Health Law: Quality & Liability

Professor Thaddeus M. Pope

Reading Packet for Week 2 (Fall 2018)

Weekly Summary

In week one, we examined formation of the treatment relationship in the typical and paradigmatic situation in which the physician manifests conduct indicating an intent to treat the patient face-to-face. This packet goes beyond such traditional situations, for example looking at formation through telemedicine.

Informal Consults. Two more situations are even more common. First, some physicians are not "directly" engaged in treating the patient but are just "consulted" by the physician who is treating the patient. These physicians are in a treatment relationship with the patient only when the consult is formal, not when it is merely informal.

IME Physicians. Second, some physicians examine patients as part of an independent medical exam (IME). These physicians are never in a regular treatment relationship. In some states, IME physicians are in a special and limited treatment relationship with the patient.

Limited Relationships. This week, we also move beyond formation and termination, to examine "limitation" of the treatment relationship, specifically the ability of the healthcare provider to limit their exposure to court litigation. Contracts waiving the patient's ability to sue for negligence are void as against public policy. But patients may (and do) waive their right to sue in lots of other situations. The main example is agreements to arbitrate (instead of litigating in court). We will come back to that when we examine defenses to medical malpractice actions. Other exceptions to the rule against waivers include leaving against medical advice.

Reading

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

- White v. Harp (Vt. 2011) (telemedicine, treating) (5 pages)
- Reynolds v. Decatur Hosp. (Ill. App. 1996) (informal consult) (5 pages)
- Skelcy v. United Health (3d Cir. 2015) (non-treating) (5 pages)
- Bazakos v. Lewis (N.Y.A.D. 2008) (IME) (12 pages)
- Bazakos v. Lewis (N.Y. 2009) (IME) (6 pages)
- Smith v. Radecki (Alaska 2010) (IME) (12 pages)
- Tunkl v. Regents U. Cal. (Cal. 1963) (waivers) (9 pages)
- Discharge against Advice Form (waiver) (1 page)

Objectives

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

- Analyze and apply legal principles concerning when a consulting or IME physician has a duty to treat an individual. (1.2)
- Analyze and apply legal principles concerning the conditions under which the normal duties triggered by a treatment relationship may be limited. (1.6)

Upcoming Assessments

Quiz 1 is due by 11:59PM on Sunday, August 26.

Quiz 2 is due by 11:59PM on Sunday, September 2, 2018. This quiz is based on the *Warren v. Dinter* case pending before the Minnesota Supreme Court (regarding informal consults).

Live Class

Remember that we will ***not*** be meeting on August 28 or August 30, the class sessions that correspond to this material. Therefore, please watch the videos covering this material. Email me about any questions and I will respond individually and/or create a podcast.

White and Searles v. Harris, Foote, Farrell, et al. (2010-246)

2011 VT 115

[Filed 29-Sep-2011]

ENTRY ORDER

2011 VT 115

SUPREME COURT DOCKET NO. 2010-246

FEBRUARY TERM, 2011

Terrence White, Individually, and as Administrator of Estate of Krystine White, and Pauline Searles	}	APPEALED FROM:
v.	}	Caledonia Superior Court
Mark S. Harris, M.D., Nancy Foote, Susan Farrell, Upper Valley Pediatrics, Northeast Kingdom Human Services, Inc., Rita M. Gelsomini Gruber, M.D., Fletcher Allen Health Care, Inc., and Gain Paolo Bentivoglio, M.D.	}	DOCKET NO. 155-6-09 Cacv
		Trial Judge: Harold E. Eaton, Jr.

In the above-entitled cause, the Clerk will enter:

¶ 1. Plaintiffs appeal from a superior court order granting summary judgment to defendant Fletcher Allen Health Care, Inc. in this wrongful death action alleging medical malpractice. This case arises from the suicide of plaintiffs' fourteen-year-old daughter. Plaintiffs sued defendant, which employed a psychiatrist who was briefly involved with decedent's case through a telepsychiatry research study. Plaintiffs argue that summary judgment was improperly granted on the issue of the duty owed to decedent by the psychiatrist. We agree, and thus reverse and remand for additional proceedings.

¶ 2. The record indicates the following. Decedent suffered from ongoing mental health problems. On the recommendation of her case manager, she consulted with defendant's psychiatrist through a telepsychiatry research study he was conducting. As part of the study, plaintiffs and decedent completed pre-assessment documentation, and they participated in a one-time, ninety-minute video-conference session with the psychiatrist in August 2006. Following the session, the participants completed a questionnaire about their

reaction to using telemedicine. The psychiatrist later completed a consultation evaluation that described decedent and the history of her present illness; it also provided the doctor's diagnostic impression of decedent and set forth recommendations for an initial treatment plan. The evaluation specifically stated that, consistent with the telepsychiatry research protocol, no follow-up services would be provided, and no medication prescriptions would be directly provided by the doctor. The report further explained that the recommended treatment plan was to be weighed by decedent's treatment team, including her primary care physician, for possible implementation. After sending his evaluation, the psychiatrist had no further interaction with plaintiffs, decedent, or any member of her treatment team.

¶ 3. On June 10, 2007, decedent committed suicide. An autopsy report indicated that she died from the combined effects of ingesting Propoxyphene, opiates, and Citalopram. The psychiatrist had not prescribed or recommended any of these medications.

¶ 4. In June 2009, plaintiffs filed an amended complaint, alleging that defendant, among eight doctors and medical care providers, treated decedent in a manner that "fell below the standard of care required of reasonably skillful, careful, and prudent professionals," and that decedent died as a proximate result. Defendant moved for summary judgment in December 2009, asserting that its doctor had no duty to decedent when she committed suicide because there was no doctor-patient relationship. Alternatively, defendant argued that any such relationship was formally terminated in writing following their one-time interaction. Defendant acknowledged that if the trial court found that a duty existed, its motion would be premature. The trial court also recognized that the motion came at an early stage in the proceedings, but reasoned that if no duty existed, then no additional discovery to show a breach of that duty would be necessary. Ultimately, the trial court agreed that the psychiatrist's contact with decedent was "so minimal as to not establish a physician-patient relationship," and consequently found that no duty existed at the time of decedent's death. Even assuming that a doctor-patient relationship was established, the court concluded that it was terminated following the video-conference and, thus, any duty was extinguished by termination of the relationship and no duty existed at the time of decedent's death. The court thus granted defendant's summary judgment motion. This appeal followed.

