Medical Litigation Newsletter

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The Physician-Patient Privilege: A Three-State Study

The patient-physician relationship is a time-honored bond. It is, at its best perhaps, a relationship built over time and based in mutual respect, trust and shared values. The relationship can be a source of comfort and improved quality of life for the patient; for the physician, the relationship may be professionally fulfilling.

However, determining when a patient-physician relationship is formed, and whether the doctor is potentially liable for negligence, is sometimes a difficult determination. For example, is there such a relationship when: (1) a physician and his or her colleague discuss the patient and the colleague asks for the physician's advice about diagnosis and treatment?; (2) the physician receives detailed information about the patient in the course of a call from a hospital nurse who is conveying a request for a consult to the doctor?; (3) the physician reviews a patient's lab results and consequently orders an electrocardiogram (EKG)?

Physician-Patient Privilege in Illinois

The existence of the patient-physician relationship serves as the measuring stick that Illinois courts use to determine whether a physician could be liable for conduct. Duty is a threshold question in medical negligence cases where plaintiffs must prove: (1) duty, (2) breach of the standard of care, (3) proximate cause, and (4) damages. Generally, a physician owes no duty of care to those who are not his or her patients. Below is a review of Illinois' court decisions defining and interpreting the patient-physician relationship and a consideration of what is required before an Illinois court will find that the physician has taken an "active role" in the patient's care.

No Duty Without Relationship

A physician's duty is limited to those situations where a direct patient-physician relationship exists or where there is a special relationship, such as when the doctor is asked by another physician to provide a service to the patient, conduct tests or review results. The relationship is a consensual one, where the patient knowingly seeks the physician's assistance and where the physician knowingly

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Hinshaw Representative Matters

Each issue of the *Medical Litigation Newsletter* will showcase a few cases that have recently been handled by Hinshaw lawyers. We are pleased to report the following:

Jerrod L. Barenbaum, a Partner in Hinshaw's Rockford, Illinois, office, obtained a defense verdict on behalf of a family medicine physician in a $3.8 million medical malpractice lawsuit filed against the doctor. A cardiologist and a health care facility were also named defendants. At the time of the subject incidents, plaintiff patient was 61 years old and had some cardiac risk factors. He saw the family medicine physician, complaining of pain in his arms, back, chest and shoulder after lifting. The physician diagnosed the patient as having muskuloskeletal back pain, prescribed Vicodin, and sent him home. The patient died of a heart attack five to six hours later at his home.

Michael Gahan, a Partner in Hinshaw's Joliet, Illinois, office, represented a hospital in a wrongful death case against three treating oncologists and a primary care physician. Defendants were alleged to have negligently allowed radiation treatment of an open biopsy site, resulting in infection and death. The hospital was named as an apparent principal of the treating doctors. At the close of plaintiff's case—which came at the end of a two-week jury trial—the trial judge found that plaintiff failed to prove that the decedent was unaware of the independent status of the doctors and directed a verdict.

James M. Hofert and *Linnea L. Schramm*, attorneys in Hinshaw's Chicago office, recently defended a surgeon in a four-week medical malpractice trial in DuPage County, Illinois. Plaintiff patient had presented to a hospital emergency room (ER) with severe abdominal pain in December 2005. At the time, she was 37 years old and 14-weeks into her first pregnancy. She was assessed in the ER and admitted to the post-partum unit. The patient continued to complain of pain throughout the early morning hours the next day, with deteriorating blood pressures and pulses. She went into septic shock approximately 10 hours following her presentation to the hospital. The surgeon had the patient admitted to the intensive care unit (ICU), where he and the intensivist proceeded to resuscitate her for the next several hours. During the patient's time in the ICU it was discovered that she had lost the baby. Once stable, the patient was taken to surgery, where she was found to have a completely necrotic small intestine due to malrotation. The surgeon removed her entire bowel. The patient went to another hospital for a complete small intestinal transplant. Due to the

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accepts the person as a patient. It is not necessary that the patient and physician have actual contact in order for the relationship, and the corresponding duty, to exist. For example, a consensual relationship can be found where a physician accepts a referral of a patient; in such situations, the law implies the patient's consent for the services provided by the consulting physician. *See, e.g., Lenahan v. University of Chicago*, 348 Ill. App. 3d 155, 163, 283 Ill. Dec. 790, 808 N.E.2d 1078 (2004).

