Health Law: Quality & Liability

Professor Thaddeus M. Pope

Reading Packet for Week 1 (Fall 2018)

Weekly Summary

In this class, we begin with the "treatment relationship." This is important, because the existence of a treatment relationship is a prerequisite for triggering four key common law, tort-based duties that we will discuss later in the course: (1) confidentiality, (2) informed consent, (3) non-abandonment, and (4) malpractice (duty to comply with standard of care).

In this class, we will answer three key questions concerning the physician-patient treatment relationship. First, when "must" a physician treat, when she must enter a treatment relationship? Second, when is a treatment relationship is formed? Third, when is a treatment relationship ended?

Duty to Treat. Physicians have a duty to treat only those patients with whom they have a treatment relationship. Only in the context of a treatment relationship do physicians owe physician duties. Only in the context of a treatment relationships can physicians be sued for medical malpractice, tortious abandonment, breach of informed consent, or breach of confidentiality. Typically, physicians have no legal duty to create/form a treatment relationship.

Formation. But even if a relationship did not need to be formed, when exactly is one formed (perhaps even unwittingly)? We look at what type and amount of physician conduct is sufficient to create/form a treatment relationship.

Termination. Termination is legally non-problematic when the patient fires the physician or when the need for medical services ends. But when the physician ends the relationship, she must provide adequate notice to the patient. Furthermore, patient abandonment (wrongful termination) is not only a matter of tort liability but also a matter of state medical board discipline.

Reading

All the following materials are collected into this single PDF document:

- Hurley v. Eddingfield (Ind. 1901) (duty to treat) (1 page)
- Jennings v. Badget (Okla. 2010) (duty to treat) (7 pages)
- Togstad v. VOMK (Minn. 1980) (formation) (8 pages)
- Adams v. Via Christi (Kan. 2001) (formation) (5 pages)
- Lyons v Grether (Va. 1977) (formation) (4 pages)
- Clanton v Von Haam (Ga. App. 1986) (formation) (4 pages)
- Ricks v. Budge (Utah 1937) (bad termination) (8 pages)
- Payton v. Weaver (Cal. App. 1982) (good termination) (7 pages)
- Iowa Admin Code Chapter 653 - Section 13.7(1) (1 page)
- AMA Code of Medical Ethics § 1.115 (2016 rev.) (1 page)

Objectives

By the end of this week, you will be able to:

- Analyze and apply legal principles concerning the existence of a physician-patient treatment relationship. (1)
- Analyze and apply legal principles concerning when a physician has a duty to enter a treatment relationship and treat an individual. (1.1)
- Analyze and apply legal principles concerning when a treatment relationship is formed/created between a physician and patient. (1.2)
- Analyze and apply legal principles concerning the conditions under which a treatment relationship may be terminated. (1.4)
- Analyze and apply legal principles concerning tortious abandonment (wrongful termination of the treatment relationship). (1.5)

C

Supreme Court of Indiana.
HURLEY
v.
EDDINGFIELD.
April 4, 1901.

Appeal from circuit court, Montgomery county; Jere West, Judge.

Action by George D. Hurley, as administrator, against George W. Eddingfield. From a judgment in favor of the defendant, the plaintiff appeals. Affirmed.

West Headnotes

***1058** Hurley & Van Cleave and Dumont Kennedy, for appellant. Clodfelter & Fine, for appellee.

BAKER, J.

The 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 prac-titioner 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 fee 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 ap-pellee'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 ap-plied. Whart. Neg. § 731. The act regulating the practice of medicine provides for a board of exam-iners, standards of qualification, examinations, li-censes 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 com-pulsive, 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 innkeep-ers, common carriers, and the like, are beside the mark. Judgment affirmed.

Ind. 1901.
Hurley v. Eddingfield
53 L.R.A. 135, 156 Ind. 416, 59 N.E. 1058, 83 Am.St.Rep. 198

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JENNINGS v. BADGETT

2010 OK 7
Case Number: 105745
Decided: 02/09/2010

THE SUPREME COURT OF THE STATE OF OKLAHOMA

Cite as: 2010 OK 7, __ P.3d __

NOTICE: THIS OPINION HAS NOT BEEN RELEASED FOR PUBLICATION IN THE PERMANENT LAW REPORTS. UNTIL RELEASED, IT IS SUBJECT TO REVISION OR WITHDRAWAL.

SHANNON JENNINGS and BRANDY CRAWFORD, Individually and as Parents and Natural Guardians of Shelby Jennings, a minor, Plaintiffs/Appellants,
v.
BLAKE ALLEN BADGETT, M.D., Individually, and d/b/a BLAKE ALLEN BADGETT, M.D., P.C., and INTEGRIS BAPTIST MEDICAL CENTER, INC., a domestic not for profit corporation, Defendants,
and
STEPHEN D. SCHLINKE, M.D., Defendant/Appellee.

ON CERTIORARI FROM THE COURT OF CIVIL APPEALS,
DIVISION II

¶0 Plaintiffs filed a medical malpractice action against medical providers, including a non-treating physician who had a conversation with the treating physician concerning the pregnant plaintiff's history and complications. The district court granted summary judgment in the non-treating physician's favor and certified the order pursuant to 12 O.S.2001, § 994(A). The Court of Civil Appeals affirmed. This Court granted the writ of certiorari.

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

Benjamin J. Butts, Butts & Marrs, P.L.L.C., Oklahoma City, Oklahoma, for the appellants.
John Wiggins and Erin A. Renegar, Wiggins Sewell & Ogletree, Oklahoma City, Oklahoma, for the appellee.

TAYLOR, V.C.J.

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

I. PROCEDURAL HISTORY

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

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

II. SUMMARY JUDGMENT AND STANDARD OF REVIEW

¶4 Under Rule 13(a) of the Rules of District Courts, 12 O.S.2001, ch. 2, app. (Rules of District Courts), a party may move for summary judgment or summary disposition of any issue when the evidentiary materials filed in support of the motion show that there is no genuine issue of any material fact. The moving party must support the motion by attaching and referencing evidentiary materials supporting the party's statement of undisputed facts. *Id.* The opposing party must state the material facts which the party contends are disputed and attach supporting evidentiary materials. *Id.* The court shall grant judgment to one of the parties if it appears that there is no substantial controversy as to any material fact and that one party is entitled to judgment as a matter of law. *Id.* at Rule 13(e). All reasonable inferences are taken in favor of the opposing party. *Wittenberg v. Fid. Bank, N.A.*, 1992 OK 165, ¶ 2, 844 P.2d 155, 156. The party opposing the motion cannot, on appeal, rely on any fact or evidentiary material not included or referenced in its statement of disputed facts. Rules of District Courts at Rule 13(b).

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

III. PARTIES' ALLEGATIONS AND CONTENTIONS

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

¶7 The plaintiffs contend that Dr. Badgett contacted Dr. Schlinke for an opinion concerning Crawford's care. Based on Dr. Schlinke's opinion, Dr. Badgett caused Shelby to be delivered prematurely and, but for

Dr. Schlinke's opinion, Shelby would not have been prematurely delivered. Dr. Schlinke knew or should have known that Dr. Badgett would rely on his opinion. Dr. Schlinke's negligence caused or contributed to Shelby' injuries and, thus, Dr. Schlinke is also liable for the injuries.

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

IV. UNDISPUTED FACTS

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

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

V. NECESSITY OF PHYSICIAN-PATIENT RELATIONSHIP

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

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

¶13 An action for malpractice is based on an employment contract. *Funnell v. Jones*, 1985 OK 73, ¶ 5, 737 P.2d 105, 107, *cert. denied*, 484 U.S. 853 (1987). To receive the professional services, the patient agrees to be treated, *Scott v. Bradford,* 1979 OK 165, ¶ 8-12, 606 P.2d 554, 556-557, and if the patient is unable to give consent, the consent may be implied. *Rolater v. Strain*, 1913 OK 634, 137 P. 96. Otherwise, a physician may be liable for assault and battery. *Scott*, 1979 OK 165 at ¶ 8-12, 606 P.2d at

556-557. Because in Oklahoma a physician is not under a general duty to provide professional services to others, *see Jackson v. Mercy Health Ctr., Inc.*, 1993 OK 155, ¶ 5, 864 P.2d 839, 842, the physician must consent to provide the services. The agreement of the physician to treat and the patient to receive treatment is the basis of the employment contract.

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

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

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

¶17 By finding the element of duty in a medical malpractice action requires a physician-patient relationship, we are not disallowing a cause of action for medical malpractice by a third-party beneficiary, such as a child, based on negligent prenatal care or a negligent delivery. Part of the purpose of a contract for medical care of a pregnant female is to insure the health of the child. In *Nealis v. Baird*, 1999 OK 98, 996 P.2d 438, we recognized that the parents of a prematurely-born child could bring a wrongful death action on the child's behalf against the mother's treating physicians. In *Graham v. Keuchel*, 1993 OK 6, 847 P.2d 342, we allowed that a wrongful death claim could be brought on behalf of an infant for a physician's failure to administer a drug after a previous delivery which would have prevented the mother's Rh-positive sensitization. In this regard, this Court allowed that the intended beneficiaries of a will could bring a legal malpractice claim or contract claim against the attorney drafting the will. *Leak-Gilbert v. Fahle*, 2002 OK 66, ¶ 27, 55 P.3d 1054, 1062.

VI. THE EXISTENCE OF A PHYSICIAN-PATIENT RELATIONSHIP

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

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

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

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

¶22 The evidence in *Flynn v. Bausch*, 469 N.W.2d 125 (Neb. 1991), is more compelling of the existence of a physician-patient relationship than the evidence before this Court here. Nonetheless, the Nebraska Supreme Court found that the record did not support a physician-patient relationship between the defendant doctor and the plaintiff. *Id.* at 129. In *Flynn*, the defendant doctor and the plaintiff's treating doctor had a conversation about the plaintiff in the hospital nursery where the plaintiff was at the time. *Id.* at 127. The two doctors agreed that additional tests on the plaintiff were needed. *Id.* The defendant did not look at the plaintiff's chart or any test results and was not aware of the plaintiff's name. *Id.* Although the defendant did look at the plaintiff in the nursery, he did not examine the plaintiff but noticed that he

appeared jaundiced and had a rash. *Id.* The defendant advised the treating doctor to wait on test results before performing a blood-exchange transfusion. *Id.* The plaintiff alleged that he suffered brain damage and other injuries which could have been avoided had he received the transfusion earlier. *Id.* at 128. The court concluded that summary judgment in the defendant's favor was proper notwithstanding he had looked at the plaintiff in the nursery and had advised the transfusion be delayed, which it was. The court reasoned that the inferences were too general to support a finding that the defendant had undertaken to participate in the plaintiff's care. *Id.* at 129.

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

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

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

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

VII. CONCLUSION

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

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

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

Edmondson, C.J., Taylor, V.C.J., and Hargrave, Opala, and Winchester, and Reif, JJ., concur.

Watt and Colbert, JJ., dissent.

Kauger, J., not participating.

FOOTNOTES

[1] After the district court awarded judgment in Dr. Schlinke's favor,the plaintiffs filed an amended petition on January 7, 2008. The amended petition was substantially the same as the petition.

Citationizer© Summary of Documents Citing This Document

Cite	Name	Level

None Found.

Citationizer: Table of Authority

Cite Name Level

Oklahoma Supreme Court Cases

Cite	Name	Level
1913 OK 634, 137 P. 96, 39 Okla. 572,	ROLATER v. STRAIN	Discussed
1992 OK 165, 844 P.2d 155, 64 OBJ 25,	Wittenberg v. Fidelity Bank, N.A.	Discussed
1993 OK 4, 846 P.2d 1088, 64 OBJ 334,	Great Plains Federal Sav. and Loan Ass'n v. Dabney	Discussed
1993 OK 6, 847 P.2d 342, 64 OBJ 420,	Graham v. Keuchel	Discussed
1993 OK 41, 850 P.2d 1087, 64 OBJ 1068,	Haney v. State	Discussed
1993 OK 155, 864 P.2d 839, 64 OBJ 3587,	Jackson v. Mercy Health Center, Inc.	Discussed
2000 OK 79, 19 P.3d 834, 72 OBJ 639,	FRANKLIN v. TOAL	Discussed at Length
1932 OK 671, 16 P.2d 123, 160 Okla. 139,	MUCKLEROY et al. v. McHENRY.	Discussed
2002 OK 66, 55 P.3d 1054,	LEAK-GILBERT v. FAHLE	Discussed
1995 OK 112, 909 P.2d 765, 66 OBJ 3292,	Jackson v. Oklahoma Memorial Hosp.	Discussed
2006 OK 67, 145 P.3d 1055,	WORSHAM v. NIX & SCROGGS	Discussed
2007 OK 38, 160 P.3d 959,	LOWERY v. ECHOSTAR SATELLITE CORP.	Discussed at Length
2008 OK 13, 184 P.3d 502,	ROX PETROLEUM, L.L.C. v. NEW DOMINION, L.L.C.	Discussed
2008 OK 65, 188 P.3d 177,	GLASCO v. STATE ex rel. OKLAHOMA DEPARTMENT OF CORRECTIONS	Discussed at Length
1977 OK 216, 572 P.2d 979,	ALLRED v. RABON	Discussed
1979 OK 165, 606 P.2d 554,	SCOTT v. BRADFORD	Discussed at Length
1999 OK 98, 996 P.2d 438, 70 OBJ 3640,	Nealis v. Baird	Discussed

Supreme Court of Minnesota
April 1980

3. The damages should not be reduced by a hypothetical contingency fee that would have been paid had the original action been successfully prosecuted.

4. The trial court's findings that certain comments by counsel were not improper was not an abuse of discretion.

Meagher, Geer, Markham, Anderson, Adamson, Flaskamp & Brennan and O. C. Adamson II, Minneapolis, Collins & Buckley and Theodore J. Collins, St. Paul, for appellants.

DeParcq, Anderson, Perl, Hunegs & Rudquist and Donald L. Rudquist, Minneapolis, for respondents.

Heard, considered and decided by the court en banc.

PER CURIAM.

This is an appeal by the defendants from a judgment of the Hennepin County District Court involving an action for legal malpractice. The jury found that the defendant attorney Jerre Miller was negligent and that, as a direct result of such negligence, plaintiff John Togstad sustained damages in the amount of $610,500 and his wife, plaintiff Joan Togstad, in the amount of $39,000. Defendants (Miller and his law firm) appeal to this court from the denial of their motion for judgment notwithstanding the verdict or, alternatively, for a new trial. We affirm.

In August 1971, John Togstad began to experience severe headaches and on August 16, 1971, was admitted to Methodist Hospital where tests disclosed that the headaches were caused by a large aneurism [1] on the left internal carotid artery.[2] The attending physician, Dr. Paul Blake, a neurological surgeon, treated the problem by applying a Selverstone clamp to the left common carotid artery. The clamp was surgically implanted on August 27, 1971, in Togstad's neck to allow the gradual closure of the artery over a period of days.

The treatment was designed to eventually cut off the blood supply through the artery and thus relieve the pressure on the aneurism, allowing the aneurism to heal. It was anticipated that other arteries, as well as the brain's collateral or cross-arterial system would supply the required blood to the portion of the brain which would ordinarily have been provided by the left carotid artery. The greatest risk associated with this procedure is that the patient may become paralyzed if the brain does not receive an adequate flow of blood. In the event the supply of blood becomes so low as to endanger the health of the patient, the adjustable clamp can be opened to establish the proper blood circulation.

In the early morning hours of August 29, 1971, a nurse observed that Togstad was unable to speak or move. At the time, the clamp was one-half (50%) closed. Upon discovering Togstad's condition, the nurse called a resident physician, who did not adjust the clamp. Dr. Blake was also immediately informed of Togstad's condition and arrived about an hour later, at which time he opened the clamp. Togstad is now severely paralyzed in his right arm and leg, and is unable to speak.