¶ 5. Plaintiffs argue that the court erred in finding that the doctor owed no duty to decedent. They maintain that the doctor had a duty to exercise reasonable care to protect decedent from the danger she posed to herself, and that the doctor did not effectively terminate the doctor-patient relationship prior to decedent's death.

¶ 6. We review motions for summary judgment de novo, using the same standard of review as the trial court. Campbell v. Stafford, 2011 VT 11, ¶ 10, ___ Vt. ___, 15 A.3d 126. We afford the non-moving party "the benefit of all reasonable doubts and inferences," Doe v. Forrest, 2004 VT 37, ¶ 9, 176 Vt. 476, 853 A.2d 48, and we will affirm summary judgment orders when there is no genuine issue as to any material fact and a party is entitled to judgment as a matter of law. V.R.C.P. 56(c)(3).

¶ 7. We agree that a duty applies to the service provided. The doctor had a duty of due care in his professional contact with decedent, which was not extinguished by the ministerial act of termination of their professional relationship. See Endres v. Endres, 2008 VT 124, ¶ 11, 185 Vt. 63, 968 A.2d 336 (noting that the existence of a legal duty is "central to a negligence claim" and is "primarily a question of law"); see also

Markowitz v. Arizona Parks Bd., 706 P.2d 364, 366 (Ariz. 1985) (en banc) ("[A] negligence action may be maintained only if there is a duty or obligation, recognized by law, which requires the defendant to conform to a particular standard of conduct in order to protect others against unreasonable risks of harm."). We have defined duty as "an expression of the sum total of those considerations of policy which lead the law to say that the plaintiff is entitled to protection." Endres, 2008 VT 124, ¶ 11 (quotation omitted). In assessing whether a duty exists, "[t]he question is whether the relationship of the parties was such that the defendant was under an obligation to use some care to avoid or prevent injury to the plaintiff." Markowitz, 706 P.2d at 368; see also Langle v. Kurkul, 146 Vt. 513, 520, 510 A.2d 1301, 1305 (1986) (in determining whether duty of care exists, courts consider relationship between parties, nature of the risk (including its foreseeability), and public policy implications of imposing a duty on defendant to protect against the risk). In their analysis of circumstances similar to those here, other courts have considered these factors:

> whether the doctor was in a unique position to prevent harm, the burden of preventing harm, whether the plaintiff relied upon the doctor's diagnosis or interpretation, the closeness of the connection between the defendant's conduct and the injury suffered, the degree of certainty that the plaintiff has or will suffer harm, the skill or special reputation of the actors, and public policy.

Stanley v. McCarver, 92 P.3d 849, 853 (Ariz. 2004).

¶ 8. The facts here disclose a consultation of limited duration. Decedent and her mother signed an informed consent form, and the doctor stated in writing that the scope of his services was limited. At the same time, however, there is no dispute that the doctor performed a psychiatric evaluation of decedent, following which the doctor offered recommendations for decedent's treatment. And the record reveals the parties' expectation that the doctor would aid in decedent's treatment through his expertise, regardless of the mechanism of doctor-patient contact. In requesting a consultation with the doctor, decedent's treatment team specifically sought recommendations about decedent's medication, particularly given the increase in decedent's angry and aggressive behavior and self-mutilation. They also sought the doctor's diagnostic impression and recommendations about the role that Attention-Deficit Hyperactivity Disorder might play in decedent's behavior. While decedent's medical records may not have been provided to the doctor, the doctor was provided with a very recent medical evaluation of decedent performed by another doctor, which was supplemented by additional information about decedent from decedent's treatment team. This included information that decedent had a history of depressive behavior and had recently exhibited an increase in angry, aggressive behavior, along with more frequent cutting behavior. All of this information bears on the scope of the professional relationship from which defendant's duty arose and it helps to frame the applicable standard of care. We find it sufficient to support the existence of a duty here.

¶ 9. A professional consultation may arise in many different circumstances. Defendant's involvement here was limited, but that does not mean it was nonexistent. It may be analogized to cases in which a doctor is asked to perform an independent medical examination (IME) of a patient as part of a legal investigation or an insurance claim. As in the current case, an IME doctor usually does not see a patient again or maintain an ongoing relationship with the patient, rather he or she performs a limited analysis of the patient's condition that is

provided to a third party. See Ritchie v. Krasner, 211 P.3d 1272, 1279-81 (Ariz. Ct. App. 2009) (considering existence of duty where insurance carrier asked defendant doctor to conduct IME); Harris v. Kreutzer, 624 S.E.2d 24, 29-32 (Va. 2006) (considering medical malpractice claim against doctor retained to conduct a court-ordered IME). Many courts addressing IME cases have concluded that an IME creates a doctor-patient relationship that "imposes fewer duties on the examining physician than does a traditional physician-patient relationship," but "still requires that the examiner conduct the examination in such a way as not to cause harm." Dyer v. Trachtman, 679 N.W.2d 311, 316 (Mich. 2004); see also Ritchie, 211 P.3d at 1280 ("[A]n IME doctor has a duty to conform to the legal standard of reasonable conduct in the light of the apparent risk." (quotation omitted)); Harris, 624 S.E.2d at 32 (holding that "a cause of action for malpractice may lie for the negligent performance of a [court-ordered medical examination]," but that the examining physician's "duty is limited solely to the exercise of due care consistent with the applicable standard of care so as not to cause harm to the patient in actual conduct of the examination").

¶ 10. Here, the relationship between doctor and patient was even more direct than a third-party-retained IME doctor. The defendant became involved on referral from decedent's treatment team and reported to them his findings and recommendations after evaluation. We hold that the ninety-minute consultation performed in this case created a doctor-patient relationship. We acknowledge that the telepsychiatry research study conducted by the doctor provided no treatment component directly to decedent, other than recommendations to her treatment team. However, through this consultation, a limited doctor-patient relationship was established and we conclude that a duty of due care applies. Through this consultation, defendant's doctor assumed a duty to act in a manner consistent with the applicable standard of care so as not to harm decedent through the consultation services provided.

¶ 11. Defendant argues that submission of the psychiatrist's consultation evaluation to decedent's treatment team terminated any doctor-patient relationship that ever existed, and defendant equates the ending of this relationship with the termination of any "further duty to the patient."[1] We hold, however, that even if doctor-patient contact had ended, this does not terminate the doctor's responsibility for the consequences of any lapses in his duty to provide services consistent with the applicable standard of care for the consultation. Under 12 V.S.A. § 1908(1), a doctor must exercise "the degree of care ordinarily exercised by a reasonably skillful, careful, and prudent health care professional engaged in a similar practice under the same or similar circumstances." A doctor may be liable for malpractice if "as a proximate result of . . . the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred." Id. § 1908(3). Under this statute, whether or not a doctor has ceased treating a patient is irrelevant to whether he or she may be held liable for injuries resulting from his or her failure to exercise the proper degree of care while treating the patient. It is the doctor's responsibility for the services provided that is significant here, and not simply the duration of the doctor-patient relationship itself.

