profession, employed to treat a case professionally, to fulfill the duty to exercise that degree of skill, care and diligence exercised by members of the same profession, practicing in the same or similar locality * * *.'" "The key to a malpractice claim is whether it is alleged that the negligence occurred within the course of a professional relationship."

In this case, as in *Becker,* plaintiff alleged that the negligence occurred in the course of such a relationship. Under this standard, plaintiff's patient abandonment claim is clearly one of malpractice. The affidavit of merit submitted by plaintiff stated, "it was a violation of the standard of practice of Dr. van de Ven to not complete the cerclage on [December 7, 1998] or arrange for some other qualified physician to perform the cerclage on that date and that his refusal to do so constituted patient abandonment." Moreover, if there was any question concerning the nature of her claim before her motion to file a fourth amended complaint, any doubt was resolved by plaintiff's request to expressly frame her patient abandonment claim as a form of malpractice. * * *

The trial court erred in ruling that plaintiff's alleged action for patient abandonment was not viable under Michigan law. The court's denial of plaintiff's motion to amend her complaint on the basis that she had no viable legal claim was an abuse of discretion. We remand this case to allow plaintiff the opportunity to file a fourth amended complaint alleging her claim of patient abandonment as a form of medical malpractice. * * *

REED v. BOJARSKI

SUPREME COURT OF NEW JERSEY

166 N.J. 89; *764 A.2d 433*

January 23, 2001, Decided

The requirement of a physician's examination as a condition of employment, often paid for by the prospective employer, is not uncommon. This case focuses on the responsibility of a physician in such circumstances. More particularly, we are confronted with the question whether a physician, performing a pre-employment screening, who determines that the patient has a potentially serious medical condition, can omit informing the patient and delegate by contract to the referring agency the responsibility of notification. The answer is no.

I

The facts of the case are not seriously disputed: Arnold Reed was a heavy-equipment operator for the Woolston Construction Company. In 1991, Woolston entered into a contract with the I.T. Davey Corporation to perform work at a New Jersey landfill. Occupational Safety and Health Administration (OSHA) regulations required Reed to undergo a pre-employment physical. Davey contracted with Environmental Medicine Resources, Inc. (EMR) to perform the examinations for the Woolston workers. EMR, located in Georgia, subcontracted the examinations to Life Care Institute Inc. (Life Care), of Glassboro, New Jersey, an outpatient medical facility that provides various types of medical imaging services, physical therapy, and occupational medicine. Pursuant to the agreement between Davey and EMR, Reed's examination was to include, among other tests, a single, frontal X ray of the chest. The EMR-Life Care contract provided that Life Care's responsibility was to analyze the chest X ray and evaluate it either as "normal" or "abnormal." If Life Care determined that the X ray was abnormal, it was to forward it to EMR within twenty-four hours. EMR took responsibility for "over-reads and evaluation to obtain a diagnosis."

Dr. Michael H. Bojarski, an employee of Life Care, conducted Reed's physical. Another physician employed by Life Care, D.A. DePersia, M.D., a radiologist, was responsible for reading the chest X rays and reporting to Dr. Bojarski. Upon reviewing Reed's X ray, Dr. DePersia told Dr. Bojarski that Reed had a widened mediastinum, the cavity in the center of the chest. Dr. Bojarski testified that he could not "personally" see the widened mediastinum on the X ray but relied on the expertise of Dr. DePersia. It is an accepted medical fact that, among men in their twenties, a widened mediastinum may be an indicator of lymphoma, including Hodgkin's disease. Dr. DePersia also noted that Reed's heart was unusually large, a medical condition known as cardiomegaly. Reed was apparently aware of that condition.

Dr. Bojarski sent the X ray, along with the rest of Reed's examination package, to EMR. He noted that the X ray was abnormal and wrote "cardiomeg" in the comments section. No reference to the widened mediastinum was made. Although two days later Dr. DePersia gave Dr. Bojarski a written report on Reed's X ray recommending a follow-up CT-scan, Dr. Bojarski never conveyed that suggestion or the report to EMR. Inexplicably, on May 14, 1991, Dr. Michael Barnes of EMR wrote to Reed and informed him that he was in good health. In the letter he made no mention of the widened mediastinum or any potentially dangerous condition.

About six months later, in November 1991, Reed returned to Life Care for another examination. In the interim, he had lost 25 pounds and was suffering from flu-like symptoms. Dr. Bojarski did not ask Reed whether he had ever learned of or followed up on the widened mediastinum. In December 1991, Reed was admitted to the hospital and, after a chest X ray showed a large mass in his mediastinum, he was diagnosed with Stage IIB Hodgkin's disease. Reed died eight months later on October 27, 1992, at the age of 28.

Linda Reed, executor of her husband Arnold's estate, brought suit on behalf of the estate and on her own behalf against Dr. Bojarski, Dr. DePersia, Life Care, EMR, and numerous John Doe defendants. Dr. DePersia was granted summary judgment and EMR settled with Reed, resulting in a stipulated dismissal. The case against Dr. Bojarski and Life Care went to trial.

At trial, Reed's counsel objected to the introduction of the EMR-Life Care contract because it appeared to limit Dr. Bojarski's duty toward Reed. He ultimately agreed to its admission if the court instructed the jury "that [agreements between EMR and Life Care] do not represent, necessarily, the law that they are going to apply." The trial court agreed and told the jury before defense counsel's opening statement: "the contractual relationship between E.M.R. and Life Care Institute does not necessarily result in the same relationship that exists as between the defendants in this case and the plaintiff. Those duties will be explained to you. . . ."

Reed presented two liability witnesses: Linda Reed and Dr. Maurice Cairoli, Arnold Reed's treating physician (an expert in medicine and oncology, although not an expert in occupational medicine), who testified regarding the standard of care applicable to Dr. Bojarski. In answering Reed's counsel's questions about the obligations of a physician in the circumstances of this case, Dr. Cairoli stated:

> That X ray has to be pursued. That X ray has to be acted upon. If a . . . certified radiologist who is entrusted with looking at an X ray and making a medical opinion says that the mediastinum is widened, until proven otherwise, the physician who has knowledge of these results must be concerned about the possibility of malignancy, must convey that information on to the patient, and must do further testing.