Plaintiffs' expert, Dr. Ward Woods, testified that Togstad's paralysis and loss of speech was due to a lack of blood supply to his brain. Dr. Woods stated that the inadequate blood flow resulted from the clamp being 50% closed and that the negligence of Dr. Blake and the hospital precluded the clamp's being opened in time to avoid permanent brain damage. Specifically, Dr. Woods claimed that Dr. Blake and the hospital were negligent for (1) failing to place the patient in the intensive care unit or to have a special nurse conduct certain neurological tests every half-hour; (2) failing to write adequate orders; (3) failing to open the clamp immediately upon discovering that the patient was unable to speak; and

1. An aneurism is a weakness or softening in an artery wall which expands and bulges out over a period of years.

2. The left internal carotid artery is one of the major vessels which supplies blood to the brain.

(4) the absence of personnel capable of opening the clamp.

Dr. Blake and defendants' expert witness, Dr. Shelly Chou, testified that Togstad's condition was caused by blood clots going up the carotid artery to the brain. They both alleged that the blood clots were not a result of the Selverstone clamp procedure. In addition, they stated that the clamp must be about 90% closed before there will be a slowing of the blood supply through the carotid artery to the brain. Thus, according to Drs. Blake and Chou, when the clamp is 50% closed there is no effect on the blood flow to the brain.

About 14 months after her husband's hospitalization began, plaintiff Joan Togstad met with attorney Jerre Miller regarding her husband's condition. Neither she nor her husband was personally acquainted with Miller or his law firm prior to that time. John Togstad's former work supervisor, Ted Bucholz, made the appointment and accompanied Mrs. Togstad to Miller's office. Bucholz was present when Mrs. Togstad and Miller discussed the case.[3]

Mrs. Togstad had become suspicious of the circumstances surrounding her husband's tragic condition due to the conduct and statements of the hospital nurses shortly after the paralysis occurred. One nurse told Mrs. Togstad that she had checked Mr. Togstad at 2 a. m. and he was fine; that when she returned at 3 a. m., by mistake, to give him someone else's medication, he was unable to move or speak; and that if she hadn't accidentally entered the room no one would have discovered his condition until morning. Mrs. Togstad also noticed that the other nurses were upset and crying, and that Mr. Togstad's condition was a topic of conversation.

Mrs. Togstad testified that she told Miller "everything that happened at the hospital," including the nurses' statements and conduct which had raised a question in her mind. She stated that she "believed" she had told Miller "about the procedure and what was undertaken, what was done, and what happened." She brought no records with her. Miller took notes and asked questions during the meeting, which lasted 45 minutes to an hour. At its conclusion, according to Mrs. Togstad, Miller said that "he did not think we had a legal case, however, he was going to discuss this with his partner." She understood that if Miller changed his mind after talking to his partner, he would call her. Mrs. Togstad "gave it" a few days and, since she did not hear from Miller, decided "that they had come to the conclusion that there wasn't a case." No fee arrangements were discussed, no medical authorizations were requested, nor was Mrs. Togstad billed for the interview.

Mrs. Togstad denied that Miller had told her his firm did not have expertise in the medical malpractice field, urged her to see another attorney, or related to her that the statute of limitations for medical malpractice actions was two years. She did not consult another attorney until one year after she talked to Miller. Mrs. Togstad indicated that she did not confer with another attorney earlier because of her reliance on Miller's "legal advice" that they "did not have a case."

On cross-examination, Mrs. Togstad was asked whether she went to Miller's office "to see if he would take the case of [her] husband * * *." She replied, "Well, I guess it was to go for legal advice, what to do, where shall we go from here? That is what we went for." Again in response to defense counsel's questions, Mrs. Togstad testified as follows:

Q And it was clear to you, was it not, that what was taking place was a preliminary discussion between a prospective client and lawyer as to whether or not they wanted to enter into an attorney-client relationship?

A I am not sure how to answer that. It was for legal advice as to what to do.

3. Bucholz, who knew Miller through a local luncheon club, died prior to the trial of the instant action.

Q And Mr. Miller was discussing with you your problem and indicating whether he, as a lawyer, wished to take the case, isn't that true?

A Yes.

On re-direct examination, Mrs. Togstad acknowledged that when she left Miller's office she understood that she had been given a "qualified, quality legal opinion that [she and her husband] did not have a malpractice case."

Miller's testimony was different in some respects from that of Mrs. Togstad. Like Mrs. Togstad, Miller testified that Mr. Bucholz arranged and was present at the meeting, which lasted about 45 minutes. According to Miller, Mrs. Togstad described the hospital incident, including the conduct of the nurses. He asked her questions, to which she responded. Miller testified that "[t]he only thing I told her [Mrs. Togstad] after we had pretty much finished the conversation was that there was nothing related in her factual circumstances that told me that she had a case that our firm would be interested in undertaking."

Miller also claimed he related to Mrs. Togstad "that because of the grievous nature of the injuries sustained by her husband, that this was only my opinion and she was encouraged to ask another attorney if she wished for another opinion" and "she ought to do so promptly." He testified that he informed Mrs. Togstad that his firm "was not engaged as experts" in the area of medical malpractice, and that they associated with the Charles Hvass firm in cases of that nature. Miller stated that at the end of the conference he told Mrs. Togstad that he would consult with Charles Hvass and if Hvass's opinion differed from his, Miller would so inform her. Miller recollected that he called Hvass a "couple days" later and discussed the case with him. It was Miller's impression that Hvass thought there was no liability for malpractice in the case. Consequently, Miller did not communicate with Mrs. Togstad further.

On cross-examination, Miller testified as follows:

Q Now, so there is no misunderstanding, and I am reading from your deposition, you understood that she was consulting with you as a lawyer, isn't that correct?

A That's correct.

Q That she was seeking legal advice from a professional attorney licensed to practice in this state and in this community?

A I think you and I did have another interpretation or use of the term "Advice". She was there to see whether or not she had a case and whether the firm would accept it.

Q We have two aspects; number one, your legal opinion concerning liability of a case for malpractice; number two, whether there was or wasn't liability, whether you would accept it, your firm, two separate elements, right?

A I would say so.

Q Were you asked on page 6 in the deposition, folio 14, "And you understood that she was seeking legal advice at the time that she was in your office, that is correct also, isn't it?" And did you give this answer, "I don't want to engage in semantics with you, but my impression was that she and Mr. Bucholz were asking my opinion after having related the incident that I referred to." The next question, "Your legal opinion?" Your answer, "Yes." Were those questions asked and were they given?

MR. COLLINS: Objection to this, Your Honor. It is not impeachment.

THE COURT: Overruled.

THE WITNESS: Yes, I gave those answers. Certainly, she was seeking my opinion as an attorney in the sense of whether or not there was a case that the firm would be interested in undertaking.

Kenneth Green, a Minneapolis attorney, was called as an expert by plaintiffs. He stated that in rendering legal advice regarding a claim of medical malpractice, the "minimum" an attorney should do would be

the evidence shows that a lawyer-client relationship is present here. The thrust of

in a case of this nature. The record, through the testimony of Kenneth Green

to request medical authorizations from the client, review the hospital records, and consult with an expert in the field. John McNulty, a Minneapolis attorney, and Charles Hvass testified as experts on behalf of the defendants. McNulty stated that when an attorney is consulted as to whether he will take a case, the lawyer's only responsibility in refusing it is to so inform the party. He testified, however, that when a lawyer is asked his legal opinion on the merits of a medical malpractice claim, community standards require that the attorney check hospital records and consult with an expert before rendering his opinion.

Hvass stated that he had no recollection of Miller's calling him in October 1972 relative to the Togstad matter. He testified that:

> A * * * when a person comes in to me about a medical malpractice action, based upon what the individual has told me, I have to make a decision as to whether or not there probably is or probably is not, based upon that information, medical malpractice. And if, in my judgment, based upon what the client has told me, there is not medical malpractice, I will so inform the client.

Hvass stated, however, that he would never render a "categorical" opinion. In addition, Hvass acknowledged that if he were consulted for a "legal opinion" regarding medical malpractice and 14 months had expired since the incident in question, "ordinary care and diligence" would require him to inform the party of the two-year statute of limitations applicable to that type of action.

This case was submitted to the jury by way of a special verdict form. The jury found that Dr. Blake and the hospital were negligent and that Dr. Blake's negligence (but not the hospital's) was a direct cause of the injuries sustained by John Togstad; that there was an attorney-client contractual relationship between Mrs. Togstad and Miller; that Miller was negligent in rendering advice regarding the possible claims of Mr. and Mrs. Togstad; that, but for Miller's negligence, plaintiffs would have been successful in the prosecution of a legal action against Dr. Blake; and that neither Mr. nor Mrs. Togstad was negligent in pursuing their claims against Dr. Blake. The jury awarded damages to Mr. Togstad of $610,500 and to Mrs. Togstad of $39,000.

On appeal, defendants raise the following issues:

(1) Did the trial court err in denying defendants' motion for judgment notwithstanding the jury verdict?

(2) Does the evidence reasonably support the jury's award of damages to Mrs. Togstad in the amount of $39,000?

(3) Should plaintiffs' damages be reduced by the amount of attorney fees they would have paid had Miller successfully prosecuted the action against Dr. Blake?

(4) Were certain comments of plaintiffs' counsel to the jury improper and, if so, were defendants entitled to a new trial?

[1] 1. In a legal malpractice action of the type involved here, four elements must be shown: (1) that an attorney-client relationship existed; (2) that defendant acted negligently or in breach of contract; (3) that such acts were the proximate cause of the plaintiffs' damages; (4) that but for defendant's conduct the plaintiffs would have been successful in the prosecution of their medical malpractice claim. *See, Christy v. Saliterman,* 288 Minn. 144, 179 N.W.2d 288 (1970).

This court first dealt with the element of lawyer-client relationship in the decision of *Ryan v. Long,* 35 Minn. 394, 29 N.W. 51 (1886). The *Ryan* case involved a claim of legal malpractice and on appeal it was argued that no attorney-client relation existed. This court, without stating whether its conclusion was based on contract principles or a tort theory, disagreed:

> [I]t sufficiently appears that plaintiff, for himself, called upon defendant, as an attorney at law, for "legal advice," and that defendant assumed to give him a professional opinion in reference to the matter as to which plaintiff consulted him. Upon this state of facts the defendant must be taken to have acted as plaintiff's

legal adviser, at plaintiff's request, and so as to establish between them the relation of attorney and client.

Id. (citation omitted). More recent opinions of this court, although not involving a detailed discussion, have analyzed the attorney-client consideration in contractual terms. *See, Ronnigen v. Hertogs,* 294 Minn. 7, 199 N.W.2d 420 (1972); *Christy v. Saliterman, supra.* For example, the *Ronnigen* court, in affirming a directed verdict for the defendant attorney, reasoned that "[u]nder the fundamental rules applicable to contracts of employment * * * the evidence would not sustain a finding that defendant either expressly or impliedly promised or agreed to represent plaintiff * * *." 294 Minn. 11, 199 N.W.2d 422. The trial court here, in apparent reliance upon the contract approach utilized in *Ronnigen* and *Christy, supra,* applied a contract analysis in ruling on the attorney-client relationship question. This has prompted a discussion by the *Minnesota Law Review,* wherein it is suggested that the more appropriate mode of analysis, at least in this case, would be to apply principles of negligence, *i. e.,* whether defendant owed plaintiffs a duty to act with due care. 63 Minn. L.Rev. 751 (1979).

[2-4] We believe it is unnecessary to decide whether a tort or contract theory is preferable for resolving the attorney-client relationship question raised by this appeal. The tort and contract analyses are very similar in a case such as the instant one,[4] and we conclude that under either theory the evidence shows that a lawyer-client relationship is present here. The thrust of Mrs. Togstad's testimony is that she went to Miller for legal advice, was told there wasn't a case, and relied upon this advice in failing to pursue the claim for medical malpractice. In addition, according to Mrs. Togstad, Miller did not qualify his legal opinion by urging her to seek advice from another attorney, nor did Miller inform her that he lacked expertise in the medical malpractice area. Assuming this testimony is true, as this court must do, *see, Cofran v. Swanman,* 225 Minn. 40, 29 N.W.2d 448 (1947),[5] we believe a jury could properly find that Mrs. Togstad sought and received legal advice from Miller under circumstances which made it reasonably foreseeable to Miller that Mrs. Togstad would be injured if the advice were negligently given. Thus, under either a tort or contract analysis, there is sufficient evidence in the record to support the existence of an attorney-client relationship.

[5] Defendants argue that even if an attorney-client relationship was established the evidence fails to show that Miller acted negligently in assessing the merits of the Togstads' case. They appear to contend that, at most, Miller was guilty of an error in judgment which does not give rise to legal malpractice. *Meagher v. Kavli,* 256 Minn. 54, 97 N.W.2d 370 (1959). However, this case does not involve a mere error of judgment. The gist of plaintiffs' claim is that Miller failed to perform the minimal research that an ordinarily prudent attorney would do before rendering legal advice in a case of this nature. The record, through the testimony of Kenneth Green

4. Under a negligence approach it must essentially be shown that defendant rendered legal advice (not necessarily at someone's request) under circumstances which made it reasonably foreseeable to the attorney that if such advice was rendered negligently, the individual receiving the advice might be injured thereby. *See, e. g., Palsgraf v. Long Island R. Co.,* 248 N.Y. 339, 162 N.E. 99, 59 A.L.R. 1253 (1928). Or, stated another way, under a tort theory, "[a]n attorney-client relationship is created whenever an individual seeks and receives legal advice from an attorney in circumstances in which a reasonable person would rely on such advice." 63 Minn.L.Rev. 751, 759 (1979). A contract analysis requires the rendering of legal advice pursuant to another's request and the reliance factor, in this case, where the advice was not paid for, need be shown in the form of promissory estoppel. *See,* 7 C.J.S., *Attorney and Client,* § 65; *Restatement (Second) of Contracts,* § 90.

5. As the *Cofran* court stated, in determining whether the jury's verdict is reasonably supported by the record a court must view the credibility of evidence and every inference which may fairly be drawn therefrom in a light most favorable to the prevailing party. 225 Minn. 42, 29 N.W.2d 450.

and John McNulty, contains sufficient evidence to support plaintiffs' position.

[6] In a related contention, defendants assert that a new trial should be awarded on the ground that the trial court erred by refusing to instruct the jury that Miller's failure to inform Mrs. Togstad of the two-year statute of limitations for medical malpractice could not constitute negligence. The argument continues that since it is unclear from the record on what theory or theories of negligence the jury based its decision, a new trial must be granted. *Namchek v. Tulley,* 259 Minn. 469, 107 N.W.2d 856 (1961).

The defect in defendants' reasoning is that there is adequate evidence supporting the claim that Miller was also negligent in failing to advise Mrs. Togstad of the two-year medical malpractice limitations period and thus the trial court acted properly in refusing to instruct the jury in the manner urged by defendants. One of defendants' expert witnesses, Charles Hvass, testified:

> Q Now, Mr. Hvass, where you are consulted for a legal opinion and advice concerning malpractice and 14 months have elapsed [since the incident in question], wouldn't—and you hold yourself out as competent to give a legal opinion and advice to these people concerning their rights, wouldn't ordinary care and diligence require that you inform them that there is a two-year statute of limitations within which they have to act or lose their rights?
>
> A Yes. I believe I would have advised someone of the two-year period of limitation, yes.

Consequently, based on the testimony of Mrs. Togstad, *i. e.,* that she requested and received legal advice from Miller concerning the malpractice claim, and the above testimony of Hvass, we must reject the defendants' contention, as it was reasonable for a jury to determine that Miller acted negligently in failing to inform Mrs. Togstad of the applicable limitations period.