¶ 12. On these facts, however, the scope of defendant's duty and the standard of care cannot yet be determined. In evaluating the standard of care, we must not conflate the existence of a duty with the appropriate standard of care, an issue that takes us beyond the limited facts in the record before us and was not properly raised below. See W. Keeton, et al., Prosser and Keeton on the Law of Torts § 53, at 356 (5th ed. 1984) ("It

is better to reserve 'duty' for the problem of the relation between individuals which imposes upon one a legal obligation for the benefit of the other . . . ."). Prosser explains that "in negligence cases, the duty is always the same—to conform to the legal standard of reasonable conduct in light of the apparent risk. What the defendant must do, or must not do, is a question of the standard of conduct required to satisfy the duty." Id.; see also Markowitz, 706 P.2d at 367 (emphasizing that conflating these issues "incorrectly leads to attempts to decide on a general basis whether a defendant has a 'duty' " to take certain actions, such as posting warning signs, or providing additional traffic signs, and recognizing that "[t]hese details of conduct bear upon the issue of whether the defendant who does have a duty has breached the applicable standard of care and not whether such a standard of care exists in the first instance" (citations omitted)).

¶ 13. As the McCarver court observed, "[t]he standard of care imposes on those with special skills or training . . . the higher obligation to act in light of that skill, training, or knowledge." 92 P.3d at 854. Thus, in McCarver, the court found that the doctor in question had "assumed a duty to conform to the legal standard of care for one with his skill, training, and knowledge," but concluded that the question of "what is necessary to satisfy the standard will depend upon the facts of each case." Id. We do not yet know plaintiffs' position on the standard of care in this case, i.e., what a "reasonably skillful, careful, and prudent health care professional" would have done under similar circumstances, or how any alleged breach of this standard was the proximate cause of harm to decedent. 12 V.S.A. § 1908(1).

¶ 14. The issue of standard of care was not raised by defendant in its motion for summary judgment, nor decided by the trial court.[2] It is not the role of this Court to set that standard or to evaluate whether it was breached at this stage of the proceedings. Expert testimony is required. See Senesac v. Assocs. in Obstetrics & Gynecology, 141 Vt. 310, 313, 449 A.2d 900, 902 (1982) (in medical malpractice action, plaintiff must ordinarily produce "expert medical testimony setting forth: (1) the proper standard of medical skill and care; (2) that the defendant's conduct departed from that standard; and (3) that this conduct was the proximate cause of the harm complained of"); see also Ritchie, 211 P.3d at 1279 (noting that, aside from duty, the remaining "elements of negligence are factual issues, and are generally within the province of the jury").

¶ 15. This is a lawsuit in its formative stages. The motion for summary judgment was filed six months after the complaint was filed and raised the sole question of the duty of care of this consulting doctor. The remaining elements of plaintiffs' claim have not yet been fully developed, and defendant did not move for summary judgment on these elements. See State v. Therrien, 2003 VT 44, ¶ 23 n.3, 175 Vt. 342, 830 A.2d 28 (recognizing "general rule that summary judgment should not be granted on an issue not raised in the summary judgment motion unless the party against whom summary judgment is granted is given full and fair notice and opportunity to respond to the issue prior to the entry of summary judgment"). Given our conclusion that a duty exists, we reverse and remand for additional proceedings.

Reversed and remanded.

BY THE COURT:

Paul L. Reiber, Chief Justice

John A. Dooley, Associate Justice

Denise R. Johnson, Associate Justice

Marilyn S. Skoglund, Associate Justice

Note: Justice Burgess was present at oral argument, but did not participate in this decision.

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[1] Defendant contends that plaintiffs failed to properly preserve their arguments pertaining to termination of the doctor-patient relationship, claiming that "[p]laintiffs here did not . . . argue that the doctor-patient relationship—if any ever existed—between [defendant] and [decedent] was not terminated in exactly the manner [defendant] contended it was." To some extent, defendant appears to conflate the issue of whether a doctor-patient relationship existed with whether defendant had a continuing responsibility for the quality of care provided to decedent. We agree that defendant had no ongoing duty to provide care for decedent after the psychiatrist's consultation ended. This does not affect, however, whether defendant can be held liable for any alleged breach of the psychiatrist's duty to meet the required standard of care during the course of the telepsychiatry research study. While plaintiffs may not have specifically addressed defendant's argument about the termination clause in the psychiatrist's consultation evaluation, whether or not the doctor-patient relationship was terminated is not dispositive.

[2] It is unclear why plaintiffs advanced any argument regarding the standard of care and the alleged breach of such standard in their response to defendant's motion for summary judgment. As defendant asserted below, plaintiffs appeared to have confused the issue of duty with the remaining elements of their medical malpractice claim. Defendant expressly noted below that its motion "turn[ed] solely on the threshold question of whether [the doctor] even had a duty to [decedent], not whether a breach of that duty occurred." It also agreed that "if the basis of [its] Motion turned on an alleged breach of the standard of care, then its Motion for Summary Judgment would be premature." As previously noted, the trial court did not address any issue other than duty in its decision.

Appellate Court of Illinois,
Fourth District.

Kevin Thomas REYNOLDS, a Minor, by Barbara Reynolds, His Mother and Next Friend, et al., Plaintiffs-Appellants,
v.
DECATUR MEMORIAL HOSPITAL, et al., Defendants (Thomas Fulbright, M.D., Defendant-Appellee).
No. 4-95-0562.

Argued Dec. 12, 1995.
Decided Jan. 4, 1996.

198HV(B) Duties and Liabilities in General
198Hk612 Duty
198Hk615 k. Professional-Patient Relationship as Requisite to Duty. Most Cited Cases
(Formerly 299k12 Physicians and Surgeons)
Physician's duty is limited to those situations in which direct physician/patient relationship exists or there is special relationship.