During the defense case, Dr. Bojarski and Leonard Kraus, President and Manager of Life Care, testified concerning the EMR-Life Care contract. The defendants also called Dr. George Mellendick as an expert in occupational medicine. Dr. Mellendick testified that, in an examination scheme like the one used by EMR and Life Care, the common approach is for "the data [to] be centrally collated and transmitted in a sensible way." He further testified that he understood that Dr. Barnes had the "responsibility . . . to get the information and to communicate directly to the patient-employee what the findings were. . . . [I]deally, we like one physician to collate the information and get it back to the patient."

Dr. Mellendick stated that the EMR-Life Care contract "clearly spelled out that [Life Care] would have certain responsibilities for getting data . . . and forward[ing] anything which was abnormal." He testified that the arrangement between EMR and Life Care was "fairly standard" and that Dr. Bojarski's conduct was "reasonable" in light of the contract and typical practices in occupational medicine.

Both sides proposed jury instructions. Reed's version incorporated the traditional duties that flow from the existence of a doctor-patient relationship. Dr. Bojarski's version focused on the

reasonableness of his conduct. Reed's counsel asked the Court to instruct the jury that Dr. Bojarski's duty to advise Reed is non-delegable, and that the duty exists notwithstanding the contract. The trial court agreed to instruct the jury that the contract affected only the relationship between EMR and Life Care.

The trial court properly informed the jury that a physician performing a pre-employment physical owes the examinee a duty of reasonable care in the conduct of the examination and that that duty encompasses taking reasonable steps to inform the examinee of findings that pose a danger to his health. He went on to say:

> What plaintiff alleges is that upon the chest X ray having been read by Dr. DePersia, and she having discussed her finding, a possibility of a mediastinal abnormality, and suggesting CT scanning, that Dr. Bojarski breached the duty of reasonable care owed by him to the plaintiff, to inform the plaintiff directly or EMR of those X ray findings.
>
> Dr. Bojarski, on the other hand, contends that he did act reasonably by reading the X ray, advising EMR that it was abnormal and forwarding the original X ray to EMR. Defendant Dr. Bojarski likewise alleges that EMR breached the standard of care by the letter written to Mr. Reed in light of the report of abnormal X ray mailed to EMR by Dr. Bojarski.
>
> Now if you find that Dr. Bojarski satisfied his duty of reasonable care, and the duty to inform, then you may not find him negligent, and your verdict should be for the defendant. On the other hand, if you find Dr. Bojarski breached the duty owed by a reasonable care, including the duty to inform, your verdict should be for the plaintiff.
>
> You must make the determination of whether Dr. Bojarski took reasonable steps to inform the plaintiff, Mr. Reed, of any findings under the facts of this case. In other words, you must determine whether it was reasonable for Dr. Bojarski to forward the materials concerning Mr. Reed to EMR and rely upon EMR's contractual obligation to review the materials and inform Mr. Reed of any adverse findings.
>
> If you find that it was reasonable for Dr. Bojarski to expect EMR to do that, then you may not find Dr. Bojarski negligent. On the other hand, if you find that Dr. Bojarski acted unreasonably in relying on EMR to inform the patient of findings, and in not informing EMR or the plaintiff of Dr. DePersia's findings, including her letter to him diagnosing a widened mediastinum, you must determine Dr. Bojarski's conduct to have been negligent.

The following day, the jury unanimously determined that Dr. Bojarski had not deviated from accepted standards of medical care. Judgment was entered accordingly. Reed's motion for a new trial on all issues was denied.

Reed appealed. The Appellate Division affirmed the judgment entered upon the jury verdict in an unpublished *per curiam* opinion. After reviewing the facts and procedural history, the panel addressed the instruction in light of Reed's contention that the trial court erred in explaining Dr. Bojarski's duties and the extent to which those duties were defined by the contract between EMR and Life Care. The Appellate Division agreed with Reed that the contract could not alter Dr. Bojarski's duties, but concluded that it was proper for the trial court to allow the jury to use the contract to determine whether Bojarski's conduct was "reasonable." Because the sole issue of

malpractice involved communication of the diagnosis, the panel determined that the charge, the testimony, and the jury's common sense provided a sufficient basis to sustain the verdict. * * *

II

Courts throughout the nation have been grappling with the question of the obligation owed by a physician to a patient in the pre-employment screening setting. Most jurisdictions adhere to the traditional malpractice model in which the absence of a classic physician-patient relationship results in the physician owing no duty to the examinee to discover and disclose abnormalities or conditions, let alone report them.

Two cases invoking the traditional model are instructive for their dissenting opinions that reveal movement away from the model. Indeed, in one of those jurisdictions, the dissenting view has subsequently been adopted as the majority rule. Both cases involve doctors who, in accordance with policy guidelines that required intermediary institutions to collate and transmit information, failed to disclose life-threatening abnormalities to examinees.

In *Beaman v. Helton, 573 So. 2d 776 (Miss.1990)*, *overruled by Meena v. Wilburn, 603 So. 2d 866 (Miss.1992)*, plaintiff sought Social Security benefits, and the Disability Determination Service (DDS) of Mississippi ordered an examination. DDS employed a physician to conduct the examination during which X rays were taken revealing "probable pulmonary malignancy." That night, in accordance with DDS guidelines requiring the agency to inform an examinee of a life threatening illness, the doctor sent a report by telephone to DDS, specifically stating his impression that the plaintiff had a malignancy and recommending that the DDS examiner contact the plaintiff about this problem. DDS, however, never informed the plaintiff of the abnormality.

In resolving the subsequent malpractice suit against the doctor, the Supreme Court of Mississippi held that no physician-patient relationship existed and refused to impose a duty upon an examining physician independent of that relationship. The court concluded that the doctor discharged his duty to the examinee when the doctor complied with the DDS guidelines in simply notifying the DDS examiner of the life-threatening condition.