Defendants also indicate that at the time Mrs. Togstad went to another attorney (after Miller) the statute of limitations may not have run and thus Miller's conduct was not a "direct cause" of plaintiffs' damages. As they point out, the limitations period ordinarily begins to run upon termination of the treatment for which the physician was retained. *E. g., Swang v. Hauser,* 288 Minn. 306, 180 N.W.2d 187 (1970); *Schmidt v. Esser,* 183 Minn. 354, 236 N.W. 622 (1931). There is other authority, however, which holds that where the injury complained of consists of a "single act," the limitations period commences from the time of that act, even though the doctor-patient relationship may continue thereafter. *See, e. g., Swang, supra.* Consequently, the limitations period began to run on either August 29, 1971, the date of the incident in question, or October 6, 1971, the last time Dr. Blake treated Mr. Togstad. Mrs. Togstad testified that she consulted another attorney "a year after [she] saw Mr. Miller." Thus, since she visited with Miller on October 2, or 3, 1972, if Mr. Togstad's injuries resulted from a "single act" within the meaning of *Swang, supra,* the limitations period had clearly run by the time Mrs. Togstad consulted another attorney. If, as defendants argue, the statutory period commenced on the date of last treatment, October 6, and Mrs. Togstad's testimony is taken literally, she would have met with a different attorney at a time when perhaps three days of the limitations period remained.

[7, 8] Defendants' contention must be rejected for two reasons. First, at trial defendants apparently assumed that the limitations period commenced on August 29, 1971, and thus did not litigate the instant issue below. Accordingly, they cannot raise the question for the first time on appeal. *E. g., Turner v. Alpha Phi Sorority House,* 276 N.W.2d 63 (Minn.1979); *Greer v. Kooiker,* 312 Minn. 499, 253 N.W.2d 133 (1977). Further, even assuming the limitations period began on October 6, 1971, it is reasonably inferable from the record that Mrs. Togstad did not see another attorney until after the statute had run. As discussed above, Mrs. Togstad testified that she consulted a lawyer a year after she met with

Miller. This statement, coupled with the fact that an action was not brought against Dr. Blake or the hospital but instead plaintiffs sued defendants for legal malpractice which allegedly caused Mrs. Togstad to let the limitations period run, allows a jury to draw a reasonable inference that the statutory period had, in fact, expired at the time Mrs. Togstad consulted another lawyer. Although this evidence is weak, it constitutes a prima facie showing, and it was defendants' responsibility to rebut the inference.

[9] There is also sufficient evidence in the record establishing that, but for Miller's negligence, plaintiffs would have been successful in prosecuting their medical malpractice claim. Dr. Woods, in no uncertain terms, concluded that Mr. Togstad's injuries were caused by the medical malpractice of Dr. Blake. Defendants' expert testimony to the contrary was obviously not believed by the jury. Thus, the jury reasonably found that had plaintiff's medical malpractice action been properly brought, plaintiffs would have recovered.

Based on the foregoing, we hold that the jury's findings are adequately supported by the record. Accordingly we uphold the trial court's denial of defendants' motion for judgment notwithstanding the jury verdict.

2. Defendants next argue that they are entitled to a new trial under Minn.R.Civ.P. 59.01(5) because the $39,000 in damages awarded to Mrs. Togstad for loss of consortium is excessive. In support of this claim defendants refer to the fact that Mr. and Mrs. Togstad were divorced in July 1974 (the dissolution proceeding was commenced in February 1974), and assert that there is "virtually no evidence of the extent of Mrs. Togstad's loss of consortium."

[10, 11] The reasonableness of a jury's damage award is largely left to the discretion of the judge who presided at trial and, accordingly, the district court's ruling on this question will not be disturbed unless a clear abuse of discretion is shown. *E. g.*, *Bigham v. J. C. Penney Co.*, 268 N.W.2d 892 (Minn.1978). Or, as stated by the court in *Dawydowycz v. Quady*, 300 Minn. 436, 440, 220 N.W.2d 478, 481 (1974), a trial judge's decision regarding the excessiveness of damages will not be interfered with on appeal "unless the failure to do so would be 'shocking' and result in a 'plain injustice.'" In this case, we believe the trial court acted within its discretionary authority in ruling that Mrs. Togstad's damage award was not excessive.

[12] "Consortium" includes rights inherent in the marital relationship, such as comfort, companionship, and most importantly, sexual relationship. *Thill v. Modern Erecting Co.*, 284 Minn. 508, 170 N.W.2d 865 (1969). Here, the evidence shows that Mr. Togstad became impotent due to the tragic incident which occurred in August 1971. Consequently, Mrs. Togstad was unable to have sexual intercourse with her husband subsequent to that time. The evidence further indicates that the injuries sustained by Mr. Togstad precipitated a dissolution of the marriage.[6] We therefore conclude that the jury's damage award to Mrs. Togstad finds sufficient support in the record.

[13] 3. Defendants also contend that the trial court erred by refusing to instruct the jury that plaintiffs' damages should be reduced by the amount of attorney fees plaintiffs would have paid defendants had Miller prosecuted the medical malpractice action. In *Christy, supra*, the court was presented with this precise question, but declined to rule on it because the issue had not been properly raised before the trial court. The *Christy* court noted, however:

> [T]he record would indicate that, in the trial of this case, the parties probably proceeded upon the assumption that the element of attorneys' fees, which plaintiff might have had to pay defendant had he successfully prosecuted the suit, was canceled out by the attorneys' fees plaintiff incurred in retaining counsel to es-

6. In *Dawydowycz v. Quady*, 300 Minn. 436, 220 N.W.2d 478 (1974), this court acknowledged that evidence of difficulty in enduring a marriage constitutes proof of loss of consortium.

tablish that defendant failed to prosecute a recoverable action.

288 Minn. 174, 179 N.W.2d 307.

Decisions from other states have divided in their resolution of the instant question. The cases allowing the deduction of the hypothetical fees do so without any detailed discussion or reasoning in support thereof. *McGlone v. Lacey*, 288 F.Supp. 662 (D.S.D. 1968); *Sitton v. Clements*, 257 F.Supp. 63 (E.D.Tenn.1966), *aff'd* 385 F.2d 869 (6th Cir. 1967); *Childs v. Comstock*, 69 App.Div. 160, 74 N.Y.S. 643 (1902). The courts disapproving of an allowance for attorney fees reason, consistent with the *dicta* in *Christy, supra*, that a reduction for lawyer fees is unwarranted because of the expense incurred by the plaintiff in bringing an action against the attorney. *Duncan v. Lord*, 409 F.Supp. 687 (E.D.Pa.1976) (citing *Christy*); *Winter v. Brown*, 365 A.2d 381 (D.C.App. 1976) (citing *Christy*); *Benard v. Walkup*, 272 Cal.App.2d 595, 77 Cal.Rptr. 544 (1969).

We are persuaded by the reasoning of the cases which do not allow a reduction for a hypothetical contingency fee, and accordingly reject defendants' contention.

4. Finally, defendants assert that during closing argument plaintiffs' counsel violated Minn.R.Civ.P. 49 by commenting upon the effect of the jury's answers to the special verdict questions. Rule 49.01(1) reads, in pertinent part, that "[e]xcept as provided in Rule 49.01(2), neither the court nor counsel shall inform the jury of the effect of its answers on the outcome of the case." Rule 49.01(2) states: "In actions involving Minn. Stat.1971, Sec. 604.01 [the comparative negligence statute] the court shall inform the jury of *the effect of its answers to the percentage of negligence question and shall permit counsel to comment thereon* * * *." (Emphasis added.) Thus, Rule 49 allows counsel to comment only upon the effect of the jury's answers to the percentage of negligence inquiries.

[14] The statements of plaintiffs' counsel which are being challenged by defendants read as follows:

> Now, this Special Verdict is not complicated, but it is a long one. The defense, of course, would like you to find 50 percent or more negligence on the part of my client. Again, whatever you put down in the damage verdict, doesn't mean anything, because he gets nothing. The Judge arrives at the conclusions of law when you answer these questions. *If you answer it, there is no causation. He gets nothing.*

(Emphasis added.) The first portion of the above comments is proper because it refers to the impact the jury's apportionment of negligence would have on the case. It is unclear, however, whether counsel's reference to causation is consistent with Rule 49. If counsel intended to disclose to the jury the effect the answers to the "direct cause" inquiries would have on whether plaintiffs recovered, then the statement violates Rule 49.

[15] In any event, the question of whether the alleged Rule 49 violation entitles defendants to a new trial is a matter within the sound discretion of the trial court. *See*, *Patterson v. Donahue*, 291 Minn. 285, 190 N.W.2d 864 (1971). Here, the district court concluded that the purported improper comments of counsel did not require a new trial. In light of the ambiguous nature of counsel's statement, we hold that the trial court did not abuse its discretion in so ruling.

Affirmed.

Terry TWOMEY, Sheriff of Carlton County, et al., Respondents,

v.

Marvin DURKEE et al., Appellants.

No. 49928.

Supreme Court of Minnesota.

April 18, 1980.

Sheriff and county brought action seeking declaratory judgment that deputies'

Supreme Court of Kansas.
Albert & Forestean ADAMS, Individually, and as Special Administrators of the Estate of Nichelle Denise Adams, Deceased, Appellants/ Cross-Appellees,
v.
VIA CHRISTI REGIONAL MEDICAL CENTER, et al., Defendants,
and
Linus Ohaebosim, D.O., Appellee/Cross-Appellant.
No. 83,947.

March 9, 2001.
As Modified May 9, 2001.

This is a personal injury and wrongful death action filed by Albert and Forestean Adams, the parents of Nichelle Adams, who died as a result of a ruptured ectopic pregnancy. The ***825** parents sued St. Francis Regional Medical Center, now known as Via Christi Regional Medical Center, and Dr. Linus Ohaebosim. The parents settled all their claims against the hospital for $170,000. The parents' action against Dr. Ohaebosim proceeded to trial, and the jury returned a verdict in favor of the parents. The jury's ****134** nonpecuniary wrongful death damage award was for $1,800,000. Because the parents already had received the statutory limit on wrongful death damages as settlement proceeds from the hospital, the trial court entered no judgment against Dr. Ohaebosim for wrongful death damages. The parents appeal from the trial court's entry of judgment. Dr. Ohaebosim cross-appeals on liability issues. The case was transferred to this court pursuant to K.S.A. 20-3018(c).

In July 1992, Nichelle Adams was 22 years old and was living with her parents and her younger sister. On July 22, Mrs. Adams got home from work at approximately 8:40 p.m. to find that Nichelle had been complaining about her stomach and had gone to bed. Mrs. Adams was concerned because Nichelle generally was a very active person.

Dr. Ohaebosim, an osteopath, who had been a family practitioner for 22 years, had been the family physician for Mr. and Mrs. Adams and their three children for several years. He had a patient file on Nichelle, but he had not seen her in his office since 1988. On July 6, Nichelle completed a form for Planned Parenthood in which she answered "no" to the question "Do you have a family physician?" Dr. Ohaebosim continued to provide medical care to other members of the family. Mrs. Adams had gotten medical advice from Dr. Ohaebosim over the telephone on a number of occasions.

Until 1990, Dr. Ohaebosim included as part of his family practice the treatment of women through pregnancy, labor, and delivery. He delivered over a thousand babies. After 1990, he continued to treat pregnant women for nonpregnancy-related conditions and to make the determination for women that they were pregnant, but he referred women to other practitioners for prenatal care, labor, and delivery. Dr. Ohaebosim testified about sending a letter to his patients to advise them that he would no longer be providing ***826** obstetrical care. He also testified that he advised all the hospitals, "I don't deliver babies any more." He further stated, "This is my notice written. I'm writing to inform you that I would cease delivering babies on January, 1990, on the 1st of January, 1990." Mrs. Adams testified that she did not receive a letter from the doctor advising that he no longer offered obstetrical care. She was unaware that Dr. Ohaebosim had eliminated obstetrical care from his practice.

At approximately 9 p.m. on July 22, Mrs. Adams called Dr. Ohaebosim. She got his answering service, and then the doctor called Mrs. Adams right back. She told Dr. Ohaebosim that Nichelle was 5 to 8 weeks pregnant and was experiencing abdominal pain. Mrs. Adams later told a doctor at the hospital that she mentioned shortness of breath to Dr. Ohaebosim in the telephone conversation, but Dr. Ohaebosim later denied it, and at the time of trial Mrs. Adams could not remember telling him anything other than Nichelle was pregnant and had abdominal pain.

Dr. Ohaebosim testified that 8 weeks is the typical time when an ectopic pregnancy becomes symptomatic because the fetus becomes too large for the fallopian tube. When Mrs. Adams told Dr. Ohaebosim of Nichelle's condition, he did not suspect that Nichelle might have an ectopic pregnancy.

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Based on his previous experiences with Mrs. Adams, he expected her to be thorough and matter-of-fact in describing whatever medical condition she called him about. According to Dr. Ohaebosim, Mrs. Adams did not express urgency or serious concern when she called him on July 22.

Dr. Ohaebosim testified that he told Mrs. Adams that abdominal pain is not abnormal during pregnancy but to take Nichelle to the emergency room if she got any worse. He also told her to have Nichelle see a doctor the next day. Mrs. Adams testified that Dr. Ohaebosim did not mention taking Nichelle to the emergency room, but that he did say to bring her into his office the next day. Dr. Ohaebosim and Mrs. Adams agreed that he did not ask her any questions about Nichelle's condition.

At approximately midnight, Mrs. Adams drove Nichelle to the hospital, where she was admitted into the emergency room at 12:25 ***827** a.m. on July 23. By the time Nichelle was taken into an examining room, she was agitated and thrashing around. While Mrs. Adams was alone with Nichelle in the examination room, Nichelle vomited. Mrs. Adams ****135** called for help, and, when hospital personnel took over Nichelle's care, Mrs. Adams was taken to a nursing station to call her husband. Mrs. Adams testified that she was taken by surprise because she "just didn't expect all this to unfold. It just unfolded so fast." Before her husband arrived at the hospital, Mrs. Adams was told that Nichelle had gone into cardiac arrest. Later she was told that Nichelle was being taken to surgery.

Dr. Ohaebosim was not contacted with regard to Nichelle until approximately 4 p.m. on July 23. He immediately went to the hospital. Nichelle was on life support systems and nonreactive to the light Dr. Ohaebosim shined in her eyes. He discussed Nichelle's condition with her family, and at approximately 6:30 p.m. she died after being removed from the support systems pursuant to her family's decision. There was evidence that Nichelle might have lived if she had received medical care at 9 or 9:30 p.m. on July 22, instead of after midnight.

Mr. and Mrs. Adams, individually and as administrators of the estate of Nichelle Adams, sued St. Francis Regional Medical Center and Dr. Ohaebosim. Mr. and Mrs. Adams settled with the hospital for $170,000. They proceeded to trial against Dr. Ohaebosim. The jury found Dr. Ohaebosim 90% at fault and the hospital 10% at fault. The jury found that a physician-patient relationship existed between Nichelle Adams and Dr. Ohaebosim on July 22, 1992. The jury determined the following damages:

> Forestean and Albert Adams' non-economic loss to date: $500,000.
>
> Forestean and Albert Adams' future non-economic loss: $500,000.
>
> Forestean and Albert Adams' economic loss: $15,000.
>
> Estate of Nichelle Adams' non-economic loss between 9 p.m. July 22, 1992 and Nichelle Adams' death: $1,000,000.

The total damage award was $2,015,000. $200,000 of the award to Nichelle's estate was for pain and suffering. In 1992, K.S.A. 60-1903(a) placed a cap of $100,000 nonpecuniary damages in a wrongful death action.

The trial court's journal entry of judgment states:

> ***828** "The plaintiffs Albert and Forestean Adams are entitled to recover a maximum of $100,000 for non-economic damages and $15,000 for economic damages for their wrongful death cause of action. The plaintiffs having previously recovered $170,000 for their wrongful death cause of action, the plaintiffs take no judgment against the defendant for their wrongful death claim. The jury having awarded the Estate of Nichelle Adams $200,000 for pain and suffering prior to her death, after application of the jury's findings of fault, the Estate of Nichelle Adams is entitled to Judgment against the defendant in the amount of $180,000."

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party shall be liable for that portion of the total dollar amount awarded as damages to any claimant in the proportion that the amount of such party's causal negligence bears to the amount of the causal negligence attributed to all parties against whom such recovery is allowed." (Emphasis added.)

The comparative negligence statute requires that the percentage of fault attributable to each party be determined and limits each party's liability to its percentage of the total damage award. Thus, it appears that the phrase, "after deduction of any amounts pursuant to K.S.A. 60-258a," in subsection (b) of K.S.A. 60-1903 refers to any percentage of the total damage award for which claimant is responsible due to imputation of the percentage of fault determined to be attributable to the decedent. It further appears that what remains after deduction of any percentage of the damage award imputed to claimant is the "aggregate sum" to which the statutory cap is applied.