Siwa v. Koch, 902 N.E.2d 1173, 327 Ill. Dec. 787 (1st Dist. 2009), demonstrates how the definition of patient-physician relationship is applied. In that case, the Appellate Court of Illinois found that no patient-physician relationship existed between a radiologist and a volunteer who had agreed to undergo a CT scan. Defendant was a staff radiology physician for a business that had an agreement to provide radiology services at a hospital. New software was installed on the CT scanner used at the hospital. In order to determine whether the software and scanner was working properly and to help train the staff radiologists, the volunteer, a CT-area clinical coordinator, volunteered to undergo a scan as part of the testing and training.

The radiologist did not know that the clinical coordinator was one of the volunteers. When he began to examine the data produced during testing, he came upon the volunteer's results, which revealed an abnormally high coronary artery calcification score. Because he was alarmed by the results of the scan, the radiologist twice spoke with the volunteer, urging him to make an appointment to see a cardiologist. The volunteer apparently scheduled an appointment after the radiologist's second conversation with him, but before he suffered a fatal heart attack while playing basketball.

In determining that there was no patient-physician relationship in this case, the court relied upon the facts that the volunteer had not sought the radiologist's medical advice, and that the radiologist had not knowingly accepted the volunteer as a patient. The court noted that: the radiologist did not even know that the volunteer would be one of the volunteers to test the software and equipment; that the volunteer was not seeking care; and that the radiologist was not asked to evaluate the volunteer's health but only to evaluate the accuracy and methodology of the new software and equipment. The court characterized the radiologist's warnings and urgings to the volunteer about the potential dangers associated with the results shown on the scan as going above and beyond, and noted that the radiologist's advice was appropriate.

Siwa illustrates the consensual nature of the patient-physician relationship in Illinois. Because the volunteer never sought care, and the radiologist never accepted him as a patient, no patient-physician relationship existed. The radiologist therefore owed no duty to the volunteer.

Consults: Requested? Accepted?

Determining whether a consult was actually sought and/or accepted has occupied Illinois courts in several cases. The following three case summaries demonstrate just how fact sensitive the issue of consults can be in the context of the patient-physician relationship.

Gathings v. Muscadin, 318 Ill. App. 3d 1091, 743 N.E.2d 659 (1st Dist. 2001), is a fairly straightforward example of a common sense result. There, the court found that no patient-physician relationship, or other special relationship, existed when a physician specifically declined a consult. Plaintiff parent brought her 20-month-old son to a hospital for complaints of fever, weakness and repeated vomiting. The child was admitted to the hospital under a general surgeon's care. Approximately two days

into the admission, the surgeon called for a pediatric consult and asked the nursing staff to contact defendant physician for it. When the nursing staff reached the physician, he explained that he was not on call and was not available to accept the consult. The following morning the child suffered cardiorespiratory arrest and died, which an autopsy later suggested was caused by complications of an undiagnosed bowel obstruction.

The case proceeded to jury trial. At the close of the parent's case, a directed verdict was entered for the physician. To support its finding that the doctor owed no duty to the child because no physician-patient or other special relationship existed, the court pointed to the facts that the physician provided no services for the child, conducted no laboratory tests, and reviewed no test results. After the initial request for consult from the hospital nurse, the physician was not contacted again. Also, the physician charged no fee and never even gave an "informal" opinion concerning the parent's case. *Gathings* seems to reinforce the concept that the patient-physician relationship is consensual: a physician cannot be forced into a duty via a request for consult.

Reynolds v. Decatur Memorial Hospital, 277 Ill. App. 3d 80, 660 N.E.2d 235 (4th Dist. 1996), involved a closer question of whether a consult was requested and/or accepted. Plaintiffs argued that a 2.5-year-old's quadriplegia resulted from a negligent neurosurgical consult. The minor was seen in the emergency room after having fallen while jumping on the family couch. He was admitted and a pediatrician was called in to examine him. The pediatrician took an X-ray, reviewed the emergency room records and X-ray reports, and formed certain differential diagnoses. She then telephoned her neurosurgeon colleague at his home at around 2 a.m. and provided the child's history to the neurosurgeon. At the end of the conversation, the neurosurgeon suggested a spinal tap to determine whether meningitis, encephalitis or something similar was causing the patient's symptoms. The pediatrician did not specifically ask the neurosurgeon to treat the patient during this telephone conversation. Nor did the neurosurgeon indicate that he would be further involved in the patient's care. About 1.5 hours after the phone call between the pediatrician and the neurosurgeon, the pediatrician instructed a nurse to enter an order in the patient's chart for a consult with the neurosurgeon in the early morning. The neurosurgeon never received the request for consult because he was in surgery. The child was transferred to another hospital later in the day, where a spinal cord injury was diagnosed.