In a dissenting opinion, three justices fashioned alternative theories of liability. First, the dissent posited that an actual physician-patient relationship, although not coextensive with the traditional model, is created when a physician examines a person at the behest of a third party and that that relationship comes with an attendant duty to the extent of the examination. Second, the dissent determined that the doctor also owes the plaintiff a common-law duty to conduct the examination with reasonable care, even in the absence of a doctor-patient relationship. Under either theory, the dissent concluded that the plaintiff could reasonably expect the doctor, in a five-minute phone call, to notify him directly of a life-threatening condition that required immediate treatment. "Under such circumstances, what, if any, duty does one human owe to another?"

Two years later, in *Meena v. Wilburn, 603 So. 2d 866 (Miss.1992)*, the Supreme Court of Mississippi adopted the latter of the two alternative theories of liability posited by the dissent in *Beaman.* The *Meena* court held that the absence of a physician-patient relationship will not insulate a physician from liability where the traditional elements of negligence are established. The court explained that "[t]he presence or absence of a doctor-patient relationship is simply a factor to consider in determining the type or nature of duty owed, if any, to the injured patient or non-patient."

In a case closely paralleling *Beaman,* a Georgia appellate court in *Peace v. Weisman, 186 Ga. App. 697, 368 S.E.2d 319 (1988)*, affirmed the classic malpractice approach. When Peace applied for Social Security benefits, the Disability Determination Service (DDS) retained a physician to conduct a physical examination. Under guidelines that were in place, the physician was to report the results of the examination to the DDS only.

The physician's report to the DDS contained an evaluation of a routine chest X ray that revealed an abnormality in the chest area. DDS denied the application for benefits without providing the applicant a copy of the report or informing him of its contents. Four months later, the applicant was diagnosed with lung cancer, the disease to which he shortly succumbed. When the applicant's wife brought a medical malpractice action on behalf of her deceased husband against the physician for failing to diagnose and notify her husband of the lung cancer, the Georgia court held that the doctor could not be held liable for malpractice because of the absence of a physician-patient relationship. The court found that the doctor's only duty was to avoid injuring the applicant during the examination.

The dissent identified a physician-patient relationship resulting from the examination, given the examinee's reasonable expectations of disclosure and the evaluative purpose of the examination itself. "Under these circumstances, who in the world would not have expected the doctor to tell him of any abnormal findings?" The dissent noted that, under the majority opinion, "[t]he only one left uninformed is the one most affected by the information." For the dissent, the facts favored a finding of a physician-patient relationship that in turn imposed on the examining physician a duty to divulge to the applicant any abnormalities. The dissenting opinion concluded that the "intolerable result" of the majority opinion "denies a remedy for a wrong, fosters irresponsibility on the part of such consulting physicians, and may allow unwitting bureaucrats to deprive a human being of a fighting chance to live."

A second line of cases acknowledges that, even in the absence of a traditional physician-patient relationship in the pre-employment physical context, there is a disclosure requirement where the examination reveals a medical abnormality. For example, in *Daly v. United States,* plaintiff, as part of a preemployment physical examination for the Veteran's Administration (VA) hospital, submitted to a chest X ray and tuberculosis test. The radiologist's review of the X ray indicated an abnormality of the lung. The radiologist, however, never informed the plaintiff. For the next two years, plaintiff sought treatment several times for lung-related disorders at the VA employee health unit. Further chest X rays were ordered, and the VA radiologist noted the lung abnormality but the radiologist again failed to inform Daly of the abnormality. Four years after the initial X ray, the plaintiff consulted a pulmonary specialist who diagnosed the lung disease sarcoidosis. Sarcoidosis is incurable and potentially fatal, but prompt treatment may halt its progress. The plaintiff in *Daly* did not receive a diagnosis until the sarcoidosis had reached an irreversible advanced stage, rendering him permanently disabled.

Although the Ninth Circuit refused to determine the "exact contours" of the doctor's duty to disclose, it nonetheless found persuasive expert testimony given at trial "that, at a minimum, the radiologist should have notified Daly of the abnormality." The court thus held that the VA radiologist had the "hardly burdensome" duty to inform Daly of what he detected in the X ray.

Also instructive is *Betesh v. United States, 400 F. Supp. 238 (D.D.C.1974)*, a case bearing some resemblance to this one. Betesh reported to an armed forces examination station in Maryland for a pre-induction physical examination. A radiologist under contract with the Selective Service System,

who read an enlargement of Betesh's X ray, observed an abnormality and prepared a report that stated "[t]he left hilium is slightly enlarged as to the upper mediastinum. This may be of no significance, but it is not possible to rule out sarcoid, tuberculosis adeniter, or lymphoma." Betesh was never shown the radiologist's report or informed of the abnormality on the X ray. He was rejected for service because of his abnormal X ray, but that explanation was not revealed to him, and he assumed the rejection was attributable to a knee injury. When he was ordered to report to the same station six months later, he looked into his medical file. Only then did he learn of the abnormality. Three days later, a series of private diagnostic tests revealed Hodgkin's disease. Although Betesh's form of Hodgkin's disease is successfully treatable at an early stage, his disease had progressed in six months to such an extent that cure was impossible.

The court found that the government's duty to inform Betesh derived from specific federal regulations on point. However, it also held that, regardless of any applicable federal regulations, the government was liable for breach of the standard of care under the common law of Maryland. More particularly, the Court stated that three theories had to be considered:

> (1) Even in the absence of a doctor-patient relationship, a doctor who assumes to act must act carefully with respect to all aspects of the examination; (2) where a doctor acts primarily for the benefit of an employer in examining a prospective employee, the doctor must act carefully with respect to all aspects of the examination; (3) where a doctor-patient relationship exists, the doctor must act with care.

The Court went on to declare that, under each of those theories, plaintiff could recover and that government physicians are "under a duty to act carefully, not merely in the conduct of the examination but also in subsequent communications to the examinee." The court, therefore, held that under Maryland common law the pre-induction physical imposed upon a physician "a duty to disclose what he had found and to warn the examinee of any finding that would indicate that the patient is in danger and should seek further medical evaluation and treatment." The court added, "[t]his duty is stronger when the physician has no reason to believe that the examinee is aware of the condition and danger."