[7] Health 198H 786

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(F) Persons Liable
198Hk786 k. Multiple Professionals or Health Care Workers in General. Most Cited Cases
(Formerly 299k12 Physicians and Surgeons)
There was no physician/patient relationship between doctor who gave informal opinion over telephone at request of treating physician and patient whose case was discussed, and thus doctor did not owe duty of care to patient despite claim that telephone conversation breached hospital rules where doctor did nothing more than answer inquiry from colleague, he was not contacted again, and he charged no fee.

****236***45*80** John J. Lowrey (argued), Lowrey & Smertz, Ltd., Chicago, for Plaintiffs-Appellants.

Garry E. Davis (argued), Erickson, Davis, Murphy, Johnson, Griffith & ***81** Walsh, Decatur, Robert Marc Chemers, Anne Scheitlin Johnson, Pretzel & Stouffer, Chartered, Chicago, for Defendant-Appellee.

Justice McCULLOUGH delivered the opinion of the court:

Plaintiffs Kevin Thomas Reynolds, a minor (born July 14, 1988), by Barbara Reynolds, his mother and next friend, and Charles W. and Barbara Reynolds, individually, appeal from a summary judgment entered by the circuit court of Macon County in favor of defendant Dr. Thomas Fulbright in this medical malpractice action based on a negligence theory. Although this case remains pending as to other defendants, the trial court made a finding pursuant to Supreme Court Rule 304(a) (155 Ill.2d R. 304(a)) and this appeal ensued.

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

Taken with the case was defendant's motion to strike the statement of facts in plaintiffs' brief. The plaintiffs have filed an objection to the motion.

The statement of facts in the plaintiffs' brief appears to be an attempt to appeal to the sympathy of the members of this court in favor of plaintiffs. The respondent's objection to this has merit. The statement of facts is not presented fairly without argu-

ment or comment, a violation of Supreme Court Rule 341(e)(6) (155 Ill.2d R. 341(e)(6)). Nevertheless, the motion to strike the entire statement of facts is denied. The parties are assured that this court has considered only those relevant facts which appear of record in rendering a decision in this case.

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

At about 10:45 p.m. on November 29, 1990, Kevin was seen in the emergency room of Decatur Memorial Hospital by Dr. Terry Balagna. The history given indicated he was injured at 8:30 or 9 p.m. by falling while jumping on the couch in the family living room. Upon examination, an abnormal breathing pattern was observed. Tests were conducted to discover the possibility of an infection or an ***82** electrolyte or metabolic problem. Cervical spine X rays were taken at about 1:05 a.m. which appeared normal. Nevertheless, Kevin was admitted to the hospital. Balagna called Bonds, a pediatrician, to examine him.

Bonds arrived at the hospital at about 1:45 a.m. on November 30, 1990. At that time, Kevin's temperature was 102 degrees fahrenheit. Bonds made a quick assessment of plaintiff and took a history from Barbara, which indicated Kevin had jumped off the couch, landed on his arm, walked to his ****237 ***46** mother, and gradually became limp after that. Bond noticed the child's breathing difficulties and that he was flaccid. She reviewed the emergency room records and X-ray reports, conducted reflex tests, and noticed he was moving his head. His neck was not tender. Among the possible reasons for his condition which Bonds considered were neurologic, traumatic, metabolic, infectious, or post-infectious problem. Because of the fever, she was leaning toward the infectious process diagnosis, and she did not consider a spinal cord injury . A history of a two-foot fall with a normal 2 1/2 - year-old child did not indicate to her the existence of a cervical cord injury from trauma.

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

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

> "Dr. Bonds called me regarding Kevin Reynolds. She related to me that the patient had presented with a history of a fall, I believe from a couch. The height estimated to be less than two feet. She related that the child was listless, and that the child was febrile with a fever of-on the order of 102 degrees Fahrenheit.
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> I questioned Dr. Bonds regarding the history. My first concern was the veracity of the history. My major concern here was the question of child abuse. There was some report on her part that the history had been somewhat inconsistent. That in itself is a ***83** hallmark of abuse. I questioned her specifically as to whether or not she felt abuse was operative in this case. She stated relatively emphatically that she did not think that it was.
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> She did not think that the fall was overly significant because of it's [*sic*] apparently benign nature, that is, a fall from a low height of a young child as happens to every young child.

> The question of the cause of the fever and the possible neurological causes of the fever was raised. The question of meningitis was discussed. The question of an ascending neuritis was discussed. The performance of a lumbar puncture was discussed. The conclusion was that Dr. Bonds would perform the lumbar puncture and let me know if she wanted me to see the child thereafter. I offered to make myself physically available if she wished. We elected to proceed with the plan of her performing the lumbar puncture and letting me know if she needed me there."

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

At 3:30 a.m. on November 30, 1990, Bonds performed the spinal tap. Before leaving the hospital, she told a nurse to write an order in Kevin's chart "to consult with Fulbright to see in early a.m." That note was posted to the chart, and the message was taken off the chart at 4:05 a.m. The usual practice was for the ward clerk or nurse to notify the operator who would place the message in the appropriate area. The message was never received by Fulbright. At 8 a.m., Bonds realized Fulbright had not received the message, attempted to locate him, and was told he was in surgery performing a very long procedure. Fulbright stated he did not receive another call from Bonds or anyone else ****238 ***47** at the hospital with regard to Kevin's condition or treatment. Kevin's family never asked Fulbright to treat Kevin, and he never saw, examined, or came to a diagnosis as to Kevin's condition. Fulbright did not bill for any services to Kevin.

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

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

> ***84** "4.1 Appropriate consultation shall be obtained by practitioners in cases in which the patient is not a good medical or surgical risk and in cases in which the diagnosis is obscure, where there is doubt as to the best therapeutic measure to be utilized, or where the treatment is difficult and especially in cases with probable disorders or complications lying within a field other than the one in which the attending physician is primarily qualified.
>
> 4.2 A consultant must be well qualified to give an opinion in the field where his opinion is sought. A satisfactory consultation must include the examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record. When operations are involved, the consultation note, except in emergency, shall be recorded prior to the operation."

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

> [1] "Summary judgment is appropriate when the pleadings, depositions and affidavits, construed most strongly against the movant and most liberally in favor of the opponent, present no genuine issue of material fact and show that judgment should be granted as a matter of law. (*Wojdyla v. City of Park Ridge* (1992), 148 Ill.2d 417 [170 Ill.Dec. 418, 592 N.E.2d 1098].) The purpose of summary judgment is not to try a question of fact but to determine whether one exists. (*Mitchell v. Jewel Food Stores* (1990), 142 Ill.2d

152 [154 Ill.Dec. 606, 568 N.E.2d 827])" *Golla v. General Motors Corp.* (1995), 167 Ill.2d 353, 358, 212 Ill.Dec. 549, 552, 657 N.E.2d 894, 897.)