The issue was whether the pediatrician's telephone call to the neurosurgeon was an informal courtesy service to a colleague or a request for consult. Plaintiffs sought to impose a duty upon the neurosurgeon, in part, by using an affidavit of their retained neurosurgeon reciting certain medical staff rules and opining that those rules under the circumstances demonstrated that he provided a negligent consultation.

The court determined that the neurosurgeon did nothing more than answer an inquiry from a colleague. Key in that determination were the facts that the neurosurgeon was not asked to provide a service to the patient, conduct any tests, or review test results. Additionally, he was not contacted again after the initial telephone call, and he charged no fee to the patient. The court was also critical of plaintiffs' attempt to bootstrap the physician into a duty through the expert affidavit interpreting the medical staff rules, stating:

> The proffered opinion of Plaintiff's expert transcends the bounds of his competence and intrudes on the exclusive province of the Court. Plaintiffs may not, in the guise of offering expert medical opinion, arrogate to

drugs that the patient must now take, she was highly advised against future pregnancy. She is doing well five years post-transplant. Hinshaw's surgeon client was found to have no liability. The hospital, however, received a judgment against it for $11.5 million—the second largest jury verdict in DuPage County for an adult woman.

Madelyn J. Lamb and *Dawn A. Sallerson*, Partners in Hinshaw's Belleville, Illinois, office, and ***William P. Hardy***, a Partner in the firm's Springfield, Illinois, office, recently successfully defended a medical malpractice case ultimately decided by the Appellate Court of Illinois, Fifth District. Plaintiff timely filed the medical malpractice claim, but during the course of discovery, defendants' counsel discovered that subsequent to the alleged malpractice plaintiff and her husband filed for bankruptcy and failed to list the malpractice claim in asset-schedules filed under oath. The trial court granted defendants summary judgment. The appellate court affirmed, holding that judicial estoppel bars a party from profiting by concealing an asset that properly belonged to the bankruptcy estate. Ms. Lamb and Ms. Sallerson defended the case in the trial court; Mr. Hardy handled the case on appeal.

Michael P. Russart, a Partner in Hinshaw's Milwaukee office, represented the Wisconsin Injured Patients and Families Compensation Fund (Fund) in a case brought by a patient who was paralyzed from T10 down during a lumbar transforaminal epidural steroid injection. The patient alleged that the injection was improperly delivered into an artery, leading the particulate of the steroid to occlude an artery and cause spinal cord shock. She also alleged that the doctor failed to properly inform her of the specific steroid used and to offer her alternative therapies. The patient had been referred specifically for the injection by a chiropractor. The jury found that the physician acted within the standard of care and had properly informed the patient of the risk of paralysis. The patient sought more than $5 million in damages. A defense verdict was rendered for the Fund, and no damages were awarded.

David A. Sorensen, a Partner in Hinshaw's Chicago office, defended an internal medicine physician in a medical malpractice case arising out of the death of a 60-year old woman who had entered a hospital without an infection but died of one several days later. One of plaintiffs' central claims was that on the first day that the decedent was in the hospital, the physician ordered a urine culture, the results of which were neither reported back to the hospital nor asked for by the physician, and that the results would have told the doctor that the patient had the same type of bacteria in her urine that was the cause of her death. Plaintiffs claimed that had the physician administered the appropriate antibiotic, the death would not have occurred. A defense verdict was rendered for the physician.

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> themselves a judicial function and obviate a ruling on the existence of or extent of a legal duty which might be owed by a physician to a patient.

This strong criticism highlights the fact that duty is a threshold issue which should be determined by the court as a matter of law before any argument is heard about whether the duty was breached.