Another third party examination case arose in the insurance setting. In *Deramus v. Jackson National Life Insurance Co., 92 F.3d 274, 275 (5th Cir.1996)*, the wife of a decedent who died of Acquired Immune Deficiency Syndrome (AIDS) brought an action against a life insurance company that had rejected decedent's life insurance application. The plaintiff alleged that the insurer had a duty to inform decedent and his wife or their private physician that decedent's blood had tested positive for Human Immunodeficiency Virus (HIV) during the examination the insurer required of all applicants. The Fifth Circuit held that under Mississippi law an insurance company has no duty to divulge the results of a medical examination to an applicant, but that a physician, regardless of whether a doctor-patient relationship exists, has a duty to disclose because a doctor's "disclosure to, at least, the patient is essential to the treatment and retardation of diseases and other ailments."

Three broad categories can be discerned from those cases. The majority rule embraces the traditional medical malpractice model and focuses on the absence of the classic physician-patient relationship in third-party examinations. Courts adhering to that rule find that a physician, examining a person at the behest of a third party, at most owes the extremely limited duty to simply avoid harming the examinee during the examination. A second category includes those courts willing to find that a third-party physician's act of examining someone creates a doctor-patient

relationship or a nontraditional doctor-patient relationship to the extent of the examination. A third category incorporates courts that find no doctor-patient relationship, but impose the duty to act with reasonable care based on common-law negligence principles. Courts in the second and third categories typically find that a physician in a pre-employment examination setting owes an examinee an affirmative and direct duty of disclosure when an examination uncovers any previously unknown, life-threatening disease.

III

New Jersey has long recognized that a physician owes a duty of reasonable care to the nontraditional patient in the context of a third-party examination. Over 35 years ago in *Beadling v. Sirotta,* this Court began its march away from applying the traditional medical malpractice paradigm. George Beadling applied for a job as a machinist and his would-be employer scheduled a pre-employment physical that included a chest X ray. The radiologist who examined Beadling found a lung abnormality that he believed to be evidence of active tuberculosis. Beadling was not hired and, after the personnel manager recommended that Beadling see his own doctor, he was admitted to the hospital for treatment of tuberculosis. The record failed to establish whether Beadling had suffered from active tuberculosis during the time at issue.

Beadling sued numerous parties, including the radiologist. The radiologist defended on the ground that he had no physician-patient relationship with Beadling, and, therefore no corresponding duty. In a bench trial, the Law Division found in favor of Beadling, and we granted certification on our own motion. Although we recognized that the relationship of an employee and a physician, to whom the latter is referred for a pre-employment physical, is not a traditional doctor-patient relationship, we nevertheless declared "that a physician in the exercise of his profession examining a person at the request of an employer owes that person a duty of reasonable care." However, we declined to fix the boundaries of the duty on the ground that there was no evidence that any breach existed in that case.

Beadling formed the foundation for the case most relevant here--*Ranier v. Frieman*--in which the Appellate Division affirmed the existence of a non-traditional physician-patient relationship in the pre-employment physical setting and invoked traditional negligence principles in divining a duty of reasonable care on the part of the physician so engaged. There, Penice Ranier who worked as a driller of boards for personal computers claimed that vision problems were making it impossible for him to continue and sought social security disability benefits. The Department of Labor, Division of Disability Determinations (Division), referred Ranier to an ophthalmologist to determine whether he was disabled. The ophthalmologist reported that Ranier was able to work, and he was denied benefits. As time passed, Ranier's vision problems continued, and, after further examination, Ranier's own ophthalmologist diagnosed a brain tumor in his optic chasm. Ranier brought a malpractice action against the ophthalmologist retained by the Division. The physician, in turn, moved for summary judgment on the ground that, because he was involved in screening rather than treating and was paid by the Department of Labor, he did not owe Ranier a duty of reasonable care. The trial court granted summary judgment.

The Appellate Division reversed, having satisfied itself that there was

> nothing in the decisional law of this jurisdiction and, indeed, nothing in the common understanding of the community regarding medical professional standards that would

> immunize a physician from liability for a professionally unreasonable diagnosis to the substantial detriment of the examinee, even if the examination is made at the expense and behest of a third party.

The court declared that it is not necessary to denominate the pre-employment physical as creating a traditional doctor-patient relationship in order to find the existence of a duty: "The substantive content of reasonable care in the third-party situation is dependent upon relevant negligence principles applied consistently with appropriate public policy concerns." Judge Pressler, writing for the panel, noted that the existence of a duty is a matter of law, and that the doctor who examined Ranier had owed him a duty "to make a professionally reasonable and competent diagnosis." The court stated that Ranier's reliance on the Division-retained ophthalmologist to make a competent diagnosis was reasonable and foreseeable, and in keeping with public policy and community expectations, stating that

> when an individual is required, as a condition of future or continued employment, to submit to a medical examination, that examination creates a relationship between the examining physician and the examinee, at least to the extent of the tests conducted. This relationship imposes upon the examining physician a duty to conduct the requested tests and diagnose the results thereof, exercising the level of care consistent with the doctor's professional training and expertise, and to take reasonable steps to make information available timely to the examinee of any findings that pose an imminent danger to the examinee's physical or mental well-being.

In short, under *Ranier,* when a person is referred to a physician for a pre-employment physical, a physician-patient relationship is created at least to the extent of the examination, and a duty to perform a professionally reasonable and competent examination exists. A professionally unreasonable examination that is detrimental to the examinee is not immunized from liability because a third-party authorized or paid for the exam. Included within the notion of a reasonable and competent examination is the need to "take reasonable steps to make information available timely to the examinee of any findings that pose an imminent danger to the examinee's physical or mental well being."

We fully subscribe to that articulation of the duty of a physician performing a pre-employment physical examination under contract to a third party. As we have often said, "'whether a duty exists is ultimately a question of fairness. The inquiry involves a weighing of the relationship of the parties, the nature of the risk, and the public interest in the proposed solution.'" A duty is said to arise out of the existence of a relationship between the "parties such that social policy justifies" its imposition.