[2] "The determination of whether a duty exists-whether the defendant and the plaintiff stood in such a relationship to one another that the law imposed upon the defendant an obligation of reasonable conduct for the benefit of the plaintiff-is an issue of law to be determined by the court." *Kirk v. Michael Reese Hospital & Medical Center* (1987), 117 Ill.2d 507, 525, 111 Ill.Dec. 944, 953, 513 N.E.2d 387, 396.

[3][4] Where a question of law is determinative of a case, summary judgment is a proper remedy. (*National Underground Construction Co. v. E.A. Cox Co.* (1991), 216 Ill.App.3d 130, 134, 159 Ill.Dec. 614, 617, 576 N.E.2d 283, 286 (construction of a contract as a matter of law).) Even if the question presented would ordinarily be a question of fact, if only one conclusion may be drawn from the undisputed facts, then a question of law is presented which may be appropriately dispensed with by summary judgment. (*Nolan v. Johns-Manville Asbestos* (1981), 85 Ill.2d 161, 171, 52 Ill.Dec. 1, 5-6, 421 N.E.2d 864, 868-69.) On review, this court considers *de novo* the propriety of granting the summary judgment. *Golla v. General Motors Corp.* (1994), 261 Ill.App.3d 143, 147, 198 Ill.Dec. 731, 734, 633 N.E.2d 193, 196, *aff'd* (1995), 167 Ill.2d 353, 212 Ill.Dec. 549, 657 N.E.2d 894.

***85** [5][6][7] In a negligence action for medical malpractice, there must be a duty owed by defendant to the plaintiff, a breach of duty, an injury proximately caused by the breach, and resultant damages. (*Curry v. Summer* (1985), 136 Ill.App.3d 468, 476, 91 Ill.Dec. 365, 371, 483 N.E.2d 711, 717 .) The determination of whether the parties stood in such a relationship to one another that the law ****239 ***48** would impose on defendant a duty of reasonable conduct for the benefit of the plaintiff is a question of law. That policy determination is based on consideration of the likelihood of injury, the magnitude of the burden of guarding against it, and the consequences of placing that burden on the defendant. (*Kirk*, 117 Ill.2d at 525-26, 111 Ill.Dec. at 952-53, 513 N.E.2d at 395-96.) A physician's duty is limited to those situations in which a direct physician-patient relationship exists or there is a special relationship such as when an infant sues for prenatal injuries foreseeably caused by the physician's negligent care of the mother prior to conception. (*Kirk*, 117 Ill.2d at 531, 111 Ill.Dec. at 956, 513 N.E.2d at 399; *Renslow v. Mennonite Hospital* (1977), 67 Ill.2d 348, 357, 10 Ill.Dec. 484, 489, 367 N.E.2d 1250, 1255.) In this case, there was no special relationship as in *Renslow*, and there was no direct physician-patient relationship, and hence no duty owed to plaintiffs by Fulbright. This determination was properly made as a matter of law.

The relationship of physician and patient is one of trust and confidence. It is a consensual relationship in which the patient knowingly seeks the physician's assistance and the physician knowingly accepts the person as a patient. (70 C.J.S. *Physicians and Surgeons* § 58, at 448 (1987).) A consensual relationship can exist where other persons contact the physician on behalf of the patient, but this is not a case in which Fulbright was asked to provide a service for Kevin, conduct laboratory tests, or review test results. Fulbright did nothing more than answer an inquiry from a colleague. He was not contacted again and he charged no fee. A doctor who gives an informal opinion at the request of a treating physician does not owe a duty of care to the patient whose case was discussed. (*Lopez v. Aziz* (Tex.Ct.App.1993), 852 S.W.2d 303, 306; see *Flynn v. Bausch* (1991), 238 Neb. 61, 66, 469 N.W.2d 125, 128-29; *Hill v. Kokosky* (1990), 186 Mich.App. 300, 304, 463 N.W.2d 265, 267; *Ingber v. Kandler* (1987), 128 A.D.2d 591, 592, 513 N.Y.S.2d 11, 11 (memorandum decision); *Oliver v. Brock* (Ala.1976), 342 So.2d 1, 4.) This is not a case in which Fulbright had accepted a referral of the patient. (See *Davis v. Weiskopf* (1982), 108 Ill.App.3d 505, 511-13, 64 Ill.Dec. 131, 135-36, 439 N.E.2d 60, 64-65.) Nor is this a case in which a physician undertook to direct the actions of hospital

employees in a telephone conversation with an emergency room nurse. See *Wheeler v. Yettie Kersting Memorial Hospital* (Tex.Ct.App.1993), 866 S.W.2d 32, 39-40.

***86** The affidavit of Oldershaw does not help plaintiffs. Whether Fulbright owed a duty to Bonds, and ultimately to plaintiffs, is a question of law, not a question of medicine. The proffered opinion of plaintiffs' expert transcends the bounds of his competence and intrudes on the exclusive province of the court. Plaintiffs may not, in the guise of offering expert medical opinion, arrogate to themselves a judicial function and obviate a ruling on the existence of or extent of a legal duty which might be owed by a physician to a patient. *Sawh v. Schoen* (N.Y.App.Div.1995), 215 A.D.2d 291, 292-293, 627 N.Y.S.2d 7, 9 (memorandum decision).

For the same reasons, the rules of Decatur Memorial Hospital are not dispositive of this case. Such rules are more appropriately considered in determining whether the standard of care was met. (See *Darling v. Charleston Community Memorial Hospital* (1965), 33 Ill.2d 326, 331-32, 211 N.E.2d 253, 257.) Such considerations only arise after a physician-patient relationship imposing a duty has been found to exist.

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

Distinguishable from this case is plaintiffs' cited case of *Hiser v. Randolph* (Ariz.App.1980), 126 Ariz. 608, 617 P.2d 774, which involved the question of whether a physician under contract to a hospital to render emergency room services had a duty to render care to anyone presenting themselves to the hospital for emergency care. In *Hiser*, the court found that the contractual relationship between a hospital and the doctor obligated ****240 ***49** the doctor to treat such patients. (*Hiser*, 126 Ariz. at 612, 617 P.2d at 778.) The rules of Decatur Memorial Hospital in this case cannot, as a matter of law, require a physician to enter into a physician-patient relationship with every person treated in the hospital whose treating physician might make an informal inquiry about that case.