***833** Neither K.S.A. 60-1903 nor K.S.A. 60-258a expressly takes the apportionment principles or procedures beyond trial proceedings. This court has held that the comparative negligence statute will not permit a jury verdict to be reduced by any amount plaintiff may have received in settlement from other defendants. See *Glenn v. Fleming,* 240 Kan. 724, 732 P.2d 750 (1987). Neither K.S.A. 60-1903 nor K.S.A. 60-258a expressly takes into account a settlement agreement between a decedent's heirs and a tortfeasor. Moreover, the interpretation given to the statutes by the trial court does not seem to be implied in the statutory language.

[3][4][5] The cap specified in K.S.A. 60-1903 is not a measure of damages, but rather limits the recovery of the damages awarded by a judge or jury. The percentage of fault is applied to the jury's nonpecuniary damages award to determine the amount of damages attributable to a defendant. Where the damages attributable to the defendant are in excess of the cap, the recovery is limited to the amount of the cap.

In the present case, the Adams' settlement with the hospital has no effect on their right of recovery from Dr. Ohaebosim. The Adamses are entitled to keep the benefit of their bargain with the hospital. The jury ****139** verdict included an award of $1,800,000 to the parents for the nonpecuniary loss of their daughter. With no fault being attributed to decedent, there was no percentage imputed to the parents to be deducted from the award. Applying the jury's apportionment of 90% fault to the doctor to the $1,800,000 produces the figure of $1,620,000. The statutory cap applies to the award of $1,620,000, thus reducing the award to $100,000. The Adamses are entitled to a judgment of $100,000 against Dr. Ohaebosim. Thus, the trial court erred in not granting the Adamses a judgment of $100,000 for their wrongful death claim.

In the trial court and in this court, appellants contend that the statutory cap on wrongful death damage awards is unconstitutional in that it impairs the right to trial by jury, violates due process, and violates equal protection. The trial court declined to declare K.S.A. 60-1903 unconstitutional. In *Leiker v. Gafford,* 245 Kan. 325, 359-65, 778 P.2d 823 (1989), *overruled in part on other grounds Martindale v. Tenny,* 250 Kan. 621, 629, 829 P.2d 561 (1992), this ***834** court upheld the constitutionality of K.S.A. 60-1903 on all grounds raised by appellants in the present case. Appellants ask the court to overrule that holding of *Leiker.* We decline to do so.

[6] In his cross-appeal, Dr. Ohaebosim first argues that he had no duty of care to Nichelle Adams. The doctor raised the issue in the trial court by motion for judgment as a matter of law and to reconsider the judgment. The trial court overruled the doctor's post-trial motions to reconsider the judgment, for remittitur, and for new trial.

[7][8] Whether a duty exists is a question of law. *Nero v. Kansas State University,* 253 Kan. 567, Syl. ¶ 1, 861 P.2d 768 (1993). This court's review of a question of law is unlimited.

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Dr. Ohaebosim contends that there was no physician-patient relationship between him and Nichelle Adams on July 22, 1992, and that in the absence of a physician-patient relationship, no duty arose. He relies on Michigan, South Carolina, Georgia, and Oregon cases for the proposition that the existence of a physician-patient relationship is a necessary prerequisite for medical malpractice liability. He cites one federal case in which Kansas law was applied and a number of cases from other states' courts but none from the courts of this state on the question of whether he had a physician-patient relationship with Nichelle Adams. None of the cases he cites involves circumstances like those in the present case.

[9][10][11][12] From the cases cited by the doctor and from other cases located in our research, certain general principles may be drawn that govern situations in which the existence of a physician-patient relationship is in question. Those cases not cited elsewhere in this discussion are: *Doran v. Priddy,* 534 F.Supp. 30 (D.Kan.1981) (obstetrician declined request of hospital nurse to intervene in patient's care in absence of patient's treating physician); *Clanton v. Von Haam,* 177 Ga.App. 694, 340 S.E.2d 627 (1986) (doctor declined to give late night medical advice over telephone); *Weaver v. U. of M. Bd. of Regents,* 201 Mich.App. 239, 506 N.W.2d 264 (Mich.App.1993) (telephone call to schedule an appointment; no medical advice sought); *Cintron by Bultron v. New York Med. College,* 597 N.Y.S.2d 705, 193 A.D.2d 551 (1993) (“on call” doctor, who was telephoned by attending doctor and concurred in attending ***835** doctor's opinion of needed treatment, did not impose on “on call” doctor duty to treat the patient); *Gibbons v. Hantman,* 395 N.Y.S.2d 482, 58 A.D.2d 108 (1977) , *aff'd* 43 N.Y.2d 941, 403 N.Y.S.2d 895, 374 N.E.2d 1246 (1978)(general practitioner instructed patient to return to surgeon who performed surgery for treatment of complication); *Roberts v. Hunter,* 310 S.C. 364, 426 S.E.2d 797 (1993) (patient left emergency room before “on call” neurologist got there); *Lection v. Dyll,* --- S.W.2d ----, 2000 WL 1612150 (Tex.App.2000) (“on call” neurologist listened over telephone to emergency room doctor's description of patient's symptoms after patient had left emergency room); *Day v. Harkins & Munoz,* 961 S.W.2d 278 (Tex.App.1997) (physicians who contracted with arena to provide medical services during a rock concert owed no duty to concertgoer who died from asthma attack after concert ended and doctors had left the premises); ****140***Fought v. Solce,* 821 S.W.2d 218 (Tex.App.1991) (telephone conversation between emergency doctor and consulting physician, who declined to see the patient); *Childs v. Weis,* 440 S.W.2d 104 (Tex.Civ.App.1969) (doctor advised patient to seek treatment from another doctor); *Oja v. Kin,* 229 Mich.App. 184, 581 N.W.2d 739 (1998) (analysis of duty based on doctor's contractual relationship with the hospital and intention that patient be third-party beneficiary). For example, a doctor's not dealing directly with a patient does not preclude the existence of a physician-patient relationship. See *St. John v. Pope,* 901 S.W.2d 420 (Tex.1995) (“on call” internist consulted about emergency room patient recommended that patient be referred either to a hospital with a neurosurgeon or to doctor who performed recent surgery). A doctor, who instead of giving medical advice, suggests that a patient contact another doctor or transfer to another facility does not form a physician-patient relationship. 901 S.W.2d at 424. A physician-patient relationship is consensual. Thus, where there is no ongoing physician-patient relationship, the physician's express or implied consent to advise or treat the patient is required for the relationship to come into being. Stated otherwise, the doctor must take some affirmative action with regard to treatment of a patient in order for the relationship to be established. See *Lopez v. Aziz,* 852 S.W.2d 303, 306-07 (Tex.App.1993).

***836** In the present case, the jury was instructed in this regard as follows:

> “The physician-patient relationship is a consensual one in which the patient knowingly seeks the

physician's assistance and the physician knowingly accepts the patient as a patient. The relationship is contractual and wholly voluntary, and is created by agreement expressed or implied.

"A physician-patient relationship may be created in any number of ways, including the act of a physician agreeing to give or giving advice to a patient in person or by telephone."

The factors Dr. Ohaebosim advances in support of his position that no physician-patient relationship existed on July 22, 1992, between him and Nichelle Adams are the following:

(1) A physician-patient relationship did exist on that date between him and Mrs. Adams.

(2) He had not seen, talked to, or treated Nichelle for approximately four years prior to July 22.

(3) He did not speak to Nichelle on July 22.

(4) His only knowledge of Nichelle's obstetric history was the information provided by Mrs. Adams during the telephone conversation.

(5) He no longer provided obstetrical care.

(6) He "took no action other than discussing, in very general terms," Nichelle's condition with Mrs. Adams.

(7) He did not consider Nichelle to be his patient, and Nichelle did not consider him to be her doctor.

Of these factors, the key to resolving this issue is Dr. Ohaebosim's own statement that he discussed Nichelle's condition with Mrs. Adams. In doing so, he consented to give medical advice about Nichelle's condition and he gave it. It is immaterial that he had not seen Nichelle for several years. It is immaterial that he did not speak directly to Nichelle on July 22. It is not significant in the circumstances that he states that he did not consider Nichelle to be his patient and that Nichelle did not consider him to be her doctor. He did consider Mrs. Adams to be his patient. He was a family physician, and in years past he had treated her daughter, Nichelle. When Mrs. Adams spoke to him by telephone on July 22 and told him that Nichelle was 5-8 weeks pregnant and experiencing abdominal pain, Dr. Ohaebosim did not say that he did not consider Nichelle to be his patient. He did not say that he no longer ***837** provided obstetrical care. Rather than suggesting to Mrs. Adams that she contact another doctor at that time, he listened to what Mrs. Adams told him about Nichelle and gave her his medical opinion in response. Dr. Ohaebosim's undertaking to render medical advice as to Nichelle's condition gave rise to a physician-patient relationship. Thus, even if the earlier physician-patient relationship****141** between Dr. Ohaebosim and Nichelle had lapsed or been extinguished, it was renewed.

The essential difference between the facts of this case and those cited by Dr. Ohaebosim is his taking some action to give medical assistance. Typical of the cases he cites is *Ortiz v. Shah,* 905 S.W.2d 609 (Tex.App.1995). Ortiz was taken to the emergency room with a gunshot wound. The emergency room nurse paged Dr. Shah, who was the "on call" surgeon. Before Dr. Shah reached the hospital, Ortiz had been treated in the emergency room and taken to surgery, where he died. Dr. Shah had no prior relationship with Ortiz. Dr. Shah never saw the patient Ortiz. He never talked to him, and he never gave any advice to anyone about Ortiz's care. He simply told the nurse who contacted him that he was on his way to the hospital. Dr. Shah had taken no action that affected the medical treatment received by Ortiz. Dr. Ohaebosim, in contrast, gave his medical opinion about Nichelle Adams' condition. His opinion was that she was experiencing nothing unusual, which served to reassure Mrs. Adams about her daughter's condition and dissuade her from promptly seeking medical attention for Nichelle.

Dr. Ohaebosim contends that he declined to treat

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Nichelle. He did not decline to express his medical opinion about her condition. Thus, he cannot be said to have declined to treat her. A physician-patient relationship existed between Dr. Ohaebosim and Nichelle, and a duty of care was owed by Dr. Ohaebosim to Nichelle.

Dr. Ohaebosim also contends that plaintiffs' counsel's remarks in closing argument prejudiced the jury and influenced its verdict.

[13] Near the end of his closing argument, counsel for Mr. and Mrs. Adams suggested to the jurors that they were responsible for setting the standard of care in their community and that their decision would be of consequence for the community. Lifted from context, the remarks complained of are as follows:

> ***838** "And what you do here today will go out into the community and will reverberate through this community ... long after you've left.
>
> ....
>
> "[I]f you return a verdict in favor of Dr. Ohaebosim, what you are basically telling the world is that everywhere else but in Wichita, Kansas this is the standard of care."

Defendant's counsel objected to both statements with the phrase "sending a message." The trial court overruled the first objection and ignored the second.

On cross-appeal, Dr. Ohaebosim contends that these arguments were improper. He invites the court to compare plaintiffs' counsel's remarks with remarks that the Court of Appeals found to be improper in *Masson v. Kansas City Power & Light Co.,* 7 Kan.App.2d 344, 642 P.2d 113, *rev. denied* 231 Kan. 801 (1982). He directs the court's attention to Masson's counsel suggesting to the jury that if it reached a verdict in his client's favor, " '*you will have done that one American duty and sent a message to a utility that you are not going to put up with the kind of treatment of your citizens,* you have got a chance to be heard that an individual never has.' Emphasis added." 7 Kan.App.2d at 348, 642 P.2d 113.

[14] Mr. and Mrs. Adams object that the partial transcript of closing argument, which includes none of the closing argument on behalf of Dr. Ohaebosim, is uncertified and, in any event, does not satisfy the requirement that an adequate record on appeal be supplied by the complaining party. We agree that this issue cannot be considered properly on the record before the court. An appellant, in this case the cross-appellant, has the duty to designate a record sufficient to establish the claimed error. Without an adequate record, the claim of alleged error fails. *In re B.M.B.,* 264 Kan. 417, 435, 955 P.2d 1302 (1998).

Judgment on wrongful death damages is reversed, and the matter is remanded to the district court with directions to enter judgment****142** against Dr. Ohaebosim in the amount of $293,500, which includes wrongful death damages in the amount of $113,500, together with interest on the judgment from June 9, 1999, until paid in full.

Kan.,2001.
Adams v. Via Christi Regional Medical Center
270 Kan. 824, 19 P.3d 132

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Supreme Court of Virginia.
Magnolia LYONS
v.
Eugene R. GRETHER.
Record No. 760815.

Nov. 23, 1977.

198HIV(G) Actions and Proceedings
198Hk813 k. Pleading. Most Cited Cases
(Formerly 299k18.40 Physicians and Surgeons)
Allegation in motion for judgment that plaintiff had appointment with defendant physician and that appointment had been given was "for treatment of a vaginal infection" was sufficient to allege a consensual transaction giving rise to a physician-patient relationship and a duty to perform the service contemplated.

[7] Health 198H **577**

198H Health
198HIV Relation Between Patient and Health Care Provider
198Hk577 k. Termination of Relationship. Most Cited Cases
(Formerly 299k12 Physicians and Surgeons)
As a general rule, unless the services to be rendered are conditioned or limited by notice or by the terms of employment, the physician-patient relationship continues until the services are no longer needed, but the relationship may be terminated earlier by mutual consent or by unilateral action of patient and, under certain circumstances, physician has a right to withdraw from a case, provided the patient

***104** ***631** Noel H. Thompson, Arlington, for plaintiff in error.

Joshua N. Fletcher, for defendant in error.

National Federation of the Blind Inc., etc., et al. (Amanda R. Ellis, Charles St. Clair Brown (D.C.), on brief), amicus curiae, for plaintiff in error.

Before ***630** CARRICO, HARRISON, COCHRAN, HARMAN, POFF and COMPTON, JJ.

POFF, Justice.

We awarded a writ of error to a final order entered June 2, 1976 sustaining a demurrer to a motion for judgment filed by Magnolia Lyons (plaintiff) against Dr. Eugene R. Grether (defendant).

[1] A demurrer confesses the truth of the facts alleged and accepts all reasonable inferences therefrom. Plaintiff, a blind person, accompanied by her four year old son and her guide dog, arrived at defendant's "medical office" on the morning of October 18, 1975, a Saturday, to keep an appointment "for a treatment of a vaginal infection". She was told that defendant would not treat her unless the

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dog was removed from the waiting room. She insisted that the dog remain because she "was not informed of any steps which would be taken to assure the safety of the guide dog, its care, or availability to her after treatment." Defendant "evicted" plaintiff, her son, and her dog, refused to treat her condition, and failed to assist her in finding other medical attention. By reason of defendant's "wrongful conduct", plaintiff was "humiliated" in the presence of other ***632** patients and her young son, and "for another two days while she sought medical assistance from other sources", her infection became "aggravated" and she endured "great pain and suffering". Alleging that defendant's waiting room "is a public place and a place to which the general public is invited and where she had a right to have her guide dog with her pursuant to Virginia Code s 63.1-171.2 [FN1]", plaintiff demanded damages ****105** resulting from "breach of his duty to treat".

> FN1. This statute, part of the "White Cane Act" (Acts 1972, c. 156), reads as follows:
>
> "s 63.1-171.2. Rights of blind and physically disabled persons in public places and places of public accommodation. (a) The blind, the visually handicapped, and the otherwise physically disabled have the same right as the able-bodied to the full and free use of the streets, highways, sidewalks, walkways, public buildings, public facilities, and other public places.
>
> "(b) The blind, the visually handicapped, and the otherwise physically disabled are entitled to full and equal accommodations, advantages, facilities, and privileges of all common carriers, airplanes, motor vehicles, railroad trains, motor buses, street cars, boats or any other public conveyances or modes of transportation, hotels, lodging places, places of public accommodation, amusement or resort, and other places to which the general public is invited, subject only to the conditions and limitations established by law and applicable alike to all persons.
>
> "(c) Every totally or partially blind person shall have the right to be accompanied by a dog guide, especially trained for the purpose, in any of the places listed in subsection (b) without being required to pay an extra charge for the dog guide; provided that he shall be liable for any damage done to the premises or facilities by such dog."