Although the pre-employment physical clearly does not establish a traditional physician-patient relationship, that is of no moment. The exact nature of the relationship is simply a factor to be considered in determining what duty exists. What is crucial is that a relationship is created in which a physician is expected to exercise reasonable care commensurate with his expertise and training, both in conducting the examination and in communicating the results to the examinee. Concomitantly, the patient is entitled to rely on the physician to tell him of a potential serious illness if it is discovered. Any reasonable person would expect that and the duty to communicate with a patient who is found to be ill is nondelegable. When the doctor who ascertains the abnormality communicates it directly to the patient, he or she has the best chance of obtaining

prompt remedial care and the best hope of avoiding falling through the cracks of a multi-party system. To the extent that a contract purports to insulate the examining physician from liability for breaching the duty to communicate abnormalities found in a pre-employment exam, it violates the basic public policy of New Jersey, along with common law notions of duty embodied in our case law.

Indeed, *N.J.A.C. 13:35-6.5(f)* describes our public policy regarding the scope and extent of the duty a physician owes to a person he or she examines at the behest of a third party in terms that are identical to those we here adopt:

> Where a third party or entity has requested examination, or an evaluation of an examinee, the licensee rendering those services shall prepare appropriate records and maintain their confidentiality, except to the extent provided by this section. The licensee's report to the third party relating to the examinee shall be made part of the record. The licensee shall:
>
> 1. Assure that the scope of the report is consistent with the request, to avoid the unnecessary disclosure of diagnoses or personal information which is not pertinent;
>
> 2. Forward the report to the individual entity making the request, in accordance with the terms of the examinee's authorization; if no specific individual is identified, the report should be marked "Confidential"; and
>
> 3. Not provide the examinee with the report of an examination requested by a third party or entity unless the third party or entity consents to its release, *except that should the examination disclose abnormalities or conditions not known to the examinee, the licensee shall advise the examinee to consult another health care professional for treatment.*
>
> [*Ibid.* (emphasis added).]

Although it is not a model of draftsmanship, that regulation of the Board of Medical Examiners recognizes contracts like those between EMR and Life Care that prescribe that examination results in a pre-employment setting will generally be forwarded to the requesting agency and not to the examinee. However, the regulation carves out a crucial exception bearing on the case before us. That exception requires the examining physician, where the examination discloses "abnormalities or conditions not known" to the examinee, to advise him or her to consult another physician for treatment.

According to the Board of Medical Examiners, *N.J.A.C. 13:35-6.5(f)* reflects a judgment that the duty owed by an examining physician to an individual being examined, even when that individual is not a traditional patient, includes and encompasses an affirmative obligation of disclosure in those circumstances where potentially life-threatening abnormalities or conditions are discovered during the course of examination. It makes no difference that the examination is conducted at the behest of a third party because an ordinary person is likely to interpret--and thus rely on--a physician's silence to mean that the physician detected no previously unknown abnormalities during the examination.

The Board's rule is in accord with other ethical pronouncements on the issue, including a recent opinion of the American Medical Association's Council on Ethical and Judicial Affairs (Council) that states:

> When a physician is responsible for performing an isolated assessment of an individual's health or disability for an employer, business, or insurer, a limited patient-physician relationship should be considered to exist. . . .
>
> *Despite their ties to a third party, the responsibilities of [industry employed physicians] and [independent medical examiners] are in some basic respects very similar to those of other physicians.*
>
> . . . .
>
> *The physician has a responsibility to inform the patient about important health information abnormalities that he or she discovers during the course of the examination. In addition, the physician should ensure to the extent possible that the patient understands the problem or diagnosis. Furthermore, when appropriate, the physician should suggest that the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.*
>
> [Council on Ethical and Judicial Affairs, American Medical Association, Opinion E-10.03 (AMA opinion), *Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations,* Current Opinions, issued Dec. 1999, based on report *Patient Physician Relationship in the Context of Work-Related and Independent Medical Examinations,* adopted June 1999 (Emphasis added).]

Although neither *N.J.A.C. 13:35-6.5(f)* nor the AMA Opinion state explicitly that a physician's duty in the described circumstances is not delegable, that notion is implicit in their formulation. Each recognizes contracts like the one between EMR and Life Care, but each is careful to preserve the duty of the physician, who discovers an abnormality, to inform the patient of the discovery; to advise him or her to consult another health care professional; and, in the case of the AMA opinion, to ensure that the patient understands the problem or diagnosis and, if requested, assist the patient in securing medical follow up.

There is nothing earth shaking about those principles. Indeed we believe them to fall squarely within our established jurisprudence as exemplified by the seminal decision in *Beadling,* and the more extensive analysis in *Ranier,* and to accord with the fundamental notions of duty embodied in our jurisprudence and in the developing caselaw across the country.

IV

Here, although Davey paid EMS, which in turn contracted with Life Care, on the day of the examination, Dr. Bojarski and Reed entered into a relationship in which Bojarski owed Reed a duty of reasonable care to the extent of the examination and in communicating its outcome. In light of the evaluative purpose of the exam, Reed concomitantly relied on Dr. Bojarski's superior knowledge to assess the state of his health. Subsumed in that reliance was an entirely reasonable belief that, if Dr. Bojarski had found a potentially life threatening abnormality, he would not have remained silent about it. Whatever else Reed might reasonably have expected of the doctor performing his pre-employment physical, he had an absolute right to expect that he would be told if something was wrong. No contract by the Doctor or his employer with a third party could relieve Dr. Bojarski of that obligation.

The admission of the EMR-Life Care contract before the jury on the issue of the "reasonableness" of Dr. Bojarski's actions was reversible error. It left the jury with the clear impression that it was free to find, consonant with Dr. Bojarski's expert's opinion, that Dr. Bojarski behaved "reasonably" in delegating to EMR the duty to advise Reed of his potentially dangerous medical condition. As we have indicated, that is not so. Whatever contract Dr. Bojarski was operating under did not relieve him of the responsibility to inform Reed of his ailment.

V

The judgment entered upon the jury verdict is reversed. The matter is remanded for trial in advance of which the trial court should determine whether to direct a verdict in favor of plaintiff on liability.