Reynolds also reinforces the consensual nature of the patient-physician relationship. Because the pediatrician did not request–and the neurosurgeon never accepted–a consult during the early morning telephone conversation, no patient-physician relationship was found. The results may have been different had the physicians testified that the neurosurgeon agreed to see the patient during the course of the telephone conversation, but was delayed in seeing the child because of his surgery schedule.

Another case, *Bovara v. St. Francis Hospital*, 298 Ill. App. 3d, 1025, 700 N.E.2d 143 (1st Dist. 1998), provides an example of a different outcome for the defendant physicians. In *Bovara*, the court found that an "informal opinion" was really a consult. In this case, plaintiff patient met with a hospital cardiologist concerning his heart disease. The hospital cardiologist took his medical history and performed an examination. The patient had already undergone an angiogram, and provided the results to the examining hospital cardiologist. The hospital cardiologist provided the angiogram results to two interventional cardiologists who provided services including angioplasty at the hospital. The interventional cardiologists reviewed the patient's angiogram and communicated back orally to the hospital cardiologist that the patient was a candidate for angioplasty.

The first defendant interventional cardiologist characterized the request from the hospital cardiologist as an informal request targeted to say whether angioplasty was *technically feasible* based upon the angiogram. He never reviewed any other of the patient's records and had no contact with the patient. The other interventional cardiologist characterized the requests to review the angiogram as answering the question about whether angioplasty was *possible*. Thus, in response he indicated that the case could be handled with angioplasty. Neither of the interventional cardiologists dictated anything or made any notes concerning their review of the angiogram. The second defendant interventional cardiologist further testified that in order to make a recommendation as to what particular treatment a patient should consider, he would have done more than simply reviewed an angiogram. More specifically, he would have examined the patient, reviewed other data and discussed the relevant risks and benefits of each type of therapy with the patient.

As a result of the communication passed on from the interventional cardiologists, the hospital cardiologist told the patient that other physicians thought he was a candidate for angioplasty. The patient was scheduled for angioplasty. One of the interventional cardiologists was scheduled to perform the procedure, but was delayed. Therefore, one of his partners began the angioplasty procedure, during which the patient went into full cardiac arrest and subsequently died. Neither of the two interventional cardiologists ever billed the patient for their time on this case.

The interventional cardiologists prevailed at trial on a motion for summary judgment. On appeal the decision was reversed and the case was remanded for further proceedings. The appellate court pointed out that the interventional cardiologists had reviewed test results and interpreted them. It also indicated that a jury could find that the interventional cardiologists knew or should have known that their medical opinion about the feasibility of angioplasty was likely to be passed on to the patient by the cardiologist and would be crucial to the patient. Because of these questions of fact, the case was returned to the trial court.

In *Bovara*, the apparent disconnect between the requesting cardiologist and the interventional cardiologists muddied the question of whether a patient-physician relationship existed. Viewing this case against the backdrop of Illinois decisions, the fact that the patient was actually scheduled for angioplasty by the interventional cardiology group was likely influential in the court's decision to remand the case to the trial court.

The "Active Role" Defense

Even in cases where a consult has been requested and assented to, a patient-physician relationship may not exist. We explore the "active role" theory that was used to exonerate a physician in the following case.

In *Gillespie v. University of Chicago Hospitals*, 387 Ill. App. 3d 540, 900 N.E.2d 737, (1st Dist. 2008), a 19-year-old new mother reported to a hospital's emergency room, complaining of shortness of breath and chest pain. In response, an EKG, chest X-ray, blood test and lung scan were performed. The results demonstrated that the patient was anemic, suffered from cardiomegaly, and had infiltrates in both lower lobes. Additionally, her EKG was abnormal. Later in her emergency room visit, the patient's heart rate returned to normal and she was discharged with a diagnosis of musculoskeletal chest pain.

The hospital's procedure was that any time a patient who did not have a primary care physician on staff at the hospital was seen in the emergency room, the internist on call as the attending or admitting physician was to be assigned. In this case, the internist on call was listed in the patient's records as the attending/admitting physician. The internist was never consulted while the patient was in the emergency room. However, she did receive the patient's test results from the EKG, lung scan, and lab tests in her doctor's box at the hospital. The day after the patient's discharge, the internist reviewed the EKG, noted that she was unable to rule

out a possible heart attack, and indicated that the patient would need to be examined to corroborate findings. She charged the patient's insurer for her service but took no further action regarding the patient's care.