The order sustaining the demurrer was based upon two grounds. Ruling as matters of law, the trial court held that "the defendant had no duty to treat the plaintiff since he had not accepted her as a patient" and that "defendant's waiting room is not a public facility or place contemplated by" the White Cane Act. We address the first ruling in our determination whether the motion for judgment was sufficient to allege the creation of a physician-patient relationship and a duty to treat. If we determine that it was, then the trial court's second ruling bears upon the question whether defendant's withdrawal from the relationship for the reasons and under the circumstances alleged in plaintiff's motion excused non-performance of the duty to treat.

[2][3][4][5] Although there is some conflict of authority, the courts are in substantial accord upon the rules concerning the creation of a physician-patient relationship and the rights and obligations arising therefrom. In the absence of a statute, a physician has no ***633** legal obligation to accept as a patient everyone who seeks his services. Findlay v. Board of Sup'rs. of County of Mohave, 72 Ariz. 58, 230 P.2d 526 (1951); Childers v. Frye, 201 N.C. 42, 158 S.E. 744 (1931); Hurley v. Eddingfield, 156 Ind. 416, 59 N.E. 1058 (1901). A physician's duty arises only upon the creation of a physician-patient relationship; that relationship springs from a consensual transaction, a contract, express or implied, general or special, McNamara v. Emmons, 36 Cal.App.2d 199, 204-05, 97 P.2d 503, 507 (1939); and a patient is entitled to damages resulting from a breach of a physician's duty. See 61 Am.Jur.2d

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Physicians, Surgeons, Etc. s 96 (1972); 70 C.J.S. Physicians and Surgeons ss 37, 38 (1951). Whether a physician-patient relationship is created is a question of fact, turning upon a determination whether the patient entrusted his treatment to the physician and the physician accepted the case. Parkell v. Fitzporter, 301 Mo. 217, 256 S.W. 239 (1923); Hansen v. Pock, 57 Mont. 51, 187 P. 282 (1920); Peterson v. Phelps, 123 Minn. 319, 143 N.W. 793 (1913).

[6] We consider first whether the facts stated in the motion for judgment, and the reasonable inferences deducible therefrom, were sufficient to allege the creation of a physician-patient relationship and a duty to treat. Standing alone, plaintiff's allegation that she "had an appointment with defendant" would be insufficient, for it connotes nothing more than that defendant had agreed to see her. But plaintiff alleged further that the appointment she had been given was "for treatment of a vaginal infection". The unmistakable implication is that plaintiff had sought and defendant had granted an appointment at a designated time and place for the performance of a specific medical service, one within defendant's professional competence, viz., treatment of a particular ailment. It is immaterial that this factual allegation might have been contradicted by evidence at trial. Upon demurrer, the test of the sufficiency of a motion for judgment is whether it states the essential elements of a cause of action, not whether evidence might be adduced to defeat it. See Grubbs v. National Life & Co., 94 Va. 589, 591, 27 S.E. 464, 465 (1897).

We are of opinion that the motion for judgment was sufficient to allege a consensual transaction giving rise to a physician-patient relationship and a duty to perform the service contemplated, and that the trial court erred in holding as a ***634** matter of law that defendant had not accepted plaintiff as a patient.

We consider next how a physician-patient relationship, once created, may be lawfully terminated.

****106** [7] As a general rule, unless the services to be rendered are conditioned or limited by notice or by the terms of employment, the physician-patient relationship continues until the services are no longer needed, Vann v. Harden, 187 Va. 555, 565, 47 S.E.2d 314, 319 (1948); however, the relationship may be terminated earlier by mutual consent or by the unilateral action of the patient; and under certain circumstances, the physician has a right to withdraw from a case, provided the patient is afforded a reasonable opportunity to acquire the services he needs from another physician. See Annot., 57 A.L.R.2d 432, 439, s 3 (1958).

Under plaintiff's construction of the White Cane Act, defendant's withdrawal from her case was not justified by the circumstances. She argues that defendant's office was a place "to which the public is invited" within the meaning of Code s 63.1-171.2(b) and that defendant's withdrawal violated the right to which she was entitled under Code s 63.1-171.2(c). Under the trial court's construction, defendant's office was not covered by the Act and plaintiff had no statutory right to take her dog there.

[8] We are persuaded by plaintiff's argument as applied to the facts alleged in this case. It fairly appears from the face of the motion for judgment that defendant's office was a place to which certain members of the public were invited by prior appointment to receive certain treatment at certain scheduled hours. Plaintiff did not allege that defendant's office was a place to which the general public was generally invited to receive general medical services. Accordingly, while we hold that, under the facts alleged here, defendant's office was within the intendment of the White Cane Act and that the trial court erred in ruling otherwise, we believe it would be beyond the issues drawn for us to hold as a matter of law that the Act as presently written covers all physicians' offices under all circumstances.[FN2]

FN2. Nor is it necessary for purposes of this opinion to decide what effect amendments, adopted since this case arose and addressed to other statutes, may have upon

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the White Cane Act. We refer to Acts 1976, c. 596, and Acts 1977, c. 608. Under Code ss 35-42.1 and 36-124 as amended by those Acts, “medical and dental offices” are expressly designated as places of public accommodation to which “it shall be lawful for a blind person accompanied by a ‘seeing eye’ dog to take such dog.”

***635** Even if the trial court had been correct in holding that plaintiff had no statutory right to take her guide dog to defendant's office, the question yet would have remained whether plaintiff's refusal to part with her dog without the assurances she sought constituted a circumstance justifying defendant's withdrawal from her case. Also remaining would have been the other question related to defendant's right to withdraw, viz., whether, as plaintiff expressly alleged, she was denied a reasonable opportunity to acquire the services she needed from another physician. Both questions were questions of fact which, even in the absence of the White Cane Act, were the subjects of proof, and we hold that the trial court erred in sustaining the demurrer.

The judgment is reversed and the case will be remanded with instructions to restore plaintiff's motion for judgment to the docket.

Reversed and remanded.

Va. 1977.
Lyons v. Grether
218 Va. 630, 239 S.E.2d 103

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Court of Appeals of Georgia.
CLANTON et al.
v.
VON HAAM.
No. 70991.

Jan. 24, 1986.
Rehearing Denied Feb. 7, 1986.
Certiorari Denied March 12, 1986.

Plaintiff brought medical malpractice action against doctor, based on doctor's alleged negligence in failing to treat her condition immediately. The Fulton Superior Court, Eldridge, J., entered summary judgment for doctor, and plaintiff appealed. The Court of Appeals, Carley, J., held that: (1) whether physician-patient relationship had ever been established between plaintiff and doctor was question well within comprehension of average layman, so that doctors' conclusory statements as to existence of relationship were not admissible as expert testimony; (2) fact that doctor had returned plaintiff's calls and listened to symptoms did not itself establish physician-patient relationship; and (3) fact that doctor advised patient to see him in morning did not create relationship.

Affirmed.

West Headnotes

[1] Evidence 157 507

157 Evidence
157XII Opinion Evidence
157XII(B) Subjects of Expert Testimony
157k507 k. Matters of Common Knowledge or Observation. Most Cited Cases
Whether physician-patient relationship existed between plaintiff and doctor was, for purposes of medical malpractice action, matter well within comprehension of average layman, so that conclusory statements of doctors as to existence or nonexistence of relationship were not admissible as expert testimony.

[2] Health 198H 674

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(C) Particular Procedures
198Hk674 k. Orthopedics; Fractures, Sprains. Most Cited Cases
(Formerly 299k12 Physicians and Surgeons)
Fact that doctor had treated plaintiff for unrelated condition, and that he returned her call and listened to her symptoms after she telephoned his office and complained of back pains, did not itself create physician-patient relationship, for purpose of plaintiff's medical malpractice action.

[3] Health 198H 674

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(C) Particular Procedures
198Hk674 k. Orthopedics; Fractures, Sprains. Most Cited Cases
(Formerly 299k12 Physicians and Surgeons)
Fact that, as part of telephone conversation in which plaintiff complained of back pains and numbness, doctor advised plaintiff to see him in morning did not create physician-patient relationship, for purpose of plaintiff's medical malpractice action, where plaintiff did not interpret doctor's comments as acceptance of her case, but sued doctor for refusing to institute treatment immediately.

****628 *698** James A. Eichelberger, Gwendolyn R. Tyre, Atlanta, for appellants.

Lawrie E. Demorest, Mark F. Dehler, Allen S. Willingham, Atlanta, Y. Kevin Williams, Marietta, for appellee.

***694** CARLEY, Judge.

Plaintiff-appellants Mr. and Mrs. Clanton filed a multi-count medical malpractice suit against numerous defendants, including appellee Dr. Von Haam. Insofar as they have relevancy to the instant appeal, the facts which underlay appellants' suit are as follows:

Mrs. Clanton went to a hospital emergency room complaining of pain in her back. While there, she developed numbness in her legs and experienced difficulty walking. She was examined by a doctor who was on duty in the emergency room and who then released her with a prescription for pain medicine. When she returned home, the pain worsened and the numbness increased. Mrs. Clanton telephoned the emergency room and was told that the doctor who had seen her had gone home. Mrs. Clanton then called the answering service of appellee and his partner, both of whom had previously treated her for a totally unrelated condition. Appellee returned her call within a few minutes and listened to a recital of her symptoms. However, according to the allegations of the complaint, appellee "refused to make a house call and refused to agree to meet Mrs. Clanton at the hospital, but rather told her that it was too late in the evening and she would have to wait to see him in the morning." After the telephone conversation with appellee, Mrs. Clanton's condition continued to deteriorate. Several hours later, she was admitted to the hospital for treatment by another physician. She is now paralyzed. Appellants' complaint alleged that appellee "knew or should have known that Mrs. Clanton's condition was critical and in the absence of action would result in paraplegia. As a direct and proximate result of [appellee's] negligent failure to recognize the need for immediate treatment and of his negligent ****629** failure to advise Mrs. Clanton to return to the hospital for immediate additional care, Mrs. Clanton has sustained painful personal injuries and is now a paraplegic."

Appellee moved for summary judgment and supported the motion by his own affidavit. In that affidavit, he stated that, insofar as Mrs. Clanton's current physical condition is concerned, no physician- ***695** patient relationship contemplating treatment thereof had existed prior to or was created by the phone call. According to appellee's affidavit, in that conversation he had "recommended that [Mrs.] Clanton take the medication prescribed for her by another physician earlier that evening [in the emergency room] and contact him later the same morning at [appellee's] office." However, Mrs. Clanton's own version of appellee's conversation was significantly different. According to her deposition, appellee "just said, you know, there wasn't nothing he could do for me." Mrs. Clanton also testified that appellee had not asked her "to come see him in the morning or [said] that he would see [her] in the morning or anything like that." In further response to appellee's motion for summary judgment, appellants submitted a physician's affidavit stating that a physician-patient relationship had been established in the telephone conversation and that appellee had failed to exercise due care in treating Mrs. Clanton. Appellants also submitted the deposition of another physician which was to the same effect.

The trial court granted appellee's motion. Appellants appeal, contending that it was error to grant summary judgment as there remained two genuine issues of material fact. The two issues that appellants perceive to remain for jury resolution are whether a physician-patient relationship existed between appellee and Mrs. Clanton and whether appellee was negligent in treating her. Appellee's focus is on the first issue. According to appellee, notwithstanding the conclusions expressed by the various medical experts as to this issue, no such physician-patient relationship existed, as a matter of law, under the facts of the case. On this basis, appellee contends that summary judgment was properly granted in his favor.

1. "The opinions of experts on any question of science, skill, trade, or like questions shall always be admissible...." OCGA § 24-9-67. "[T]he correct rule is as follows: Expert opinion testimony on issues to be decided by the jury, even the ultimate is-

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sue, is admissible where the conclusion of the expert is one which jurors would not ordinarily be able to draw for themselves; i.e., the conclusion is beyond the ken of the average layman. [Cits.]" *Smith v. State,* 247 Ga. 612, 619, 277 S.E.2d 678 (1981). Thus, "[e]xcept in extreme circumstances," the issue of whether the defendant-physician in a medical malpractice action has complied with applicable standards of professional conduct "must be presented through expert testimony. [Cits.]" *Fountain v. Cobb Gen. Hosp.,* 167 Ga.App. 36, 37, 306 S.E.2d 37 (1983). However, it is equally clear that the scope of what is admissible as expert opinion testimony is not unlimited. It is the established rule "[i]n Georgia, [that] where (a) the path from evidence to conclusion is not 'shrouded in the mystery of professional skill or knowledge,' and (b) the conclusion determines the ultimate issues of fact in ***696** a case, the jury must make the journey from evidence to conclusion without the aid of expert testimony. [Cits.] A party may not bolster his opinion as to the ultimate issue with expert testimony when the jury could reach the same conclusion 'independently of the opinion of others.' [Cit.]" *Williams v. State,* 254 Ga. 508, 510, 330 S.E.2d 353 (1985).

[1] With regard to the issue of a physician-patient relationship in the instant case, the affidavit of appellee and the affidavit and deposition of appellants' experts all contain statements which merely express an ultimate conclusion to the effect that such a relationship either did or did not exist. In no instance is there a showing of any objective standard which was relied upon and applied in reaching those differing conclusions. It does not appear, however,****630** that any particular professional skill or specialized medical knowledge would necessarily be required to penetrate a "shroud of mystery" surrounding that issue. The established test in Georgia for determining the initial creation of a physician-patient relationship is well within the comprehension of the average layman, in that it more nearly involves the application of non-expert concepts of a contractual nature rather than any expert medical principles. The physician-patient relationship " 'is a consensual one wherein the patient knowingly seeks the assistance of the physician and the physician knowingly accepts him as a patient.' [Cit.]" *Buttersworth v. Swint,* 53 Ga.App. 602, 603-604(2), 186 S.E. 770 (1936). Accordingly, as to this issue, the differing ultimate conclusions of the physicians in the instant case evince no more than a difference of non-medical opinion between witnesses who happen to be physicians. Those conclusions are neither admissible nor probative as expert medical testimony. See generally *Williams v. State,* 254 Ga. supra at 510(2), 330 S.E.2d 353.

[2] 2. The issue remains, however, whether disregarding the opinion testimony, a jury would be authorized to find that the requisite relationship existed in the instant case. "[B]efore a plaintiff may recover on the theory that he received negligent treatment from a defendant physician, the plaintiff must show that a doctor-patient relationship existed between them. In such cases, called 'classic medical malpractice actions' ..., doctor-patient privity is essential because it is this 'relation ... which is a result of a consensual transaction' that establishes the legal duty to conform to a standard of conduct. [Cit.]" *Bradley Center, v. Wessner,* 250 Ga. 199, 201, 296 S.E.2d 693 (1982). The evidence is that, notwithstanding the late hour, appellee, who had treated Mrs. Clanton previously but for a totally unrelated condition, elected to return her telephone call. He then listened to a full recital of her symptoms. However, this alone does not create a patient-physician relationship. "Merely that the defendant was a physician and knew of the condition of the plaintiff would not devolve ***697** upon him the duty of rendering to her medical care, even though he was applied to for services by the plaintiff herself and through others; for there is no rule of law that requires a physician to undertake the treatment of every patient who applies to him.... '[O]ne who has secured a [medical] license according to statute is not liable for damages alleged to result from the refusal to take a case.' [Cits.]" *Buttersworth v. Swint,* supra 53 Ga.App. at 604, 186 S.E. 770.