COURT OF APPEALS
EIGHTH DISTRICT OF TEXAS
EL PASO, TEXAS

HELEN ESTRADA, INDIVIDUALLY AND ON BEHALF OF ALL WRONGFUL DEATH BENEFICIARIES AND AS REPRESENTATIVE OF THE ESTATE OF RICHARD ESTRADA, DECEASED,	§	No. 08-10-00290-CV
Appellant,	§	Appeal from
v.	§	346th District Court
ENCARNACION MIJARES, N.P. AND JEANETTE TAN, M.D.,	§	of El Paso County, Texas
Appellees.	§	(TC #2010-3305)

O P I N I O N

This appeal arises from a medical malpractice suit against a nurse practitioner, Encarnacion Mijares, and her employer, Jeanette Tan, M.D., on a theory of vicarious liability. The trial court granted summary judgment in favor of Mijares on the ground that she did not have a nurse-patient relationship with Richard Estrada. For the reasons that follow, we affirm.

FACTUAL SUMMARY

On July 21, 2007, Richard Estrada was admitted to Del Sol Medical Center by his primary physician, James Gibson, M.D. due to complaints of a cough and shortness of breath. The following day, Dr. Gibson requested a pulmonary evaluation from the on-call pulmonologist. Ahmad M. Hajj, M.D was covering for Dr. Tan, meaning that he was seeing all of Dr. Tan's ICU patients at Del Sol in addition to the new consults.

Encarnacion Mijares is a nurse practitioner. The summary judgment evidence related to Mijares' motion for summary judgment shows that Mijares worked for Dr. Tan as a nurse

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practitioner in 2007 and did not work for Dr. Hajj.[1] On July 22, 2007, Mijares was at the hospital seeing some of Dr. Tan's existing patients when one of the nurses told her about the consult for Dr. Tan. Mijares told the nurse that Dr. Tan was not taking calls and Dr. Hajj was on-call. The nurse subsequently told Mijares that a call had been made to Dr. Hajj's answering service. Mijares telephoned Dr. Hajj "out of courtesy" to let him know about the pulmonary consult. Mijares relayed to Dr. Hajj the information in Estrada's chart, including the lab results and the results of the CT scan of the lungs. Mijares then transcribed Dr. Hajj's verbal orders onto Estrada's chart. The record does not include a copy of the order itself but Mijares stated during her deposition that Dr. Hajj ordered Rocephin, one gram IV piggyback every 24 hours; "Neb" treatments with Xopenex, 0.63, and Atrovent unit dose via E-Z pack four times a day, as needed, and sputum for gram stain and CNS. He also ordered the hospital to document the O2 saturation in the progress notes. Both Mijares and Dr. Hajj signed the orders. Mijares explained in her deposition that she could not write orders at the hospital and hospital policy required that the consulting doctor "countersign" the verbal orders. Dr. Hajj never asked Mijares to evaluate Estrada.

Dr. Gibson discharged Estrada from the hospital on July 23, 2007. The following nursing note is found in Estrada's chart for July 23, 2007: "M.D. Gibson has seen PT down in x-ray. He has given the OK to DC PT home today. [Mijares] has been notified. She has spoken with M.D. Hajj. He has given the OK to DC PT." Mijares specifically denied having any conversation

[1] Appellant's claims against Dr. Tan are based on a theory of vicarious liability. Dr. Tan filed a motion for summary judgment in which she denied being Mijares' employer or supervising physician. The trial court did not rule on Dr. Tan's motion for summary judgment and the court instead concluded that the summary judgment in favor of Mijares rendered moot all of Estrada's claims against Dr. Tan. Evidence that may be considered in determining a summary judgment motion includes deposition transcripts, interrogatory answers, and other discovery responses referenced or set forth in the motion or response as well as affidavits on file at the time of the hearing. Tex.R.Civ.P. 166a(c). The summary judgment order does not indicate that the trial court, in addressing Mijares' motion for summary judgment, considered any of the evidence attached to Dr. Tan's motion for summary judgment or to Appellant's response to that motion. Consequently, we will not consider that evidence in reviewing the trial court's ruling.

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with the nurse or Dr. Hajj regarding the discharge of Estrada, explaining that she would not have given the order because Estrada was not her patient. Dr. Hajj recalled speaking to the nurse at the hospital about the discharge but he did not recall speaking to Mijares.

Estrada followed up with Dr. Gibson following his discharge, but he had a heart attack on September 2, 2007 and died. Helen Estrada, individually and on behalf of the wrongful death beneficiaries, and as the representative of the estate of her husband, filed suit against Dr. Gibson, Dr. Hajj, Dr. Tan, and Mijares, alleging that the defendants knew or should have known that Estrada was at risk of coronary heart disease and were negligent in failing to properly diagnose and treat him for heart disease. Mijares filed a motion for summary judgment on the sole ground that she did not have a nurse-patient relationship with Estrada. The trial court granted the motion and severed the claims against Mijares and Dr. Tan from the remaining claims.

NURSE-PATIENT RELATIONSHIP

In her sole issue on appeal, Appellant contends that the trial court erred by granting summary judgment because Mijares failed to conclusively prove that she did not have a nurse-patient relationship with Estrada. Alternatively, Appellant argues that a fact issue precludes the granting of summary judgment.