Approximately six weeks later, the patient returned to the hospital with bilateral lung infiltrates, congestive heart failure and cardiomegaly. She was admitted and treated for pneumonia. During the patient's admission, her blood pressure dropped, she seized and her heart stopped. She was resuscitated and transferred to a second hospital to receive a heart transplant that was deemed necessary because of previously undiagnosed postpartum cardiomyopathy.

The case proceeded to trial against the internist. At the close of the patient's evidence, the doctor moved for a directed verdict based on the fact that the patient could not establish a patient-physician relationship with her. The court granted that motion, noting that: (1) the emergency room doctors who treated the patient did not contact the internist at any time for a medical opinion; (2) the internist received the patient's test results and examined her EKG only *after* the patient was discharged from the hospital; and (3) the internist's EKG report was not used to assess or treat the patient's condition, nor did any physician rely on it for a diagnosis. Ultimately, the court determined that the internist was not "actively involved" in the patient's care. The court distinguished other cases where physicians were found to have a duty to the patient by virtue of having provided services by pointing out that the internist's interpretation of plaintiff's EKG and billing for that service occurred after the patient's discharge and therefore played no role in the patient's treatment or care.

Closing Thoughts

The patient-physician relationship in Illinois is a two-way street: the physician has to agree to accept the patient, and the patient has to be seeking care. In some circumstances, applying this rather simple definition can become quite complicated, especially where consults and/or informal opinions are requested. Understanding the potential consequences of a hallway conversation about another physician's patient is important. Clear communication between colleagues about whether the discussion is an informal question or a true request for a consult is key.

Even where there is no issue about the existence of a consulting relationship, Illinois courts may require that a physician play an "active role" in the patient's care before imposing any duty. The Illinois Supreme Court has yet to comment on the "active role" analysis. It will be interesting to see how the "active role" concept evolves.

Physician-Patient Privilege in Wisconsin

Wisconsin has a unique statutory scheme governing medical malpractice claims. *See* Wis. Stat. Chapter 655. This system limits those who can bring a claim for injury or death arising out of medical negligence to a "patient or patient's representative." *See* Wis. Stat. Section 655.007.

Despite this requirement, the issue of patient-physician relationship has not been heavily litigated in Wisconsin. The two primary cases that discuss the relationship relate to a physician's informed consent duty, probably because in Wisconsin only a "treating" physician has a duty to inform his or her patient of the risks, benefits and alternatives of any proposed treatment or therapy. See Wis. Stat. Section 448.30.

One of the cases discussing the patient-physician relationship is *Bubb v. Brusky, M.D.*, 2008 WI App. 104, 313 Wis. 2d 187, 756 N.W.2d 584. There, the court held that a neurologist did not owe the patient an informed consent duty because he provided no treatment to the patient.

In *Bubb*, the patient was taken to the hospital by ambulance after he experienced trouble eating and subsequently fell out of a chair. At the emergency room (ER), the ER physician ordered several tests and reviewed the patient's symptoms. The patient's symptoms improved while in the emergency room. Based upon this information, the ER physician concluded that the patient had suffered a transient ischemic attack. The ER doctor called a local neurologist who could provide follow-up care, to discuss the patient's case. Upon discharge, the ER doctor advised the patient to call the neurologist for a follow-up appointment. The next day, a follow-up appointment was made for the next available date, which was 10 days later. Two days later, the patient suffered a significant stroke.

The patient and his wife sued the ER doctor and the neurologist for negligence and a failure in each of their duties to provide informed consent. The trial court dismissed the informed consent claims on motions and a jury absolved both doctors for the negligence claims. The dismissal of the informed consent claims was appealed.

The appellate court held that the neurologist had no informed consent duty "until he treated [the patient]." Without explicitly stating so, the court concluded that no treating relationship existed between the patient and the doctor. The phone call from the ER doctor and the scheduled follow-up appointment were insufficient to establish a patient-physician relationship.