[3] The crucial issue is whether the evidence regarding the telephone conversation would authorize a finding of a "consensual transaction" whereby Mrs. Clanton became appellee's patient for treatment of her then existing condition. Appellee testified that, in his late night conversation, he "recommended" that Mrs. Clanton continue the immediate course of treatment prescribed by another physician and that she should call him back in the morning. An individual, hearing only such a recommendation in response to a late night solicitation for medical assistance might well assume that he or she had been accepted as a patient by the physician rendering it and, to his or her ultimate detriment, follow that advice and suspend further efforts to secure medical treatment from another source. However, it is undisputed that that did not happen in the instant case. Notwithstanding what appellee states he may have "recommended" to Mrs. Clanton, she herself interpreted the conversation as a total refusal of her efforts to secure appellee's medical services. It is undisputed that she never considered that, as the result of the telephone call, appellee had undertaken to render his medical expertise available to her then or at any time in the future. There is no dispute that Mrs. Clanton never relied upon any medical advice whatsoever from appellee and that she was in no way dissuaded from seeking medical attention elsewhere as the result of the conversation. She ultimately seeks to recover, not on the basis that appellee actually afforded her negligent treatment which she then followed**631 to her injury, but solely on the basis that appellee refused to initiate non-negligent treatment by which she might have avoided injury. The evidence thus shows without contradiction that there was never a "consensual transaction" between appellee and as treating physician and Mrs. Clanton as patient regarding her current physical condition. The evidence showing that no relationship was created which gave rise to any professional duty, the breach of which duty proximately caused Mrs. Clanton's existing condition, the trial court did not err in granting summary judgment. See generally *Buttersworth v. Swint,* supra; *Meeks v. Coan,* 165 Ga.App. 731, 733(2), 302 S.E.2d 418 (1983); *Hansell, Post, Brandon & Dorsey v. Fowler,* 160 Ga.App. 732, 288 S.E.2d 277 (1981).

Judgment affirmed.

BIRDSONG, P.J., and SOGNIER, J., concur.
Ga.App.,1986.
Clanton v. Von Haam
177 Ga.App. 694, 340 S.E.2d 627

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Supreme Court of Utah.
RICKS
v.
BUDGE ET AL.
No. 5605.

Jan. 4, 1937.
As Corrected on Denial of Rehearing Feb. 9, 1937.

Duty
198HV(G) Actions and Proceedings
198Hk824 Questions of Law or Fact and Directed Verdicts
198Hk825 k. In General. Most Cited Cases
(Formerly 299k18.90 Physicians and Surgeons)
Evidence that physician refused to treat patient's infected hand and finger and that patient was damaged thereby *held* for jury.

Health 198H **820**

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk815 Evidence
198Hk820 k. Admissibility. Most Cited Cases
(Formerly 299k18.70 Physicians and Surgeons)
In patient's action against physician for damages arising out of physician's refusal to treat patient, refusal to permit patient to testify whether he was prepared for another operation when physician came to hospital *held* erroneous.
***209** George C. Buckle and J. Quill Nebeker, both of Ogden, and Walter S. Acheson, of Seattle, Wash., for appellant.

Budge, Parker & Romney, of Salt Lake City, for respondents.

EPHRAIM HANSON, Justice.

This is an action for malpractice against the defendants who are physicians and surgeons at Logan, Utah, and are copartners doing business under the name and style of the "Budge Clinic." The complaint contains two causes of action. The first alleges that the defendants were negligent in failing to properly treat and care for plaintiff and were negligent in discharging him from the hospital before his condition warranted such discharge. For the second cause of action plaintiff alleges that he was suffering from an infected right hand and was in immediate need of medical and surgical care and treatment, and there was danger of his dying unless he received such treatment; that defendants for the purpose of treating plaintiff sent him to the Budge Memorial Hospital at Logan, Utah; that while at the hospital and while he was in need of medical and surgical treatment, defendants refused to treat or care for plaintiff and abandoned his case. At the conclusion of the evidence defendants moved for and the court granted a directed verdict as to each cause of action. To review the rulings of the court granting these motions, plaintiff appeals to this court.

We shall deal with each cause of action separately. The evidence shows that on or about March 8, 1935, plaintiff caught the middle finger of his right hand on a barbed wire. Soon thereafter the finger and hand began to swell and became reddened. In the early morning of March 11th, plaintiff went to the Budge Memorial Hospital to seek treatment from the defendants. Dr. S. M. Budge, one of the defendants, was performing an emergency operation at the hospital at the time plaintiff arrived. Immediately on finishing the ***210** operation, he made an examination of plaintiff to determine the nature and extent of plaintiff's injury and the treatment necessary therefor. Dr. Budge made two lateral incisions in the finger, waited a few hours to see the result, and then later the same morning deepened the incisions in order to reach the pus, which he believed had developed. A gauze wick was then put in each incision for the purpose of drainage.

The plaintiff remained in the hospital from March

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11th until March 15th, during which time he was under the care of Dr. S. M. Budge. Plaintiff received while in the hospital the usual care and treatment given for such an injury, and under that treatment made favorable progress towards recovery. On the morning of March 15th, plaintiff told the nurse and Dr. Budge that he intended leaving the hospital that morning. Dr. Budge advised plaintiff against leaving, but notwithstanding the protests of Dr. Budge, plaintiff left the hospital after paying the amount that was due at that time.

There is no evidence whatever to show that the treatment which plaintiff received from Dr. Budge was not proper in every respect. We have examined the record carefully and are unable to find any evidence that even tends to show that the defendants were negligent as alleged in the first cause of action. As to the claim that plaintiff was discharged from the hospital before his condition warranted such discharge, there is no merit whatever. The evidence shows that plaintiff believed his condition to be such that he could take care of himself at home and save the hospital expense; that he was advised by Dr. Budge to remain in the hospital until his condition was further improved, but instead of doing so, over the objection of Dr. Budge, he left the hospital and returned to his home. Under the evidence the trial court was justified in directing a verdict in favor of the defendants in the first cause of action.

The second cause of action, however, presents a more serious question. As to that cause of action the evidence shows that when plaintiff left the hospital on March 15th, Dr. Budge advised him to continue the same treatment that had been given him at the hospital, and that if the finger showed any signs of getting worse at any time, plaintiff was to return at once to Dr. Budge for further treatment; that on the morning of March 17th, plaintiff telephoned Dr. Budge, and explained the condition of his hand; that he was told by the doctor to come to his office, and in pursuance of the doctor's request, plaintiff reported at the doctor's office at 2 p. m. of that day. Dr. Budge again examined the hand and told plaintiff the hand was worse; he called in Dr. D. C. Budge, another of the defendants, who examined the hand, scraped it some, and indicated thereon where the hand should be opened. Dr. S. M. Budge said to plaintiff: “You have got to go back to the hospital.” Plaintiff said he would like a different room from the one he had before, but the doctor told him he would have to take the same room. Plaintiff left immediately for the hospital. Upon arriving there, he was assigned by the matron to the same room he had before, and went to bed at once. The nurse who previously had charge of plaintiff, brought a boric acid solution in which plaintiff began to soak his hand. Within a short time after the arrival of plaintiff, Dr. S. M. Budge arrived at the hospital. Plaintiff testified: “He [meaning Dr. S. M. Budge] came into my room and said, ‘You are owing us. I am not going to touch you until that account is taken care of.’ ” (The account referred to was, according to plaintiff, of some years' standing and did not relate to any charge for services being then rendered.) Plaintiff testified that he did not know what to say to the doctor, but that he finally asked the doctor if he was going to take care of him, and the doctor replied: “No, I am not going to take care of you. I would not take you to the operating table and operate on you and keep you here thirty days, and then there is another $30.00 at the office, until your account is taken care of.” Plaintiff replied: “ If that is the idea, if you will furnish me a little help, I will try to move.”

Plaintiff testified that this help was furnished, and that after being dressed, he left the Budge Memorial Hospital to seek other treatment. At that time it was raining. He walked to the Cache Valley Hospital, a few blocks away, and there met Dr. Randall, who examined the hand. Dr. Randall testified that when the plaintiff arrived at the Cache Valley Hospital, the hand was swollen with considerable fluid oozing from it; that the lower two-thirds of the forearm was red and swollen from the infection which extended up in the arm, and that there was some fluid also oozing ***211** from the back of the hand, and

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that plaintiff required immediate surgical attention; that immediately after the arrival of plaintiff at the hospital he made an incision through the fingers and through the palm of the hand along the tendons that led from the palm and followed those tendons as far as there was any bulging, and opened it up thoroughly all the way to the base of the hand and put drain tubes in. Plaintiff remained under the care of Dr. Randall for approximately a month. About two weeks after the plaintiff entered the Cache Valley Hospital, it became necessary to amputate the middle finger and remove about an inch of the metacarpal bone.

Dr. S. M. Budge testified that at the time he sent the plaintiff to the Budge Memorial Hospital on March 17th, plaintiff was in a dangerous condition and needed immediate surgical and medical attention; that the reason for sending him to that hospital was in order to give him the necessary immediate surgical and medical attention. There can be no question that both Dr. S. M. Budge and Dr. D. C. Budge, on the examination of plaintiff's hand at their office on March 17th, decided that immediate surgical intervention thereon was necessary. The plaintiff testified that at the time he was sent to the hospital by the defendants on March 17th, his hand was badly swollen; that he was unable to move any of his fingers on that hand; that the hand was full of blisters which had broken and were oozing; and that blood was dripping from the places scraped by Dr. D. C. Budge. Dr. S. M. Budge arrived at the hospital a short time after the arrival of plaintiff for the purpose of giving plaintiff such medical and surgical attention as he deemed necessary. There can be no question from the evidence that it was the intention of Dr. S. M. Budge to operate at once on plaintiff's hand.

Defendants contend: (1) That there was no contract of employment between plaintiff and defendants and that defendants in the absence of a valid contract were not obligated to proceed with any treatment; and (2) that if there was such a contract, there was no evidence that the refusal of Dr. S. M. Budge to operate or take care of plaintiff resulted in any damage to plaintiff.

We cannot agree with either of these propositions. The evidence shows that plaintiff had been under the care and treatment of the defendants at the Budge Memorial Hospital from March 11th to March 15th; that when he left that hospital on March 15th, Dr. S. M. Budge said to him: "If you are going home, you had better follow out the treatment at home just as near as you can the same as you were doing here. Here is another thing I want to tell you, if you see any signs of that finger getting worse at any time, you come in and see me immediately." On March 17th, plaintiff, realizing that his condition was getting worse, telephoned Dr. S. M. Budge and was told by that doctor to come to the doctor's office, which plaintiff did; that there both Dr. S. M. Budge and Dr. D. C. Budge examined the hand; that Dr. D. C. Budge indicated on it where it should be opened; and that under the instructions of these doctors plaintiff was returned to the hospital for no other purpose than having his hand operated upon at once.

Under this evidence, it cannot be said that the relation of physician and patient did not exist on March 17th. It had not been terminated after its commencement on March 11th. When the plaintiff left the hospital on March 15th, he understood that he was to report to Dr. S. M. Budge if the occasion required and was so requested by the doctor. Plaintiff's return to the doctor's office was on the advice of the doctor. While at the doctor's office, both Dr. S. M. Budge and Dr. D. C. Budge examined plaintiff's hand and they ordered that he go at once to the hospital for further medical attention. That plaintiff was told by the doctor to come to the doctor's office and was there examined by him and directed to go to the hospital for further treatment would create the relationship of physician and patient. That the relationship existed at the time the plaintiff was sent to the hospital on March 17th cannot be seriously questioned.

We believe the law is well settled that a physician

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or surgeon, upon undertaking an operation or other case, is under the duty, in the absence of an agreement limiting the service, of continuing his attention, after the first operation or first treatment, so long as the case requires attention. The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship, or by the discharge of the physician by the patient, or by the withdrawal from the case by the physician after giving the patient reasonable notice so as to enable the patient to secure other medical***212** attention. A physician has the right to withdraw from a case, but if the case is such as to still require further medical or surgical attention, he must, before withdrawing from the case, give the patient sufficient notice so the patient can procure other medical attention if he desires. 21 R.C.L. 389; 48 C.J. 1128, § 115; Bolles v. Kinton, 83 Colo. 147, 263 P. 26, 56 A.L.R. 814; Williams v. Gilman, 71 Me. 21; Stohlman v. Davis, 117 Neb. 178, 220 N.W. 247; Bowers v. Santee, 99 Ohio St. 361, 124 N.E. 238; Gillette v. Tucker, 67 Ohio St. 106, 65 N.E. 865, 93 Am.St.Rep. 639; Moore v. Lee, 109 Tex. 391, 211 S.W. 214, 4 A.L.R. 185; Huber v. Hamley, 122 Wash. 511, 210 P. 769.

In Mucci v. Houghton, 89 Iowa 608, 57 N.W. 305, 306, the court announces the law as follows: "If a physician or surgeon be sent for to attend a patient, the effect of his responding to the call, in the absence of a special agreement, will be an engagement to attend the case as long as it needs attention, unless he gives notice of his intention to discontinue his services, or is dismissed by the patient; and he is bound to exercise reasonable and ordinary care and skill in determining when he should discontinue his treatment and services."

The Maine court in Ballou v. Prescott, 64 Me. 305, said:

"The care and skill which a professional man guarantees to his employer are elements of the contract to which he becomes a party on accepting a proffered engagement. They are implied by the law as resulting from that engagement, though it be but verbal, and nothing said in relation to such elements. So continued attention to the undertaking so long as attention is required in the absence of any stipulation to the contrary, is equally an inference of the law. If a counsellor at law undertakes the management of a cause, nothing more being said or done than simply an offer and acceptance of a retainer for that purpose, it will hardly be denied that an abandonment of the cause before its close would be as much a violation of the contract with the client as a neglect to use the requisite care and skill in its prosecution, and the duty of continued attention is equally an implication of the law as that of exercising the required care and skill.

That the same principles apply to the employment of a physician or surgeon there can be no doubt. If he is called to attend in the usual manner, and undertakes to do so by word or act, nothing being said or done to modify this undertaking, it is quite clear as a legal proposition that not only reasonable care and skill should be exercised, but also continued attention so long as the condition of the patient might require it, in the exercise of an honest and properly educated judgment, and certainly any culpable negligence in this respect would render him liable in an action. Barbour v. Martin, 62 Me. 536; Shearman & Redfield on Negligence, § 441."

"A physician who leaves a patient, at a critical stage of the disease, without reason, or sufficient notice to enable the party to procure another medical attendant, is guilty of a culpable dereliction of duty." Barbour v. Martin, 62 Me. 536.

"When a physician is employed to attend upon a sick person, his employment continues while the sickness lasts, unless put to an end by the assent of the parties, or revoked by the express dismissal of the physician. * * * In the absence of special agreement, his engagement is to attend the case as long as it requires attention, unless he gives notice of his intention to discontinue his visits, or is dismissed, as aforesaid; and he is bound to exercise reasonable and ordinary care and skill in determining when his attendance should cease." Lawson v. Conaway, 37

W.Va. 159, 16 S.E. 564, 18 L.R.A. 627, 38 Am.St.Rep. 17.

When a physician is employed to attend upon a sick person, his employment, as well as the relation of physician and patient, continues, in the absence of a stipulation to the contrary, as long as attention is required; and the physician or surgeon must exercise reasonable care in determining when the attendance may be properly and safely discontinued." Dashiell v. Griffith, 84 Md. 363, 35 A. 1094, 1096.

We have briefly reviewed the evidence showing the urgent need of plaintiff for medical and surgical attention at the time Dr. S. M. Budge refused plaintiff further treatment. As the case stands on the record before us, we must consider the evidence in the most favorable light of which it is reasonably susceptible in behalf of plaintiff. The evidence warrants the inference that plaintiff was being prepared for an operation when Dr. S. M. Budge arrived at the hospital and told the plaintiff that he would give him no further medical attention until something was done ***213** about the old account.

We cannot say as a matter of law that plaintiff suffered no damages by reason of the refusal of Dr. S. M. Budge to further treat him. The evidence shows that from the time plaintiff left the office of the defendants up until the time that he arrived at the Cache Valley Hospital his hand continued to swell; that it was very painful; that when he left the Budge Memorial Hospital he was in such condition that he did not know whether he was going to live or die. That both his mental and physical suffering must have been most acute cannot be questioned. While the law cannot measure with exactness such suffering and cannot determine with absolute certainty what damages, if any, plaintiff may be entitled to, still those are questions which a jury under proper instructions from the court must determine.

