05-11-16

Medical Jurisprudence

Behavioral Sciences Term
St. Georges University School of Medicine

Visiting Professor
Thaddeus Pope, JD, PhD

Thursday
July 28

Segment 1 of 8

Treatment Relationship

Objectives

At the conclusion of this unit, the medical student should be able to answer the following 11 questions

1. Why does a treatment relationship **matter**?
2. What is a physician's **legal** duty to treat **without** a treatment relationship?
3. What is a physician's **ethical** duty to treat **without** a treatment relationship?
4. When **must** a treatment relationship be formed?
5. What physician conduct is sufficient to **form** a treatment relationship?
6. When is a relationship formed with **formally consulted** physicians
7. When is a relationship formed with **INformally consulted** physicians
8. When is a relationship formed with **IME** physicians
9. What **duties** are triggered upon formation of relationship

10. What are the 4 ways to **end** a relationship?
11. How can a physician terminate a relationship without **abandonment**

Why does a treatment relationship matter

Physicians owe **4** key duties to patients

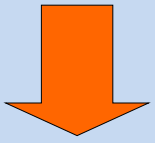
Standard of care
Non-abandonment
Informed consent
Confidentiality

These duties owed only if in a **treatment relationship** – if PTF is patient and you are her physician

Existence of a treatment relationship **creates** these duties

These duties are those owed by a physician **qua physician**

No treatment relationship



These duties not owed
(because no "patient" to owe them to)

None of these 4 duties are owed without a treatment relationship

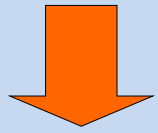
Duty to Treat

We will later address **when/how** such duties spring into being

We will later address **when/how** a treatment relationship is **formed**

First, let's examine when physician **must** treat (even if not want to)

No treatment relationship



May refuse to treat for **any** reason

Default starting point

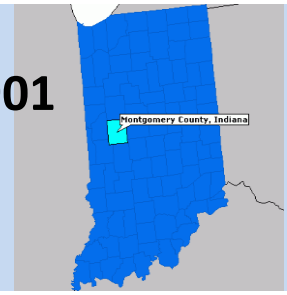
No duty to treat

Providers **may refuse** to treat for any reason or for no reason

Duty to treat created by physician's **own** voluntary consent

Hurley v. Eddingfield

1901



Medical need is **not** sufficient to create a duty

Patient "dangerously ill"
Physician **only one** available
Physician treated this family for years
Husband tendered fee
Physician had **no reason**

Patient dies
Family sues

Duty to treat based on consent, **contract**

Even if physician delivered prior babies, treatment relationship is by "episode of illness"

Physician has **no duty** to deliver **this** baby, unless he agrees.

Still the law 115 years later

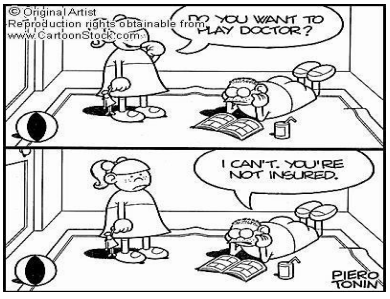
Takeaway rule

When **must** physician treat a patient?

Never, if not **already** in treatment relationship

Providers **may refuse** to treat for any reason or for no reason

Big reason: nonpayment

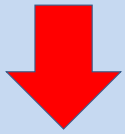


3 limits

Limit 1	Cannot refuse for an **illegal** reason	Invidious discrimination Race Disability National origin Gender Others
Limit 2	Cannot refuse if **already** agreed	2 main types of prior agreement
MCO contract e.g. You agreed to be listed in Blue Cross network	On call e.g. When get staff privileges, you agreed to treat ED patients	**Legal vs. ethical duties**

We focus on **legal duties** actionable by patient

No contract

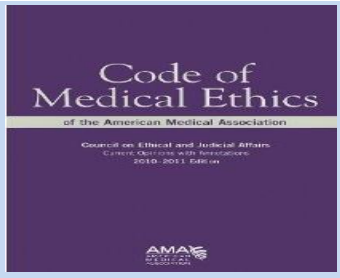


No tort

Standard of care
Non-abandonment
Informed consent
Confidentiality

No lawsuit

Ethical duties may be broader



VI. A physician shall . . . be **free to choose** whom to serve . . . .

. . . **except** in emergencies

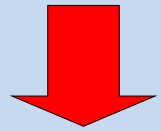
In 2016, Hurley still cannot sue Dr. Eddingfield