Plaintiffs suggest that what needs to be done is to find a physician-patient relationship to result from every such conversation. The consequence of such a rule would be significant. It would have a chilling effect upon practice of medicine. It would stifle communication, education and professional association, all to the detriment of the patient. The likely effect in adopting plaintiff's argument also would be that such informal conferences would no longer occur. To reiterate, this would inhibit the exchange of information ***87** and expertise among physicians and would not benefit the medical profession or persons seeking treatment. *Lopez*, 852 S.W.2d at 307.

Agreeing with the trial court that there was no physician-patient relationship between plaintiffs and Fulbright, and therefore no duty owed by Fulbright to plaintiffs, the summary judgment of the circuit court of Macon County is affirmed.

Affirmed.

GREEN and STEIGMANN, JJ., concur.
Ill.App. 4 Dist.,1996.
Reynolds v. Decatur Memorial Hosp.
277 Ill.App.3d 80, 660 N.E.2d 235, 214 Ill.Dec. 44

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620 Fed.Appx. 136
This case was not selected for
publication in West's Federal Reporter.
See Fed. Rule of Appellate Procedure 32.1 generally
governing citation of judicial decisions issued
on or after Jan. 1, 2007. See also U.S.Ct. of
Appeals 3rd Cir. App. I, IOP 5.1, 5.3, and 5.7.
United States Court of Appeals,
Third Circuit.

Linda S. **SKELCY**, Individually and as General Administrator and Administrator ad Prosequendum of the Estate of James T. **Skelcy**, Appellant
v.
UNITEDHEALTH GROUP, INC; Oxford Health Insurance, Inc; Denise Beighe, M.D., individually and as an employee/agent of Medical Evaluations Specialists, Inc.; Medical Evaluation Specialists, Inc.; Dennis Sandoval, M.D., individually and as an employee/agent of UnitedHealth Group; Gail Wilder, M.D., individually and as an employee/agent of UnitedHealth Group.

No. 15–1012.
|
Submitted Under Third Circuit
L.A.R. 34.1(a) Sept. 18, 2015.
|
Filed: Sept. 22, 2015.

Synopsis

Background: Wife, individually and as administratrix of estate of patient, who was her husband, brought medical malpractice action against medical evaluation company and doctor who performed peer review assessment on patient, alleging negligence and negligence per se. Medical evaluator and doctor moved to dismiss. The United States District Court for the District of New Jersey, Anne E. Thompson, J., granted motion. Wife appealed.

Holding: The Court of Appeals, Jordan, Circuit Judge, held that under New Jersey law, as predicted by federal court, neither medical evaluation company which recommended doctor, nor doctor who performed peer assessment review on patient with chronic dermatomyositis, owed duty of care to patient.

Affirmed.

West Headnotes (1)

[1] Health
Insurance;workers' compensation

Under New Jersey law, as predicted by federal court, neither medical evaluation company which recommended doctor, nor doctor who performed peer assessment review on patient with chronic dermatomyositis to review medical records and answer questions posed by patient's insurance company, owed duty of care to patient, where there was no privity or doctor-patient relationship with them given that patient had absolutely no interaction of any kind with doctor, patient had no awareness that doctor existed, let alone that she was performing services connected to his insurance claim, patient did not rely on doctor to help him understand his physical condition or determine an appropriate course of treatment, and even if patient had relied on doctor at all, it was to help him get reimbursed for his desired course of treatment, not for making medical decisions.

1 Cases that cite this headnote

***137** On Appeal from the United States District Court for the District of New Jersey (D.C. No. 3–12–cv–01014), District Judge: Hon. Anne E. Thompson.

Attorneys and Law Firms

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Before: FISHER, CHAGARES, and JORDAN, Circuit Judges.

OPINION [*]

JORDAN, Circuit Judge.

Appellant Linda Skelcy, in her individual capacity and as the administratrix of the estate of her husband, James Skelcy, asks us to reverse an order of the United States District Court for the District of New Jersey dismissing her complaint against Medical Evaluation Specialists, Inc. ("MES") and Dr. Denise Beighe, M.D ("Dr. Beighe"). Because we agree with the District Court that neither MES nor Dr. Beighe owed a duty of care to Mr. Skelcy, we will affirm.

I. BACKGROUND

*138 A. FACTUAL BACKGROUND [1]

In July of 2007, Mr. Skelcy was diagnosed with dermatomyositis, a connective tissue disease. Later, he was diagnosed with interstitial lung disease ("ILD"), as a secondary condition. At all relevant times, Mr. Skelcy was covered by a health insurance policy issued by UnitedHealth Group, Inc. ("UnitedHealth"), by and through Oxford Health Insurance, Inc. ("Oxford").

Mr. Skelcy was first treated with various first-line medications, but they proved ineffective. Then, in August 2009, his treating rheumatologist prescribed Rituximab ("Rituxan"), a common next-step therapy. UnitedHealth and Oxford (collectively "the UnitedHealth Defendants") approved and covered Mr. Skelcy's Rituxan treatments without delay or question. Mr. Skelcy received two doses of the drug, to which he responded very well. In fact, he responded so positively that he was able to maintain remission of his dermatomyositis and ILD for almost one full year with those two doses of Rituxan.

In July 2010, his symptoms returned. His treating rheumatologist immediately prescribed another dose of Rituxan, which was scheduled to be administered later that month. But, two days before the scheduled treatment, the UnitedHealth Defendants had still not approved the dose of Rituxan. Mr. Skelcy's treating rheumatologist therefore faxed a letter of medical necessity to Oxford expressing Mr. Skelcy's urgent need for a dose of Rituxan or an intravenous immunoglobin ("IVIG") infusion. The imminent need for one of the treatments was or should have been immediately apparent to the UnitedHealth Defendants, given Mr. Skelcy's deteriorating condition and prior response to Rituxan. Nevertheless, on the same day that they received the fax, the UnitedHealth Defendants denied the claim for Rituxan or an IVIG infusion. Mr. Skelcy's treating rheumatologist had numerous follow-up conversations with the UnitedHealth Defendants' representatives in which he explained the need for treatment. He also immediately responded by filing an "Expedited Utilization Review Appeal," as permitted by Mr. Skelcy's insurance policy.