Inasmuch as the views heretofore expressed require us to remand the case for a new trial, it becomes our duty to consider certain other specifications of error. We think it is immaterial and irrelevant as to how many children plaintiff might have and, therefore, the objection to such question was properly sustained.

A question propounded to plaintiff by his own attorney as to whether he was at the time Dr. Budge came to the hospital prepared for another operation was objected to, and the objection sustained, as being leading and calling for a conclusion. This we think was error. It would seem to relate wholly to his readiness and convenience to have the operation performed at that time. We think the ruling erroneous, although not prejudicial. Plaintiff was further asked to compare the treatment he gave his hand while at home with the treatment he had received at the hospital. Objection thereto was sustained and we think erroneously. Inasmuch as plaintiff, before he left the hospital, had been directed quite specifically how to treat his hand while at home, it would seem to be most obvious for him to be permitted to state just how he treated his hand during the time he was at home. Nor do we see any reason why plaintiff should not be permitted to state what treatment was given to his hand after the operation, during the time he remained at the hospital. We think the objection thereto was erroneously sustained.

Other specifications of error are made, and while some of them may be said to be well taken, it nevertheless appears that they were not prejudicial.

Respondents filed a motion to dismiss the appeal because the transcript was not filed within the time fixed by law and the rules of this court, or within the period of any extension of time granted for the filing thereof. The appeal was perfected by the service and filing of the notice of appeal on July 19, 1934. The transcript on appeal was received by the clerk of this court August 2, 1934. Because the necessary fees were not forwarded to the clerk, the transcript was not filed until August 24, 1934. This, as counsel for plaintiff states in their brief, "may technically show that the appellant was four days late in filing the transcript, due to the fact that appellant and his counsel live in different parts of the

state."

We have held that a delay in filing the record is not jurisdictional and will not justify a dismissal of the appeal when no prejudice results. Lukich v. Utah Construction Co., 48 Utah, 452, 160 P. 270; Merrill v. Coon, 57 Utah, 240, 193 P. 1108; Robinson v. Union Pac. R. Co., 70 Utah, 441, 261 P. 9; Obradovich v. Walker Bros. Bankers, 80 Utah, 587, 16 P.(2d) 212.

In this case no prejudice is made to appear because of the late filing of the transcript. Especially is that true as the motion to dismiss did not come until after the briefs were filed and the case argued on merits.

For the reasons stated, the judgment of the lower court is reversed, and the cause is remanded to the district court of Cache county for a new trial. Appellant to recover his costs.

ELIAS HANSEN, C. J., and MOFFAT, J., concur.WOLFE, Justice (concurring).

If there was any evidence which was competent to go to the jury on the first cause of action, there certainly was no evidence of damage suffered. Up to the time plaintiff left the hospital against the advice of the doctors on the 15th of March, he was rapidly improving. He complains: (a) That his hand was bathed in water of improper temperature; (b) that respondents***214** failed to lance the finger deep enough properly to drain the pus; (c) that respondents failed to remove a piece of metal from the finger; (d) that gauze was inserted in the incision too tightly to permit drainage; and (e) that respondents failed to examine the incisions frequently enough. There is no expert testimony as to (b) and (d). A layman's opinion on these matters would not be sufficient. There may be acts of commission or omission which a jury of intelligent laymen could say were negligence. I doubt if (a) or (e) are of this character, but even if there is evidence of such acts which could go to the jury without expert testimony that it did not constitute the treatment usually employed by skilled and competent physicians in that locality, there certainly was no evidence that it did any harm. As to (c) there is no evidence that there was any metal in the finger to take out. Dr. Randall testified that he found none. If there was any negligence, the patient improved because or in spite of it--most of us would be satisfied with treatment that brought recovery. I concur in the findings of the prevailing opinion that the directed verdict for the defendants on the first cause of action was proper. On the 15th of March the relationship of doctor and patient was terminated by the acts of plaintiff. Any advice the doctors gave him prior to his departure was because of their solicitation for his future. Such ministrations, if according to standard, cannot be converted into a basis of liability.

I concur with the findings of that opinion that the directed verdict on the second cause of action was improperly directed, but for a different reason. We must assume the evidence in its most favorable light for the plaintiff in testing this motion. I think there was sufficient evidence to go to the jury on the question as to whether the defendants reassumed the relationship of doctor and patient on March 17th. The plaintiff was told to come to the doctor's office; Dr. S. M. Budge examined the hand; Dr. D. C. Budge scraped it and indicated that it would have to be opened. They thereupon sent the patient to what was, to all intents and purposes of this case, their hospital. The jury might well come to the conclusion that they sent him to their hospital only on the assumption that they intended to treat him. If the jury should find that the relationship of doctor and patient had been resumed on March 17th, which it well might, they would next have to determine whether the doctors abandoned that relationship with too peremptory a notice under such circumstances as would make the plight of the plaintiff more dangerous and in such a way as not to give him opportunity to procure other medical aid in order to make the transition from one doctor to another without substantial hazard. I think there was evidence to go to the jury on this issue.

As to whether the several hours' delay and

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plaintiff's having to walk out in the rain aggravated the danger or made recovery more difficult, or resulted in the loss of the finger which might have been otherwise saved, is for the jury if there is evidence to go to it on that point. While I have some doubt as to whether there is competent evidence on this point, I think the doubt must be resolved in favor of plaintiff and that it was for the jury. There certainly may have been prolonged suffering by the delay and on that element the jury may find him entitled to some damages.

There are several assignments of error on rulings rejecting evidence, which, since this opinion was written, the main opinion now mostly covers. Error in every case, if any, was inconsequential. The sustained objections to the questions as to the number of children and financial condition of plaintiff were proper rulings. The answers sought to be elicited were immaterial. The question as to whether plaintiff "suffered great mental anguish" was too ultimate to be proper. Objection was properly sustained on the ground that it was a conclusion. The call should have been for the underlying fact of plaintiff's state of mind so this might or might not be inferred.

Plaintiff was asked whether, at the time Dr. Budge came to him in the hospital on March 17th, he was "prepared for another operation." This was equivalent to asking him if he "was ready" for another operation. It is difficult to see how it could be broken down into more elemental constituents. It was the same as asking him if he was then willing that the doctor go ahead and operate. The sustaining of the objection was error.

The plaintiff was asked to describe the treatment he gave to his hand at home as compared to that given at the hospital. ***215** The question was plainly improper in form. The witness, if the question was at all material, should have been asked what treatment he gave his hand at home and the jury be left to make the comparison. But on the theory that there was not a continuing relationship of doctor and patient between March 15th, when plaintiff left the hospital, and March 17th, when he returned to the clinic, the question is immaterial. The objection was properly sustained.

The other assignments were not argued in the brief.

FOLLAND, Justice (concurring in part, dissenting in part).

I concur fully in that part of the opinion sustaining the trial court in directing a verdict in favor of defendants on the first cause of action. I cannot concur in what is said or in the result with respect to the second cause of action. As I view the case the contract of employment between Dr. Budge and Mr. Ricks was terminated by Ricks at the time he paid his bill and left the hospital on March 15th. There is no dispute whatsoever in the testimony with respect to the fact that he did this without the consent and against the advice of Dr. Budge. The testimony of Dr. D. C. Budge and Dr. S. M. Budge shows their protest was much more emphatic than indicated by plaintiff's testimony. A physician ought not to be censured or held liable for any bad results following the voluntary action of a patient in leaving the hospital where he could receive proper treatment. At the time Ricks left the hospital his hand was responding to treatment and the patient was in the process of recovery. Instructions given by the doctor were such as any physician would give under the circumstances, and his admonition to "come and see me immediately" if the condition became worse was merely the equivalent of advising him to go and see a physician if there was any change for the worse. The contract relationship having terminated, Dr. Budge was, of course, under no obligation to treat the patient at the Ricks' home some six miles out of Logan. The appellant did not ask for nor expect any such thing. He determined to treat himself at his home and to take the chances of what might happen when he did so.

Before there can be liability on the second cause of action, there must have been. first, a new contract of employment between the parties, and, second, damage because of failure or refusal of Dr. Budge to operate and further treat the patient. I think the

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evidence does not support a finding either that there was a new contract of employment or that any damage resulted from failure to treat the patient, and therefore the trial court properly directed a verdict.

Plaintiff's second cause of action alleges that the contract of employment was entered into on or about the 17th of March. The theory of plaintiff as evidenced in his complaint is that there was no continued relationship from the first employment but that a new relationship was entered into. He visited the clinic on March 17th; the Doctors Budge examined his hand and told him an immediate operation was necessary and for him to go to the hospital. I do not think a new contract was entered into at that time. There was no consideration for any implied promise that Dr. Budge or the Budge Clinic would assume the responsibility of another operation and the costs and expenses incident thereto. As soon as Dr. Budge reached the hospital he opened negotiations with the plaintiff which might have resulted in a contract, but before any contract arrangement was made the plaintiff decided to leave the hospital and seek attention elsewhere. As soon as he could dress himself he walked away. There is conflict in the evidence as to the conversation. Plaintiff testified in effect that Dr. Budge asked for something to be done about an old account. The doctor's testimony in effect was that he asked that some arrangement be made to take care of the doctor's bill and expenses for the ensuing operation and treatment at the hospital. The result, however, was negative. No arrangement was made. The plaintiff made no attempt whatsoever to suggest to the doctor any way by which either the old account might be taken care of or the expenses of the ensuing operation provided for. Of course, for the purpose of deciding the rightfulness of the trial court's action in directing a verdict, we must take plaintiff's version as true. The jury might well have found that the doctor's version was far more reasonable and the true version of what actually happened. Under either view Dr. Budge had a right to refuse to incur the obligation and responsibility incident to one or more operations and the treatment and attention which would be ***216** necessary. If it be assumed that the contract relationship of physician and patient existed prior to this conversation, either as resulting from the first employment or that there was an implied contract entered into at the clinic, yet Dr. Budge had the right with proper notice to discontinue the relationship. While plaintiff's condition was acute and needed immediate attention, he received such immediate attention at the Cache Valley Hospital. There was only a delay of an hour or two, and part of that delay is accounted for by reason of the fact that the doctor at the Cache Valley Hospital would not operate until some paper, which plaintiff says he did not read, was signed. Plaintiff said he could not sign it but that it was signed by his brother before the operation was performed. We are justified in believing that by means of this written obligation, provision was made for the expenses and fees about to be incurred. I am satisfied from my reading of the record that no injury or damage resulted from the delay occasioned by plaintiff leaving the Budge Hospital and going to the Cache Valley Hospital. He was not in such desperate condition but that he was able to walk the three or four blocks between the two hospitals. Dr. Randall testified he gave the same treatment and performed the same operation as would have been given and performed two or three hours earlier.

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91 Utah 307, 64 P.2d 208

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Court of Appeal, First District, Division 1, California.
Brenda Marie PAYTON, Appellant,
v.
John C. WEAVER, Jr., M.D., Providence Hospital, Herrick Hospital, Alta Bates Hospital, BMA of Oakland, Inc., etc., Respondents.
Civil 50094.

April 26, 1982.
Hearing Denied June 23, 1982.
As Modified on Denial of Rehearing May, 26, 1982.

250III Jurisdiction, Proceedings, and Relief
250k187 Appeal and Error
250k187.10 k. Determination and Disposition of Cause. Most Cited Cases
In proceedings in form of petition for writ of mandate, Court of Appeal had no authority to "remand" for institution of voluntary conservatorship over petitioner. West's Ann.Prob.Code § 1802.
****226 *40** Warren B. Wilson, Joanne F. Casey, Wilson & Casey, Oakland, for appellant.

Charles Bond, Professional Law Corp., San Francisco, Marrs A. Craddick, Craddick & Candland, Walnut Creek, for respondents John C. Weaver, Jr., M.D. and BMA of Oakland, Inc.

Phillip S. Berry, Berry & Berry, Oakland, for respondent Providence Hospital.

William J. Bush, Stephen B. Peck, Hanson, Bridgett, Marcus, Vlahos & Stromberg, San Francisco, for respondents Alta Bates Hospital and Herrick Hospital.

Jerome Berg, San Francisco, for amicus curiae Union of American Physicians and Dentists.

Kenneth L. Freeman, San Francisco, Robert J. Pristave, Drew P. Kaplan, Ross, Hardies, O'Keefe, Babcock & Parsons, Chicago, Ill., for amicus curiae Renal Physicians Ass'n.

GRODIN, Associate Justice.FN*

FN* Assigned by the Chairperson of the Judicial Council.

Occasionally a case will challenge the ability of the law, and society, to cope effectively and sensitively with fundamental problems of human existence. This is such a case. Appellant, Brenda Payton, is a 35-year-old black woman who suffers from a permanent and irreversible loss of kidney function, a condition known as chronic end stage renal disease. To stay alive, she must subject herself two or three times a week to hemodialysis (dialysis), a process in which the patient's circulatory system is connected to a machine through which the blood is passed. Using salts and osmotic membrances, artificial kidneys in the machine drain the blood of excess liquids and accumulated impurities.***41** Without such treatment, the volume of liquids in the patient's system will increase dangerously; liquid will begin to fill the lungs, making breathing difficult and possibly leading to heart failure. The resulting toxic waste build-up and chemical imbalances can also threaten the function of the heart and other organs.

Brenda has other difficulties. Unable to care for her children, she lives alone in a ****227** low-income housing project in West Oakland, subsisting on a $356 per month Social Security check. She has no family support; one brother is in prison and another is a mental patient. She confesses that she is a drug addict, having been addicted to heroin and barbiturates for over 15 years. She has alcohol problems, weight problems and, not surprisingly, emotional problems as well.

Despite these difficulties Brenda appears from the record to be a marvelously sympathetic and articulate individual who in her lucid moments possesses a great sense of dignity and is intent upon preserving her independence and her integrity as a human being. At times, however, her behavior is such as to make extremely difficult the provision of medical care which she so desperately requires.

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The other principal figure in this case is respondent John C. Weaver, Jr., a physician specializing in kidney problems. He conducts his practice through respondent Biomedical Application of Oakland, Inc. (BMA), which operates an outpatient dialysis treatment unit on the premises of respondent Providence Hospital.

Dr. Weaver began treating Brenda in 1975 when, after the birth of Brenda's twin daughters, her system rejected a transplanted kidney. He has been treating her ever since. To her, "Dr. Weaver is and was and still is the man between me and death ... other than God, I don't think of nobody higher than I do Dr. Weaver."

On December 12, 1978, Dr. Weaver sent Brenda a letter stating he would no longer permit her to be treated at BMA because of her "persistent uncooperative and antisocial behavior over ... more than ... three years ... her persistent refusal to adhere to reasonable constraints of hemodialysis, the dietary schedules and medical prescriptions ... the use of barbiturates and other illicit drugs and because all this resulted in disruption of our program at BMA."

***42** In the latter part of 1978, Brenda applied for admission to the regular dialysis treatment programs operated by respondents Alta Bates and Herrick hospitals, and was refused.

For several months Dr. Weaver continued to provide Brenda with necessary dialysis on an emergency basis, through Providence. On April 23, 1979, he again notified her by letter that he would no longer treat her on an outpatient basis. This letter led to Brenda's filing of a petition for mandate to compel Dr. Weaver, BMA, and Providence to continue to provide her with outpatient dialysis services. That litigation was settled by a stipulated order which called for continued treatment provided Brenda met certain conditions: that she keep all appointments at their scheduled time; that she refrain from use of alcohol and drugs; that she maintain prescribed dietary habits; and that she "in all respects cooperate with those providing her care and abide by her physician's prescribed medical regimen." Later, a sixth stipulation was added: that Brenda would "enter into and participate in good faith in a program of regular psychotherapy and/or counselling."

Dr. Weaver and BMA continued treatment of Brenda as an outpatient pursuant to the stipulation, but on March 3, 1980, Dr. Weaver, contending that Brenda had failed to fulfill any part of the bargain, again notified her that treatment would be terminated. He provided her with a list of dialysis providers in San Francisco and the East Bay, and volunteered to work with her counsel to find alternative care.