But the Indiana medical board could **discipline** Dr. Eddingfield

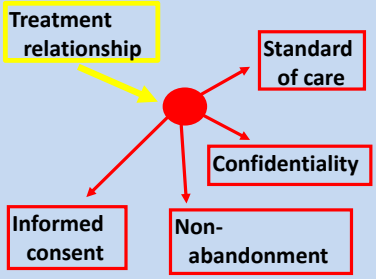
Let's leave now when you **must** form a treatment relationship

When is a Relationship Formed

No treatment relationship



No physician duties

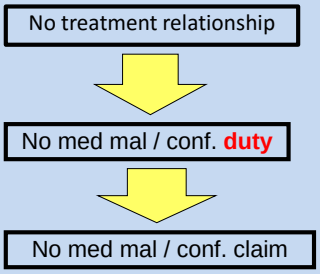


Other duties (e.g EMTALA) do not depend on a treatment relationship. But that is not our focus.

Formation Examples

Not concerned with the **merits** of these cases

Our focus is on the **existence** of a treatment relationship



Key question

Did the physician **consent** to treat

Sometimes Clear & Easy

Patient seeks care

Physician provides it

But sometimes consent is **less clear**

Some physician – patient interaction

But is it **enough**?

What **type**

What **amount**

is sufficient

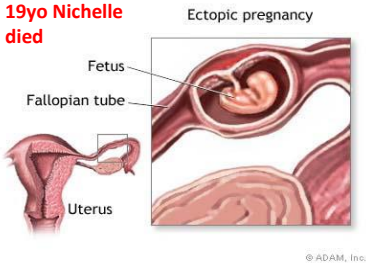
Look for **detrimental reliance**

Adams

v.

Via Christi Reg. Med.

19yo Nichelle died



Called Dr. O

"Go to ED, if it gets worse"

So, they **delayed** going to the ED

Theory of professional negligence (medical malpractice)

Dr. O should have suspected ectoptic pregnancy

Dr. O should have advised of danger

9:30pm ER visit would have saved her

Breach	fail diagnose
Damages	death
Causation	diagnosis would prevent

Dr. O argues:

No duty

Merits of malpractice action irrelevant

Doctor O argument

(no duty because no treatment relationship)

Not seen, talked, treated Nichelle for 4 years

Not speak Nichelle on July 22

No longer even provided obstetrical care AT ALL

Took no action

Only discussed Nichelle's condition in general terms with mother

Not consider Nichelle his patient

Nichelle not consider him her doctor

Mrs. Adams argument

"family physician for Mr. and Mrs. Adams and their three children for several years"

Not enough

See Hurley

Relationship defined by each **"episode of illness"**

Doctor O called her "right back"

Still not enough

This is "affirmative action." But it is not itself sufficient.

He could have said "I cannot help you"

Doc listened and gave medical opinion (3 separate pieces)

- Abdominal pain not abnormal
- Take ER if got worse
- See doc next day

This is the conduct that **forms** the treatment relationship

"reassure"

"dissuade"

Objective test

Look to **external** acts, not subjective intent

Dr. Did not **want** to treat

But he used his judgment to offer a recommendation

It **looks** like he is treating

Lyons v. Grether

Physician **refused** to see patient with service dog

Complaint is abandonment (wrongful termination).

Not "bad" treatment but "no" treatment

Only a duty to treat if **already** in a treatment relationship

This case predates the ADA (1991)

Physician argument

Not **yet** seen (or examined)

Did not even speak to patient (or patient's agent)

Patient argument

Patient did "entrust her treatment to the physician"

The physician did accept the case

Appointment

- Specific time
- Specific place
- Specific purpose

All 3 cumulatively sufficient

Formation because detrimental reliance

Bilateral contract

"Will you treat me?"

"Yes, I will"

Let's now turn to a separate question

When is relationship formed with <u>NON</u>-treating physicians

2

situations

1. Informal consult
2. IME

Informal or "curbside" consult

Reynolds v. Decatur Memorial

ED doc in treatment relationship

ED doc calls pediatrician

Pediatrician examines → in treatment relationship

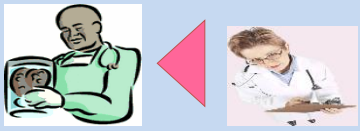
Pediatrician insure:

Infectious problem

vs.