Within two days of receiving the clinical information necessary to process the expedited appeal, the UnitedHealth Defendants transmitted the appeal to MES for a peer review assessment. MES assigned Dr. Beighe, a rheumatologist located and licensed in Arizona, to provide the peer review assessment of the expedited appeal. [2] After reviewing the materials provided *139 by Mr. Skelcy's treating rheumatologist, including medical records indicating that Mr. Skelcy had previously responded well to Rituxan, Dr. Beighe stated in her peer review assessment that, "[t]his type of therapy is not [the] standard of care for this disease" and "[t]his specific therapy is not [the] standard of care for this patient's disease." (App. at 49.) Dr. Beighe further specified that there was inadequate medical literature to conclude that Rituxan was effective in treating Mr. Skelcy's condition,

but she also concluded that "IVIG would be [the] standard of care at this point for the member." (*Id.*)

The next day after receiving Dr. Beighe's assessment, the UnitedHealth Defendants again denied the request to treat Mr. Skelcy with Rituxan or an IVIG infusion. In an internal memorandum, the UnitedHealth Defendants stated, "[a] board certified rheumatologist has reviewed the request and has [determined] that the request for Rituxan should be denied as unproved. The clinical data from the prevailing peer reviewed published medical literature is not adequate to conclude that the requested medication is effective in treating the member's condition." (App. at 50.) Despite Dr. Beighe's specific recommendation in favor of an IVIG infusion, the UnitedHealth Defendants did not approve that therapy.

Approximately two weeks after the denial of Mr. Skelcy's expedited appeal, his treating rheumatologist faxed a letter to the UnitedHealth Defendants pleading that Mr. Skelcy had received Rituxan in August 2009 "with excellent response," and stating that the "patient is a father, is a husband, and the main bread winner of his family" and that "[a] further deterioration of his condition ... is imminent." (App. at 50–51.) On August 9, 2010, thirty-two days after receiving Mr. Skelcy's claim for treatment, the UnitedHealth Defendants reversed their decision and approved the Rituxan treatment. The record reveals no explanation for their tragically belated change of heart. Within 36 hours of the UnitedHealth Defendants' decision to approve the Rituxan treatment, Mr. Skelcy died. The Union County Medical Examiner's Office determined that the cause of death was chronic dermatomyositis, interstitial pulmonary fibrosis, endomyocardial fibrosis, and cardiac arrhythmia.

B. PROCEDURAL HISTORY

Mrs. Skelcy filed her First Amended Complaint on April 13, 2012, asserting, *inter alia,* claims for negligence and negligence per se against MES and Dr. Beighe. On June 29, 2012, MES and Dr. Beighe filed a motion to dismiss all claims against them, advancing three arguments: (1) neither owed a duty of care to Mr. Skelcy; (2) the statute underlying the negligence per se claims did not impose a duty upon them; and (3) the court lacked personal jurisdiction over Dr. Beighe. Mrs. Skelcy responded by filing a motion for leave to file a Second Amended Complaint, withdrawing the negligence per se claims. She also opposed MES's and Dr. Beighe's motion to dismiss the negligence claims.

The District Court granted MES's and Dr. Beighe's motion to dismiss, reasoning that "there is both a lack of a demonstrable duty to Mr. Skelcy on the part of [MES or Dr. Beighe] and of causation." (*Id.* at 22.) The Court said that, because neither MES nor Dr. Beighe had a special or contractual relationship with Mr. Skelcy, "there exists no grounds for traditional ***140** medical malpractice [or negligence] claims against Dr. Beighe" or MES. (*Id.*) Moreover, given that neither MES nor Dr. Beighe set the standard for review in the UnitedHealth Defendants' treatment approval process or made the final judgment on treatment certification, the District Court found no "sufficient nexus between the actions of [MES or Dr. Beighe] and Mr. Skelcy's death." (*Id.*) The District Court also denied Mrs. Skelcy's motion to amend her remaining claims against MES and Dr. Beighe, stating that any motion to amend the remaining negligence claims would be futile. [3]

The claims against the remaining defendants survived and the case proceeded through discovery. It was ultimately closed on December 5, 2014, pursuant to a settlement between Mrs. Skelcy and those defendants, thereby rendering the dismissal of Mrs. Skelcy's claims against MES and Dr. Beighe a final order subject to appeal. Mrs. Skelcy then timely appealed.

II. DISCUSSION [4]

The District Court dismissed Mrs. Skelcy's claims against MES and Dr. Beighe because it found as a matter of law that neither defendant owed her a duty of care and also that she failed to demonstrate that their negligence, if any, caused Mr. Skelcy's death. Because we agree that neither defendant owed Mr. Skelcy a duty of care, we do not reach the second basis for the District Court's ruling.

"The fundamental elements of a negligence claim are a duty of care owed by the defendant to the plaintiff, a breach of that duty by the defendant, injury to the

plaintiff proximately caused by the breach, and damages." *Robinson v. Vivirito,* 217 N.J. 199, 86 A.3d 119, 124 (2014). The existence of a duty and the scope of that duty are generally questions of law for the court to decide. *Carvalho v. Toll Bros. & Developers,* 143 N.J. 565, 675 A.2d 209, 212 (1996). "[W]hether a duty exists is ultimately a question of fairness. The inquiry involves a weighing of the relationship of the parties, the nature of the risk, and the public interest in the proposed solution." *Reed v. Bojarski,* 166 N.J. 89, 764 A.2d 433, 443 (2001) (internal quotation marks omitted). "A duty is said to arise out of the existence of a relationship between the parties such that social policy justifies its imposition." *Id.* (internal quotation marks omitted). Whether a physician owes any duty to an individual who is the subject of a peer review assessment as part of that individual's claim for health insurance coverage is a question that has not been addressed by the New Jersey Supreme Court. We must therefore "predict how the New Jersey Supreme Court would rule if presented with this case." *Repola v. Morbark Indus., Inc.,* 934 F.2d 483, 489 (3d Cir.1991).

Mrs. Skelcy relies on a small set of cases to argue that, "under New Jersey law, no traditional doctor-patient relationship or special duty is required to maintain a cause of action for negligence against a ***141** physician...." (Opening Br. at 14.) She asserts that, given the broad duty of care imposed upon physicians under New Jersey law, MES and Dr. Beighe owed her husband a duty of care, even though no privity or doctor-patient relationship bound him to them.