Brenda then instituted a second proceeding, again in the form of a petition for writ of mandate, this time naming Herrick and Alta Bates hospitals as respondents, along with Dr. Weaver, BMA and Providence. As pertinent here, the petition alleges that all respondents have "wrongfully failed and refused and continue to fail and refuse to provide Petitioner with regular hemodialysis treatment and medical supervision as required by her chronic end-stage kidney condition"; and, more specifically, that the refusal by Herrick and Alta Bates to admit her as an outpatient to their dialysis treatment programs violated their obligations under Health and Safety Code section 1317 to provide "emergency" treatment. The petition also contained allegations that Herrick and Alta Bates had discriminated ****228** against her on grounds of race and indigency, in violation of the Civil Rights Act of 1968 and the Hill-Burton Act (42 U.S.C. § 291), but the trial court found these allegations to be unsupported, and they are not at issue here.

***43** The trial court, after a lengthy evidentiary hearing, found that Brenda had violated each and every condition which she had accepted as part of the stipulated order providing for continued treatment, and that finding is basically undisputed. There was evidence that Brenda continued, after the stipulated order, to buy barbiturates from pushers on the street at least twice a week; that she failed to restrict her

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diet, gaining as much as 15 kilograms between dialysis treatments; that she continued to be late and/or miss appointments; that due primarily to missed appointments she had 30 emergencies requiring hospitalization in the 11 months preceding trial; that she would appear for treatment in an intoxicated condition; that she discontinued her program of counseling after a brief period; and, as the trial court found, she displayed in general "gross non-cooperation with her treating physician, BMA of Oakland and Providence Hospital." The trial court found that her behavior in these respects was "knowing and intentional."

Brenda's behavior was found to affect not only Dr. Weaver but the other patients and the treating staff as well. Dialysis treatment is typically provided to several patients at a time, all of them connected to a single dialysis machine. There was evidence that Brenda would frequently appear for treatment late or at unscheduled times in a drugged or alcoholic condition, that she used profane and vulgar language, and that she had on occasion engaged in disruptive behavior, such as bothering other patients, cursing staff members with obscenities, screaming and demanding that the dialysis be turned off and that she be disconnected before her treatment was finished, pulling the dialysis needle from the connecting shunt in her leg causing blood to spew, and exposing her genitals in a lewd manner. The trial court found that during the times she has sought treatment "her conduct has been disruptive, abusive, and unreasonable such as to trespass upon the rights of other patients and to endanger their rights to full and adequate treatment," and that her conduct "has been an imposition on the nursing staff." The court determined that, on balance, the rights and privileges of other patients endangered by Brenda's conduct were superior to the rights or equities which Brenda claimed.

The court also found, contrary to Brenda's contentions, that Dr. Weaver had given sufficient notice to Brenda, and that Dr. Weaver was not responsible for Brenda being refused dialysis by any other respondent. It concluded that Dr. Weaver had "discharged all obligations imposed by the patient-physician relationship" with Brenda.

***44** As to Alta Bates and Herrick hospitals the court found that they had not refused Brenda "emergency" treatment in violation of Health and Safety Code section 1317. In late 1978, after receiving notification from Dr. Weaver that he would no longer treat her, Brenda made application to the *regular outpatient dialysis programs* at these two hospitals and was refused-for reasons, as the trial court found, that did not include her race, her indigency, or any actions on the part of Dr. Weaver. It concluded, on the basis of reasoning which we shall discuss later in this opinion, that Brenda's chronic kidney disease did not itself constitute an "emergency" within the meaning of that section.

Finally, the trial court found that Brenda "has freedom of several choices available by which she can be kept away from dangerous drugs and alcohol, helped to stay on a proper dietary regimen, and in all other ways caused to cooperate with those attempting to provide her with care," so that she is "not without means to arrange for her own care." It concluded, after a weighing of the equities, that Brenda "has no legal right to compel medical service from any of the Respondents for chronic or regular care of her kidney problems through dialysis," and so denied her petition for writ of mandate. At the same time, however, the court stayed execution of its judgment ****229** and continued in effect its temporary order requiring Dr. Weaver, and BMA, to provide hemodialysis to Brenda on a regular basis pending appeal.[FN1]

FN1. Dr. Weaver initially appealed from this order, and then sought relief through petition for writ of supersedeas. On February 20, 1981, this court granted the supersedeas petition, but on March 11, 1981, the Supreme Court ordered that the June 30, 1980, trial court order should stay in effect during the pendency of the appeal. Since the trial court's order will cease to have ef-

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fect once our opinion becomes final, it is unnecessary for us to consider it as an independent subject of review.

Discussion

[1] We begin our analysis by considering the trial court's conclusion that Dr. Weaver and the clinic with which he is associated have no present legal obligation to continue providing Brenda with dialysis treatment. Brenda does not claim that Dr. Weaver has any such obligation on the basis of the stipulated order that was entered in the prior proceeding, nor could she reasonably do so. The trial court found that she was estopped from so claiming by her frequent violations of the conditions contained in that order, and that finding is amply supported by the evidence.

***45** Rather, Brenda relies upon the general proposition that a physician who abandons a patient may do so "only ... after due notice, and an ample opportunity afforded to secure the presence of other medical attendance." (*Lathrope v. Flood* (1901) 6 Cal.Unrep. 637, 639, 63 P. 1007, 1008, revd. on other grounds (1902) 135 Cal. 458, 67 P. 683; see also *Capps v. Valk* (1962) 189 Kan. 287, 369 P.2d 238; *McGulpin v. Bessmer* (1950) 241 Iowa 1119, 43 N.W.2d 121, 125; *Johnson v. Vaughn* (Ky.App.1963) 370 S.W.2d 591, 596.)

[2] The trial court found, however, that Dr. Weaver gave sufficient notice to Brenda, and discharged all his obligations in that regard, and that finding, also, is amply supported. Dr. Weaver supplied Brenda with a list of the names and telephone numbers of all dialysis providers in San Francisco and the East Bay, and it is apparent from the record that nothing would have pleased him more than to find an alternative facility for her, but there is no evidence that there is anything further he could have done to achieve that goal under the circumstances.

During the proceedings, the trial court observed that Dr. Weaver "is one of the most sensitive and honest physicians that I have been exposed to either in a courtroom or out of a courtroom," that he was "in fact sensitive to [Brenda's] needs, that he has attempted to assist her to the best of his medical abilities, that he continues to have concern for her as a person and has continued to serve her medical needs," and that "[t]he man has the patience of Job." It appears that Dr. Weaver has behaved according to the highest standards of the medical profession, and that there exists no basis in law or in equity to saddle him with a continuing sole obligation for Brenda's welfare. The same is true of the clinic, the BMA.

We turn now to Brenda's contention that Herrick and Alta Bates hospitals violated their obligations under Health and Safety Code section 1317, the text of which is set forth in the margin,[FN2] by denying her admission to their regular out-patient dialysis programs in late 1978. The trial court found that at the time Brenda applied for admission***46** to these programs she was not in an "emergency condition," by which the court obviously meant that she was in no imminent physical danger on the day she applied. Brenda contends, however, that her illness is itself "a chronic/acute emergency which requires that she receive medical treatment every third day to avoid ****230** death," and that such a condition qualifies for mandated service under section 1317.

FN2. Health and Safety Code section 1317 provides in pertinent part: "Emergency services and care shall be provided to any person requesting such services or care, or for whom such services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when such health facility has appropriate facilities and qualified personnel available to provide such services or care."

The trial court, in response to Brenda's contention,

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found that a patient with end stage renal disease "will not become a medical emergency if that person obeys medical orders, avoids drug abuse and appears for and has regularly scheduled hemodialysis treatments," and that regular outpatient dialysis treatment requires expertise and equipment not normally found in emergency rooms. It concluded that a chronic requirement for continued dialysis treatment does not constitute a need for "emergency" services or care within the meaning of section 1317. It declared, in that connection, that should Brenda present herself at any emergency department of any of the respondent health care providers claiming a need for emergency care, "a determination shall be made at that time by qualified physicians to see whether her condition constitutes an emergency" and, if so, she would be entitled to medical services under section 1317. Since that was not the situation at the time of Brenda's application to the two hospitals, the court found no liability.

[3] We agree with the trial court's conclusion. While end stage renal disease is an extremely serious and dangerous disease, which can create imminent danger of loss of life if not properly treated, the need for continuous treatment as such cannot reasonably be said to fall within the scope of section 1317. There are any number of diseases or conditions which could be fatal to the patient if not treated on a continuing basis. If a patient suffering from such a disease or condition were to appear in the emergency room of a hospital in need of immediate life-saving treatment, section 1317 would presumably require that such treatment be provided. But it is unlikely that the Legislature intended to impose upon whatever health care facility such a patient chooses the unqualified obligation to provide continuing preventive care for the patient's lifetime.

It does not necessarily follow that a hospital, or other health care facility, is without obligation to patients in need of continuing medical services for their survival. While it has been said that "[a] private hospital owes the public no duty to accept any patient not desired by it, and it is not necessary to assign any reason for its refusal to accept***47** a patient for hospital service" (41 C.J.S. Hospitals § 8, p. 345; see *Birmingham Baptist Hospital v. Crews* (1934) 229 Ala. 398, 157 So. 224, 225; cf. *Wilmington General Hospital v. Manlove* (Sup.Ct.Del.1961) 174 A.2d 135), it is questionable whether a hospital which receives public funding under the Hill-Burton Act (42 U.S.C. § 291), and perhaps from other sources, can reasonably be said to be "private" in that sense. (Cf. *Ascherman v. Saint Francis Memorial Hosp.* (1975) 45 Cal.App.3d 507, 512-513, 119 Cal.Rptr. 507.) Rather, where such a hospital contains a unique, or scarce, medical resource needed to preserve life, it is arguably in the nature of a "public service enterprise," and should not be permitted to withhold its services arbitrarily, or without reasonable cause. (Cf. *Gay Law Students Ass'n v. Pacific Tel. & Tel. Co.* (1979) 24 Cal.3d 458, 482-483, 156 Cal.Rptr. 14, 595 P.2d 592; see also *James v. Marinship Corp.* (1944) 25 Cal.2d 721, 731, 155 P.2d 329; *Tunkl v. Regents of University of California* (1963) 60 Cal.2d 92, 98-100, 32 Cal.Rptr. 33, 383 P.2d 441; Tobriner and Grodin, The Individual and the Public Service Enterprise in the New Industrial State (1967) 55 Cal.L.Rev. 1247, passim.). And, while disruptive conduct on the part of a patient may constitute good cause for an individual hospital to refuse continued treatment, since it would be unfair to impose serious inconvenience upon a hospital simply because such a patient selected it, it may be that there exists a *collective* responsibility on the part of the providers of scarce health resources in a community, enforceable through equity, to *share* the burden of difficult patients over time, through an appropriately devised contingency plan.

[4] Whatever the merits of such an approach might be in a different factual context, however--and we recognize that it poses difficult problems of administration and of relationship between hospitals and physicians--it cannot serve as a basis for imposition of responisbility upon these respondents under the

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circumstances present here. Apart from the fact that the record does not demonstrate to what extent respondent hospitals are the sole providers of dialysis treatment in the area accessible to Brenda, her present behavior, as found by the trial court, is of such a nature as to justify their refusal of dialysis treatment on either an individual or collective basis. Whatever collective responsibility may exist, it is clearly not absolute, or independent of the patient's own responsibility.

****231** What we have said to this point is analytically sufficient to dispose of Brenda's legal arguments, and thus to sustain the trial court's ruling, ***48** but the circumstances are such that we cannot responsibly avoid confronting the more fundamental question posed by Brenda's challenge, and considered at some length by the parties in their briefs and at oral argument, namely: what alternatives exist for assuring that Brenda does not die from lack of treatment as a result of her uncooperative and disruptive behavior.

One possibility which has been considered is an involuntary conservatorship under the Lanterman-Petris-Short (LPS) Act (Welf. & Inst.Code, § 5350 et seq.). Such a conservatorship is appropriate in the case of persons "gravely disabled as a result of mental disorder or impairment by chronic alcoholism" (§ 5350). The County of Alameda has apparently determined, however, that the conditions of that statute cannot be met in Brenda's case. FN3

FN3. This determination is reflected in a letter to the trial court which, though not formally part of the record, has been referred to by the parties in their briefs and at oral argument.

The County of Alameda has not been a party to this litigation. In support of the writ of supersedeas in the Supreme Court, Dr. Weaver and BMA moved to join the county as a necessary party, but that motion was denied. We consequently express no views as to the responsibility of the county in this matter, or as to the propriety of its determination.

A second possibility is an involuntary conservatorship under the provisions of Probate Code section 1801 et seq. Under section 1801, subdivision (a), "[a] conservator ... may be appointed for a person who is unable properly to provide for his or her personal needs for physical health, food, clothing, or shelter." Such a conservator "may consent to medical treatment to be performed upon the conservatee, and may require the conservatee to receive such medical treatment, in any case which the conservator determines in good faith based upon medical advice that the case is an emergency case in which the medical treatment is required ...." (Prob.Code, § 2354, subd. (c); see also § 2354, subd. (a).) This possibility remains a viable alternative.

A third possibility, and the one which appears from recent developments to be the most promising, is a voluntary conservatorship under Probate Code section 1802. While Brenda has heretofore resisted consenting to such a conservatorship, her attorneys advise us in a post-argument declaration that they are willing to use their influence to persuade Brenda to consent and that they believe they can arrange for her placement in a private, closed psychiatric facility. They suggest that ***49** we remand the matter to the superior court for the institution of appropriate proceedings. Respondents also appear to consider a voluntary conservatorship the best approach.

[5] We have no authority to "remand" for the institution of a voluntary conservatorship, as Brenda's attorneys suggest. The trial court's order requiring Dr. Weaver to provide dialysis treatment to Brenda pending appeal will, however, remain in effect until our decision becomes final. If, during that period, Brenda institutes proceedings for a voluntary conservatorship, and a conservator is appointed, it will be that person's obligation to arrange for continued treatment under statutory authority, and subject to such conditions as the court may impose. FN4 The

judgment is affirmed.

FN4. Brenda's attorneys, recognizing that a conservatorship will not automatically solve the problem of continued treatment, propose that Dr. Weaver be ordered to provide Brenda with dialysis “until he can, by the use of his resources, arrange for an orderly transfer to another physician.” This we are not disposed to do. As we have indicated, Dr. Weaver has already fulfilled his obligations to Brenda, and more. It appears from the record and from the briefs of the parties, however, that other resources may be available.

RACANELLI, P. J., and ELKINGTON, J., concur.
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Iowa Administrative Code

(Rules written by the Executive Branch which have the full force and effect of law.)

Chapter 653 - Section 13.7

Standards of practice—office practices.

13.7(1)

Termination of the physician-patient relationship.

A physician may choose whom to serve. Having undertaken the care of a patient, the physician may not neglect the patient. A physician shall provide a patient written notice of the termination of the physician-patient relationship. A physician shall ensure that emergency medical care is available to the patient during the 30-day period following notice of the termination of the physician-patient relationship.

13.7(2)

Patient referrals.

A physician shall not pay or receive compensation for patient referrals.

13.7(3)

Confidentiality.

A physician shall maintain the confidentiality of all patient information obtained in the practice of medicine. Information shall be divulged by the physician when authorized by law or the patient or when required for patient care.

13.7(4)

Sexual conduct.

It is unprofessional and unethical conduct, and is grounds for disciplinary action, for a physician to engage in conduct which violates the following prohibitions:

a.

In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient, or with the patient's parent or guardian if the patient is a minor.

b.

A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.

c.

A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

d.

A psychiatrist, or a physician who provides mental health counseling to a patient, shall never engage in any sexual conduct with a current or former patient, or with that patient's

1.1.5 Terminating a Patient-Physician Relationship

Physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients. At the beginning of patient-physician relationship, the physician should alert the patient to any foreseeable impediments to continuity of care.

When considering withdrawing from a case, physicians:

(a) Must notify the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician.

(b) Must facilitate transfer of care when appropriate.

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