Spinal cord injury

Pediatrician calls neurologist



Misdiagnosis – sues all 3 physicians

But no claim against neurologist

Only **informal** consult

No treatment relationship with physician who provided only **informal** consult

No see patient

No see record

No write in record

No bill

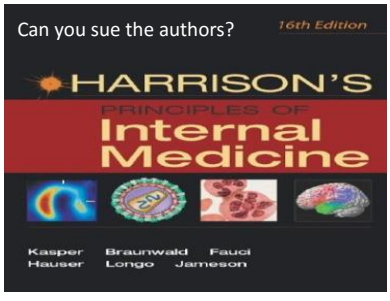
No see labs

Treating physician retains independent judgment

No reliance by patient

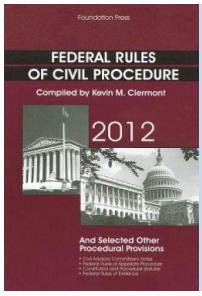
To impose duty would create "chilling effect" on communication, education (via curbside, hallway chats)

Fuzzy line between formal & informal



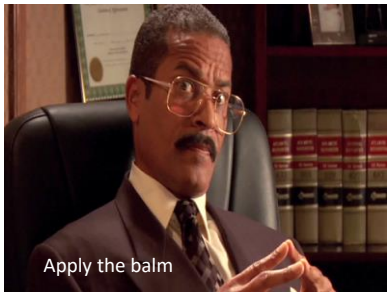
2nd situation non-treating physician

IME



Rule 35

The court . . . may order a party whose mental or physical . . . is in controversy to submit to . . . examination



IME physician is **not** in a treatment relationship with examinee

Physician interacts with the "examinee"

BUT	IME is not "treatment"	Not consensual
Examinee does not select physician	Examinee does not pay physician	Physician does not report to examinee
But …	IME can **cross** the line from examination to treatment	e.g. offers recommendation

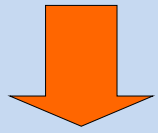
Summary of rules on formation of treatment relationship

INTERACTION	RELATIONSHIP
Provide care	Yes
Make recommendation	Yes
Telephone call	Maybe
Formal consult 2d physician	Yes with both
Informal consult 2d physician	Not with 2d doc
IME	No

Move now from forming to ending

How to terminate the relationship

No treatment relationship



May refuse to treat for **any** reason

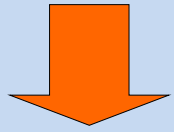
Unless

Invidious discrimination (e.g. race, disability)

Prior agreement to treat (e.g. MCO, on-call)

Contrast

Existing treatment relationship



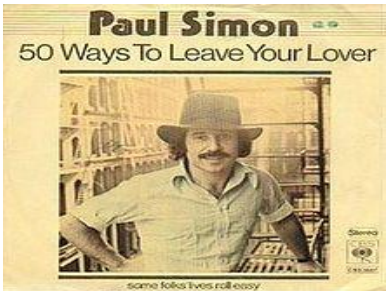
Must **continue** to treat

Until

Termination of relationship (in 1 of 4 valid ways)

Otherwise, termination is

Tortuous abandonment



3 easy ways to terminate

1. Mutual consent
2. Patient dismisses physician
3. Medical services no longer needed

4th way to terminate is trickier

Physician unilateral withdrawal

Once treatment relationship is formed, **limits** on physician ability to terminate

Lots of reasons to "fire" a patient

Noncompliance
Failure to pay
Verbal abuse, threats
Drug seeking
Fail keep appointments

Violate policies
CBO
Lack skills for adequate Tx
Lack resources
Others ??

Reason for terminating does **not** matter

Unilateral physician withdrawal is permitted **with sufficient notice**

Sufficient notice = amount of time required for patient to get another provider

Otherwise,
physician termination is

Tortuous abandonment

Physician **may** terminate

Physician **may not** abandon (i.e. terminate with insufficient notice)

Abandonment

Intentional, purposeful, deliberate decision

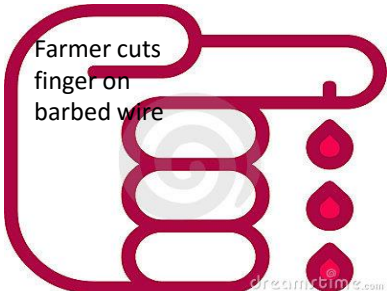
Non-medical reason

Contrast misdiagnosis

"You're cured and no longer need my services"