The patient-physician relationship was not discussed in the context of the negligence claims brought against the neurologist in *Bubb*. Wisconsin courts have defined medical negligence claims

as those asserting allegations of "professional misconduct or unreasonable lack of skill." *McEvoy v. Group Health Coop. of Eau Claire*, 570 N.W.2d 397, 213 Wis. 2d 507, 527-30 (1997). In *Bubb*, plaintiffs' alleged in their negligence claim that the neurologist failed to inform his staff that the patient's follow-up appointment should be given priority in scheduling. The nature of this allegation likely does not amount to professional misconduct or an unreasonable lack of skill. It is more properly characterized as a failed administrative task that does not call into question the presence or lack of a patient-physician relationship.

The other primary case discussing Wisconsin's view on the patient-physician relationship is *Ande v. Rock*, 256 Wis. 2d 365, 647 N.W.2d 265 (Ct. App. 2002). There, the inability to establish a patient-physician relationship proved fatal to claims for medical negligence against several health care providers arising out of a cystic fibrosis treatment research study.

In *Ande*, parents who entered a hospital for their first child's birth were given a pamphlet about different tests that were required to be completed on a newborn's blood, and on a cystic fibrosis test that would be run as part of a research project. The pamphlet arguably implied that positive results would be reported to the infant's physician, and a phone number was provided for anyone who wanted additional information.

The research protocol required that the parents of half of the newborns in the study were told if their child tested positive for cystic fibrosis. A nutritional program was immediately made available to them based upon the theory that earlier nutritional intervention would slow the progression of the disease and improve overall health. The other half were in the "blinded" study group and were not told the results of the cystic fibrosis screening.

Soon after birth, the parents' child had difficulty thriving. When she was nearly two years old, she was diagnosed with cystic fibrosis. In the interim, the parents conceived another child. The second child was also born with cystic fibrosis.

The parents sued numerous researchers and physicians associated with the study. They claimed that defendants failed to diagnose their first born child's condition, that no one informed them of their child's positive test result, and that no one obtained their consent to participate in the study.

Some state-employed researchers and physicians were dismissed based upon the parents' failure to timely bring their claims. Others were dismissed based upon the lack of a patient-physician relationship between the remaining defendants and the parents. The parents made no allegation and had no facts to support the establishment of a patient-physician relationship as to the remaining physician defendants. The physicians' link to the cystic fibrosis study, without any other relationship to the parents, was insufficient to create a patient-physician relationship. Without that relationship, the claims for medical malpractice were dismissed.

Conclusion

Under its statutory scheme, a medical negligence claim in Wisconsin can only be brought by a patient or a patient's representative. The lack of a patient-physician relationship should result in the dismissal of medical negligence claims and the lack of "treating" physician status has resulted in the dismissal of informed consent claims. Despite these foundational requirements, the boundaries of Wisconsin's law on patient-physician relationships have not been heavily litigated.

Physician-Patient Privilege in Missouri

In Missouri, a physician's liability to a patient for medical negligence is predicated on the existence of a physician-patient relationship. *Braun v. Riel*, 40 S.W.2d 621, 622 (Mo. 1931); *Corbet v. McKinney*, 980 S.W.2d 166, 169 (Mo. App. E.D. 1998). It is this relationship alone that creates a duty of care on the part of the physician to act with the same degree of skill and learning ordinarily employed by other members of his or her profession. Absent the relationship, no duty exists, and a medical malpractice claim must fail. *Corbet*, 980 S.W.2d at 169; *Millard v. Corrado*, 14 S.W.3d 42, 49 (Mo. App. E.D. 2000).

Missouri cases define the physician-patient relationship as "a consensual one in which the patient, or someone acting on the patient's behalf, knowingly employs a physician who consents to treat the patient." Traditionally, this relationship has been recognized only in situations where the physician personally examines the patient, and has not been thought to exist absent such contact. Nonetheless, Missouri courts have long recognized that in certain situations, liability may be imposed on a consulting physician even absent direct, personal contact with the patient.

In *Corbet*, the Missouri Court of Appeals analyzed cases from a variety of jurisdictions for guidance in determining when a physician-patient relationship arises with a consultant. Generally, it found the consultant's consent to the relationship to be the determinative factor. Importantly, express consent is not required. Instead, the consultant's actions alone may evince the necessary assent to the relationship even if the consultant and patient never personally communicate or meet. For example, if a consultant participates in making a diagnosis or prescribing a definite course of treatment, a physician-patient relationship may be formed. Further, conduct such as billing a patient for a service (*e.g.* reviewing a study) or for a communication with another physician about the patient's case may suffice to establish the relationship. In addition, if a consultant has a contractual obligation to provide assistance in diagnosing or treating patients (such as an "on-call" physician), such obligation alone may qualify as consent to the existence of a formal relationship with the patient.