Standard of Review

The standard of review for traditional summary judgment under TEX.R.CIV.P. 166a(c) is well established. *Nixon v. Mr. Property Management Company, Inc.*, 690 S.W.2d 546, 548 (Tex. 1985). The moving party carries the burden of showing there is no genuine issue of material fact and it is entitled to judgment as a matter of law. *Diversicare General Partner, Inc. v. Rubio*, 185 S.W.3d 842, 846 (Tex. 2005); *Browning v. Prostok*, 165 S.W.3d 336, 344 (Tex. 2005). Evidence favorable to the non-movant will be taken as true in deciding whether there is a disputed issue of

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material fact. *Fort Worth Osteopathic Hospital, Inc. v. Reese*, 148 S.W.3d 94, 99 (Tex. 2004); *Tranter v. Duemling*, 129 S.W.3d 257, 260 (Tex.App.--El Paso 2004, no pet.). All reasonable inferences, including any doubts, must be resolved in favor of the non-movant. *Fort Worth Osteopathic Hospital*, 148 S.W.3d at 99. A defendant is entitled to summary judgment if the evidence disproves as a matter of law at least one element of each of the plaintiff's causes of action or if it conclusively establishes all elements of an affirmative defense. *D. Houston, Inc. v. Love*, 92 S.W.3d 450, 454 (Tex. 2002); *Randall's Food Markets, Inc. v. Johnson*, 891 S.W.2d 640, 644 (Tex. 1995). Once the defendant establishes a right to summary judgment as a matter of law, the burden shifts to the plaintiff to present evidence raising a genuine issue of material fact. *City of Houston v. Clear Creek Basin Authority*, 589 S.W.2d 671, 678-79 (Tex. 1979); *Scown v. Neie*, 225 S.W.3d 303, 307 (Tex.App.--El Paso 2006, pet. denied). We review the grant or denial of a traditional motion for summary judgment *de novo*. *Valence Operating Company v. Dorsett*, 164 S.W.3d 656, 661 (Tex. 2005); *Texas Integrated Conveyor Systems, Inc. v. Innovative Conveyor Concepts, Inc.*, 300 S.W.3d 348, 365 (Tex.App.--Dallas 2009, pet. denied).

Existence of a Duty

In a medical malpractice claim, the plaintiff must prove four elements: (1) a duty by the physician/nurse/hospital to act according to applicable standards of care; (2) a breach of the applicable standard of care; (3) an injury; and (4) a causal connection between the breach of care and the injury. *Morrell v. Finke*, 184 S.W.3d 257, 271 (Tex.App.--Fort Worth 2005, pet. denied); *Cruz v. Paso Del Norte Health Foundation*, 44 S.W.3d 622, 629-30 (Tex.App.--El Paso 2001, pet. denied). The existence of a duty is a threshold question of law which must be decided

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before the issue of standard of care arises. *Lection v. Dyll*, 65 S.W.3d 696, 704 (Tex.App.--Dallas 2001, pet. denied), *citing St. John v. Pope*, 901 S.W.2d 420, 424 (Tex. 1995).

In *St. John v Pope*, the Supreme Court explained that medical malpractice developed as a theory of liability discrete from common-law negligence and is imbued with both contract and tort principles. *St. John*, 901 S.W.2d at 423. Medical malpractice also differs from ordinary negligence in the circumstances under which a duty arises. *St. John*, 901 S.W.2d at 423. In an ordinary negligence case, the duty to refrain from negligently injuring others requires no prior relationship. *Id.* Professionals, on other hand, do not owe a duty to exercise their particular talents, knowledge, and skill on behalf of every person they encounter. *Id.* "As is true of all callings, physicians are not obligated to practice their profession or render services to everyone who asks." *Id.* It is only with the physician's express or implied consent that the physician-patient relationship is created. *Id.* The court held in *St. John* that the duty to treat the patient with proper professional skill flows from the consensual relationship between the patient and physician, and only when that relationship exists can there be a breach of a duty resulting in medical malpractice. *Id.* Creation of the physician-patient relationship does not require the formalities of a contract. *Id.* at 424. The fact that a physician does not deal directly with a patient does not preclude the existence of a physician-patient relationship. *Id.* If there is no prior relationship between the physician and the patient, there must be some affirmative action on the part of the physician to treat the patient to create such a relationship. *Gross v. Burt*, 149 S.W.3d 213, 221 (Tex.App.--Fort Worth 2004, pet. denied); *Majzoub v. Appling*, 95 S.W.3d 432, 436 (Tex.App.--Houston [1st Dist.] 2002, pet. denied); *Lection*, 65 S.W.3d at 705.

Texas courts have recognized the existence of the nurse-patient relationship but have not written extensively about how it is created in the context of a medical malpractice claim. *See*

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Lunsford v. Board of Nurse Examiners for the State of Texas, 648 S.W.2d 391, 395 (Tex.App.--Austin 1983, no writ); *Childs v. Greenville Hospital Authority*, 479 S.W.2d 399, 401-02 (Tex.Civ.App.--Texarkana 1972, writ ref'd n.r.e.). Citing *Lunsford*, Appellant suggests that Mijares' duty to act according to the applicable standards of care arises from the mere fact that she possesses a nursing license.

In *Lunsford*, a nurse appealed an order of the Board of Nurse Examiners finding she had violated a board rule which requires a registered nurse to evaluate the status of a patient and to institute appropriate nursing care to stabilize a patient's condition and prevent complications. *Lunsford*, 648 S.W.2d at 394. Lunsford was employed by the Willacy County Hospital in Raymondville. Donald Wayne Floyd was traveling to Houston with Frances Farrell when he began experiencing chest pain so Farrell took Floyd to the Willacy County Hospital for medical assistance. Farrell left Floyd in the waiting area and tried to find a doctor to attend to Floyd who was experiencing significant pain and pressure in his chest as well as pain and numbness in his left arm. Farrell found a physician and explained that Floyd was suffering from chest pains, but he instructed her to seek help from the nurse on duty because he was busy. When Farrell persisted, he told her that the hospital's only cardiac care equipment was in use on another patient. The physician then instructed Lunsford to send Floyd to Valley Baptist Hospital in Harlingen. Lunsford approached Floyd who was continuing to complain of chest pain. Lunsford questioned Floyd about what he had eaten and whether he had engaged in heavy exercise that day. Lunsford did not take Floyd's vital signs even though she suspected "cardiac involvement" and she instructed Farrell to drive Floyd twenty-four miles to Valley Baptist Hospital in Harlingen. Lunsford told Farrell to use the emergency flashers and to "speed." She also asked

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Farrell if she knew C.P.R. since there was a chance that she might have to use it while in route to Harlingen. Floyd died less than five miles from the Willacy County Hospital.