Mistake, if negligent, is medical malpractice

Ricks v. Budge



Mar. 8	R finger on wire
Mar. 11	Budge treats R
Mar. 12-15	R in hospital
Mar. 15	R leaves hospital AMA Dr. B instructs R

Mar. 16	Gets worse
Mar. 17	R to Dr. B office
Mar. 17	Dr. B. "go to hospital" ASAP

Mar. 17	Dr. B arrives at hospital but **refuses to treat (unpaid)**
Mar. 17	R to another hospital

Contrast with the following case

Payton v. Weaver

1975-1978
Dialysis w/ Dr. Weaver
Drugs & alcohol
Not following rules
Antisocial

12-12-78 Dr. Weaver notice

04-23-79 Dr. Weaver notice

1979 Writ of mandate settlement: Dr. Weaver will treat, if Payton complies with 6 conditions

1980 Brenda fails to comply with **any** of the 6 conditions

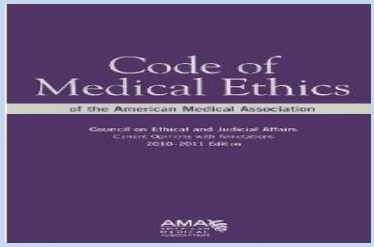
03-03-80 Dr. Weaver 3d notice + offer to help

All the (bad) facts about Ms. Payton make no difference to the abandonment analysis

Proper termination

Lots of **notice** (opportunity to find new provider)

Law parallels ethics



AMA Opinion 8.115

"Physicians have an obligation to support **continuity of care** for their patients."

"While physicians have the option of withdrawing from a case, they cannot do so without giving **notice** . . . sufficiently long **in advance** . . . to permit another medical attendant to be secured."

Abandonment

Not just a tort

Licensure too

Abandonment is **not** just one type of medical malpractice

Licensure codes and regulations **also** define the duty

E.g. New Jersey requirements for terminating a licensee-patient relationship

1. Notify the patient, in writing, . . . no less than **30 days prior** to the date on which care is to be terminated, and shall be made by certified mail…

"Notwithstanding . . . a licensee **shall not terminate** a . . . relationship . . . circumstances"

"Where to do so would be for any **discriminatory purpose"**

"Where . . . **no other licensee** is currently able to provide the type of care or services . . ."

Want to refuse → try transfer

No transfer → must comply

Treatment relationship RECAP

We answered 4 key questions

Question 1

When **must** a HCP enter a treatment relationship

Never, except through **consent**

Consent can be **prior** (e.g. assumption of on-call duties, MCO listing)

Limits on right to refuse

- ADA
- Race
- Gender . . .

Question 2

When is a treatment relationship formed

Conduct by physician that evidences consent to treat

- Words or action
- Interpret from **patient** perspective (do they **think** they are being treated)

Formation often evidenced by patient **reliance**

Physicians who provide only **informal, curbside consults** are **not** in a treatment relationship with patient, even if treating physician relies on consultant's advice

IME physician

Never in regular treatment relationship

Question 3

When is a treatment relationship terminated

1. Patient consent (e.g. patient fires doc)
2. End of medical need (e.g. cure, recovery)
3. Doc fires patient

Doc can fire patient for **any** non-illegal reason (e.g. ADA)

But must give sufficient **notice** (to get new doc)

Failure to provide sufficient notice = **abandonment**

Question 4

What **duties** arise on formation of treatment relationship

There are 4

Non-abandonment

Duty not to prematurely terminate treatment relationship (makes sense only if one already exists)

We will examine the next 3 in upcoming sessions

Informed consent

Exercise reasonable judgment/skill

(i.e. be non-negligent, avoid malpractice)

Standard of Care

Judgment & skill of reasonably prudent physician under the circumstances

Confidentiality

Do not reveal PHI when not permitted

Thaddeus Mason Pope, JD, PhD
Director, Health Law Institute
Mitchell Hamline School of Law
875 Summit Avenue
Saint Paul, Minnesota 55105
T 651-695-7661
F 901-202-7549
E Thaddeus.Pope@mitchellhamline.edu
W www.thaddeuspope.com
B medicalfutility.blogspot.com

240