Informal Phone Inquiry to Specialist—No Relationship Formed

Applying these principles, the *Corbet* court examined whether the requisite relationship arose when defendant, a physician specialist, gave advice to plaintiff patient's treating emergency room (ER) physician during a phone conversation. The ER doctor called the specialist for guidance at the suggestion of the patient's primary care physician. He described the patient's complaints to the specialist, who responded "this is usually a viral illness." The ER physician admitted that he alone diagnosed plaintiff's condition but that he based his plan of treatment on the specialist's recommendations. Nonetheless, the specialist never saw, spoke with, examined or diagnosed the patient, and there was no indication that he knew the ER physician would follow his advice. Further, he had no contractual obligation to consult on the case. Under these facts, the court held that there was no physician-patient relationship, and affirmed summary judgment for the specialist.

Absent "On Call" Physician—Relationship May Be Formed

In *Millard v. Corrado*, the Missouri Court of Appeals again considered whether a physician-patient relationship could arise in the absence of direct contact between the two. Defendant was the designated "on call" general surgeon when plaintiff patient was transported to his hospital after sustaining injuries in a car accident. The general surgeon was attending a medical conference in another city at the time, however. Although he had arranged for a colleague to take his calls while he was away, the colleague was an orthopedic surgeon, not a general surgeon. Further, the general surgeon neglected to inform anyone at the hospital of this arrangement. As such, hospital staff paged the general surgeon, not the orthopedic surgeon, when the patient arrived. The orthopedic surgeon learned of the patient's arrival independently and responded approximately 20 minutes later. But he was unable to assist because he was not qualified to perform the abdominal surgery she needed (although the general surgeon was). Eventually, the general surgeon did respond to his pages. By that time, arrangements had already been made for the patient's transfer to another institution. Ultimately, the patient's surgery was delayed by over two hours due to the general surgeon's absence.

On the general surgeon's motion for summary judgment, the trial court held that there was no physician-patient relationship because he had not treated the patient, consulted on her case or provided any advice that was used in her treatment. The court of appeals reversed and held that the general surgeon's contractual relationship with the hospital, alone, was enough to create a physician-patient relationship with the patient under the facts. In particular, the court cited to uncontradicted evidence that the terms of the contract required the general surgeon to treat all emergency patients who presented for care and to respond to pages within 30 minutes. The court also held that the patient could state a general negligence claim against the general surgeon because under "public policy," the general surgeon had a duty to any reasonably foreseeable emergency patient to fulfill his on call obligations, or to provide reasonable notice to the appropriate personnel if unable to do so. (As discussed in more detail below, subsequently, other plaintiffs have attempted to use this "public policy" argument to impose liability on health care providers under the more lenient general negligence standard with varying degrees of success.)

Relationship May Be Formed With Group As a Whole When There Is Continuing Care

In *Montgomery v. South County Radiologists*, 49 S.W.3d 191 (Mo. 2001), the Missouri Supreme Court considered the confines of the physician-patient relationship in the context of continuing care and treatment provided by a medical group as a whole. Here, plaintiff patient sued a radiology group and three of its physician members individually for failing to diagnose a cancerous tumor on her spine. The patient had three studies performed over a nine-month period; each one was reviewed and interpreted by a different physician member of the medical group. The group and one of the doctors moved for summary judgment on the statute of limitations as to the first study in the series because the doctor had interpreted it more than two years before the patient filed suit. After the court of appeals affirmed the lower court's judgment as to both of them on this basis, the Supreme Court considered the issue and reversed as to the group because of its continuing relationship with the patient. It found that the group as an entity had consented to the formation of a relationship with the patient by virtue of its contractual obligation to be the sole provider of radiological services for the treating institution and physician. Nonetheless, the Court agreed that the patient's claim against the individual radiologist who interpreted the first study was untimely.