The Board of Nurse Examiners suspended Lunsford's nursing license for one year based on its finding that her conduct had been "unprofessional and dishonorable conduct likely to injure the public." *Lunsford*, 648 S.W.2d at 393. The Board determined that Appellant had violated a board rule which requires a registered nurse to evaluate the status of a patient and to institute appropriate nursing care to stabilize a patient's condition and prevent complications by failing to assess Floyd's condition, inform the attending physician of the "life-death" nature of Floyd's instability, and take appropriate measures to stabilize Floyd's condition and prevent his demise. *Id.* at 394.

Lunsford argued on appeal that she had no legal duty to care for Floyd because he was not the patient of the hospital or the on-duty physician. *Lunsford*, 648 S.W.2d at 394. In making this argument, Lunsford relied on a hospital policy which required that Floyd be sent to Valley Baptist unless he had a physician on the staff of Willacy County Hospital or unless it was a "life-death" situation. Lunsford also claimed on appeal that taking Floyd's vital signs and informing the on-duty physician of her findings would have been futile since he had already ordered her to send Floyd to Valley Baptist. In rejecting these arguments, the Austin Court of Appeals held that Lunsford's duty is not derivative of the relationship between Floyd and the hospital or the on-duty physician. *Lunsford*, 648 S.W.2d at 394. Her duty instead arises from the privilege granted Lunsford by the state in licensing her as a nurse. *Id.* Consequently, her duty could not be relieved by a hospital policy or a physician's order. *Id.* The Court of Appeals concluded that a nurse in Lunsford's situation has a duty to evaluate the medical status of the ailing person

seeking his or her professional care, and to institute appropriate nursing care to stabilize a patient's condition and prevent further complications of physical and mental harm. *Id.* at 395.

Lunsford is distinguishable because we are concerned here with whether a nurse had a duty to act according to the applicable standard of care in a medical malpractice action. The Austin Court of Appeals was careful to note that the suit against Lunsford was not brought in contract or in tort by an individual who feels he or she has been wronged by Lunsford's action or inaction. *Lunsford*, 648 S.W.2d at 395. It instead was brought by the State for Lunsford's violation of her contractual duties to always act in a professional and honorable manner. *Id.* Even if *Lunsford* could be construed as holding that a nurse's duty to act according to the applicable standard of care arises from the mere fact that she has a nursing license, such a holding would be contrary to *St. John v. Pope* because it would impose a duty on nurses to practice their profession or render services to everyone who asks. We therefore decline to apply *Lunsford* to this case.

The first question to be decided is whether the summary judgment evidence conclusively shows that Mijares did not consent or agree, either expressly or impliedly, to accept Estrada as a patient. Mijares stated the following in paragraphs four through six of her affidavit:

> 4. I never evaluated or treated Richard Estrada. I never examined Mr. Estrada or gave orders for his treatment, either personally or through an intermediary. I never exercised any medical judgment with regard to Mr. Estrada's care. I was never instructed or assigned to evaluate or treat Mr. Estrada.
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> 5. On July 22, 2007, when asked to do so by a floor nurse at Del Sol Medical Center I, as a courtesy, communicated to Dr. Hajj that a pulmonary consult had been requested for Mr. Estrada. Also on July 22, 2007, Dr. Hajj gave orders via a telephone call for Mr. Estrada. I transcribed these orders onto Mr. Estrada's chart per Dr. Hajj's request.
>
> 6. I did not participate in the decisions to treat or not treat, or to discharge Mr. Estrada, nor did I have any other involvement in Mr. Estrada's care or treatment.

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Dr. Hajj also testified that he never asked Mijares to evaluate Estrada. This evidence is sufficient to conclusively prove that Mijares did not have a nurse-patient relationship with Estrada, and therefore, she did not owe a duty to act according to the applicable standards of care. The burden shifted to Appellant to present evidence raising a genuine issue of material fact.

Appellant asserts that a fact issue exists because Mijares telephoned Dr. Hajj to inform him of the consultation with Estrada but Mijares insisted that she made the call as a courtesy to the doctor. Mijares did not by merely advising Dr. Hajj that he has been requested to provide a pulmonary consultation, consent or agree to accept Estrada as her patient.

Appellant next claims that a fact issue exists because Mijares provided Dr. Hajj with information from Estrada's chart regarding his condition. Mijares did not evaluate Estrada or take it upon herself to review his chart. The evidence instead shows that Dr. Hajj requested that Dr. Mijares provide him with information from Estrada's chart. There is no evidence that Mijares' reviewed the chart with the purpose of diagnosing Estrada or providing him with treatment. *See St. John*, 901 S.W.2d at 424 (even though doctor listened to another doctor's description of a patient's symptoms and came to a conclusion about the basis of the patient's condition, he did so for the purpose of evaluating whether he should take the case, not as a diagnosis for a course of treatment).

Appellant also claims that a fact issue exists with respect to the nurse-patient relationship because Mijares wrote orders on Estrada's chart. The evidence showed that Mijares transcribed Dr. Hajj's verbal orders onto the chart and he countersigned the orders in accordance with hospital policy. She explained that she was not authorized to write orders in the hospital setting and she was simply transcribing the orders dictated to her by Dr. Hajj. Dr. Gibson, however, made the following statement in his discharge summary: "Apparently, [Estrada] was seen by

Dr. Hajj's, I suspect, PA, who simply added Rocephin and as there is nothing to find clinically, I think we will send this man home." There is no evidence that Dr. Gibson was necessarily referring to Mijares when he made this statement. While we are required to take the evidence in the light most favorable to the non-movant, the summary judgment standard does not require the Court to assume facts not shown in the record.

Finally, Appellant claims, without citing any of the summary judgment evidence, that Dr. Hajj relied on Mijares' skill, education, and training as a nurse and nurse practitioner. We have reviewed all of the summary judgment evidence, including the excerpts of Dr. Hajj's deposition testimony and we have found no evidence supporting this statement. Having found no fact issues precluding summary judgment, we overrule the sole issue presented on appeal and affirm the judgment of the trial court.

February 20, 2013

ANN CRAWFORD McCLURE, Chief Justice

Before McClure, C.J., Rivera, and Antcliff, JJ.
Antcliff, J., not participating

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