Even Absent Relationship, in Missouri, Liability May Be Imposed for Providing or Failing to Provide Medical Services Under General Negligence Theory in Some Situations

In *Millard*, the Missouri Court of Appeals held that the patient might have a general negligence claim against the general surgeon because the general surgeon had a general duty under public policy to the patient, or to any reasonably foreseeable emergency patient, to fulfill his "on call" obligations by providing emergency surgical services if necessary. Since then, at least one plaintiff has successfully used the public policy argument to pursue a general negligence claim against a health care institution. *See Meekins v. St. John's Regional Health Center*, 149 S.W.3d 525 (Mo. App. S.D. 2004). Interestingly, in *Meekins*, the appellate court held that the hospital's interpretation of a drug screen test was *not* a health care service because it was not done "within the confines of a physician/patient relationship."

Except as outlined above, Missouri courts have otherwise declined to extend the *Millard* analysis by allowing plaintiffs to pursue health care providers for general negligence under the "public policy" theory. For instance, in *Virgin v. Hopewell Center*, 66 S.W.3d 21 (Mo. App. E.D. 2002), the appellate court expressly held that plaintiff driver could not pursue a general negligence claim against defendant health care providers for failing to warn her of a psychiatric patient's dangerous propensities. The driver was injured when a car driven by the health care providers' patient collided with her vehicle. The court found that the health care providers had no legal duty to warn as a matter of "public policy" because there was no "reasonably foreseeable" group of people to whom the health care providers might hold such a duty, unlike in *Millard*.

Summary

If there is some evidence that a consultant knows that his or her advice, recommendations or other participation will be used in the active care and treatment of the patient, a physician-patient may be formed, and the consultant can be held liable even if he or she has no contact whatsoever with the patient directly. Likewise, a physician may be held liable in the absence of direct contact or communication with a patient if he or she fails to provide treatment to the patient when contractually obligated to do so. Finally, under Missouri law, a physician may also be held accountable for failing to provide care under a general negligence theory *independent* of any physician-patient relationship in cases "public policy" favors the recognition of a duty, or when the harm is particularly foreseeable.

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What Will State Estate and Inheritance Taxes Look Like in 2011?

In addition to the federal government, individual states charge death taxes as well. After 2010, the resurrected federal estate tax and any other changes in the federal estate tax may also have significant *state* estate and/or inheritance tax implications. For example, many states tie their estate taxes to the federal estate tax state death tax credit. Beginning in 2011, barring other changes by Congress, there will be a state death tax credit on the federal estate tax return. In Illinois and Florida, this would mean that those states would impose a state estate tax equal to the state death tax credit allowed on the federal estate tax return. No estate tax exists in either state in 2010. Further, Florida's estate tax did not apply in years that the state death taxes were allowed as a deduction—rather than as a credit—on the federal estate tax return.

States with their own inheritance tax regime should not be affected by the changes in the federal estate tax. For example, in Indiana, changes to the federal estate tax are unlikely to change liabilities under the Indiana inheritance tax.

State death taxes can be considerable enough that taxpayers need to consider them in their estate plans. Accordingly, taxpayers should discuss the applicable state death tax issues with their tax and estate planning professionals.

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U.S. Department of Justice Investigates Hospitals for Cardiac Billing

The U.S. Department of Justice (DOJ) is investigating hospital billing for implantable cardiac defibrillator (ICD) surgery. The DOJ has a broad scope of investigation, potentially encompassing medical necessity and diagnosis-related group (DRG) coding. ICD's are small electronic devices that shock the heart during life-threatening arrhythmias. They are not pacemakers, but are life-saving devices.

Medicare pays for ICD implantation for specific conditions. A patient must not have had an acute myocardial infarction (MI) within 40 days of a heart attack. The DOJ investigation is requesting that hospitals respond as to whether they think implantation of an ICD within 40 days of an MI is medically necessary and, if so, why they believe so. Most ICD implantations result in an inpatient stay of one or two days. Medicare is investigating whether this is improper coding (inpatient v. outpatient) due to inaccurate and/or insufficient documentation of medical necessity. The risks are high because reimbursement for a typical ICD implant is in the range of $40,000.

Hospital providers that receive a letter from the DOJ about ICD implantations should immediately contact their legal counsel so that any internal investigation conducted is protected by the attorney-client privilege. In addition, such providers should ensure that they comply with the National Coverage Determination (NCD) through Medicare for coding of ICDs.

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