The first case presented as support is *Beadling v. Sirotta,* 41 N.J. 555, 197 A.2d 857 (1964). George Beadling had applied for a job as a machinist. His would-be employer scheduled a pre-employment physical, which included a chest x-ray. Dr. Sirotta, the radiologist who examined Beadling's x-ray, detected a lung abnormality that he believed was evidence of active tuberculosis. Dr. Sirotta told Beadling that something was generally amiss with the x-ray, but he did not reveal any details of the condition to Beadling. Instead, Dr. Sirotta disclosed those details to the would-be employer who decided not to hire Beadling. Dr. Sirotta did, however, subsequently communicate with Beadling's treating physicians, who were able to resolve the illness. Nevertheless, after undergoing a series of tests at the hospital and six weeks' home confinement, Beadling sued numerous parties, including Dr. Sirotta who had failed to immediately inform him of his malady. Dr. Sirotta defended on the ground that he had no physician-patient relationship with Beadling, and, therefore, no corresponding duty. The Supreme Court of New Jersey rejected Dr. Sirotta's absolute claim that the absence of a physician-patient relationship forecloses the existence of any duty, stating, "[w]hether or not a physician-patient relationship exists, ... a physician in the exercise of his profession examining a person at the request of an employer owes that person a duty of reasonable care." *Id.* at 860. But the *Beadling* court did not define the scope of a physician's duty of reasonable care to an examinee because, "even assuming a duty was owed to [Beadling] to examine and report with reasonable care," the court found "no evidence of its breach" since Dr. Sirotta's post-examination communications had been instrumental in helping Beadling's treating physicians head off the tuberculosis. *Id.* at 861.

Mrs. Skelcy next relies on *Ranier v. Frieman,* 294 N.J.Super. 182, 682 A.2d 1220 (N.J.Super.Ct.App.Div.1996). The plaintiff in that case, Penice Ranier, claimed that his ability to work had been compromised by deteriorating vision, so he applied for social security disability benefits. In July 1992, the Department of Labor referred Ranier to Dr. Frieman, a board-certified ophthalmologist. Dr. Frieman examined Ranier and, in his report, described the examination as a "normal ocular examination," diagnosed myopia (nearsightedness) and presbyopia (farsightedness), and opined that there was a possibility of malingering. *Id.* at 1221. Based on Dr. Frieman's report, the disability claim was rejected. A few months later, Ranier's vision problems persisted. After visiting his own ophthalmologist, a brain tumor was discovered in his optic chiasm, which was the cause of his declining eyesight. Ranier sued Frieman, claiming that he had negligently failed to find the tumor. Frieman moved for summary judgment. He argued that, since he was retained by the Department of Labor to examine Ranier on its behalf and to report only to it, there was never a physician-patient relationship between him and Ranier, and, thus, he owed no duty to Ranier to render a professionally reasonable diagnosis. The New Jersey Superior Court rejected Dr. Frieman's argument. Relying on *Beadling,* the *Ranier* court recognized that "a professional's duty of care is owed not only to his

patient or client but also to those third parties who will foreseeably and reasonably rely on his skill and care in ***142** the performance of a particular professional undertaking." *Id.* at 1223. And, on the facts presented, the *Ranier* court concluded that, because Ranier had "relied, both reasonably and foreseeably, on the examining physician's diagnosis," Dr. Frieman had a duty, "as a matter of fairness," to Rainier as well as to the Department of Labor to make a professionally reasonable and competent diagnosis. *Id.*

Finally, Mrs. Skelcy buttresses her argument that New Jersey law would impose a duty of care on MES and Dr. Beighe by relying upon *Reed v. Bojarski,* 166 N.J. 89, 764 A.2d 433 (2001). Like *Beadling* and *Ranier, Reed* called upon a New Jersey court to further define the boundaries of the duty of care that a physician owes to an examinee. In that case, the decedent, Arnold Reed, underwent a pre-employment physical examination. The would-be employer had contracted with Environmental Medicine Resources, Inc. ("EMR") to perform the examination. EMR subcontracted with Life Care Institute, Inc. ("Life Care") to perform physicals and medical imaging services, including evaluations of pre-employment x-rays. Dr. Bojarski, an employee of Life Care, conducted Reed's physical. A radiologist who examined Reed's chest x-ray told Dr. Bojarski that Reed had a widened mediasternum, which may be an indicator of lymphoma, including Hodgkin's disease. Dr. Bojarski subsequently sent the x-ray, along with the rest of Reed's examination package to EMR. Reed stated in his report to EMR that the x-ray was "abnormal," but he made no reference to the widened mediasternum. Two days after Dr. Bojarski sent his report to EMR, the radiologist gave Dr. Bojarski a written report on Reed's x-ray, recommending a follow-up CT scan, but Dr. Bojarski never conveyed that suggestion or the report to EMR. About six months later, Reed was admitted to the hospital and, after a chest x-ray showed a large mass in his mediasternum, he was diagnosed with Stage IIB Hodgkin's disease. He died eight months later. Reed's widow sued Dr. Bojarski and Life Care. At trial, the judge instructed the jurors that, if they found that it was reasonable for Dr. Bojarski to forward the materials concerning Reed to EMR and rely on EMR's contractual obligation to independently review the materials and inform Reed of any adverse findings, then they could not find Dr. Bojarski negligent. With that instruction, the jury unanimously found for Dr. Bojarski. The New Jersey Supreme Court reversed. It held that, while a pre-employment examination does not establish a traditional physician-patient relationship, the examination still creates a relationship "in which a physician is expected to exercise reasonable care commensurate with his expertise and training, both in conducting the examination and in communicating the results to the examinee." *Id.* at 443. That is so, the court explained, because "the patient is entitled to rely on the physician to tell him of a potential serious illness if it is discovered. Any reasonable person would expect that and the duty to communicate with a patient who is found to be ill is non-delegable." *Id.*

Relying on those cases,[5] Mrs. Skelcy argues that MES and Dr. Beighe owed her ***143** husband a duty of care. In fact, she says, "[t]his matter presents a more compelling context to impose a duty of reasonable care upon a physician, than the pre-employment examination context of *Reed, Beadling* and *Ranier.*" (Opening Br. at 19). In those cases, the purpose of the physician's examination was not to affect medical treatment but to determine fitness for employment. Here, she argues, MES and Dr. Beighe were delegated a much weightier responsibility —reviewing and influencing whether a patient would have coverage for treatment or a procedure, potentially preempting a treating physician's opinions and interfering with patient care. Mrs. Skelcy contends that often only a physician in Dr. Beighe's position will have the requisite expertise to perform an independent review to decide the ultimate outcome of an insurance claim. And, she continues, the peer review that Dr. Beighe undertook caused the arbitrary denial of a proven treatment for Mr. Skelcy's deteriorating condition, which was a substantial factor in causing his death. According to Mrs. Skelcy, "[a]bsent the imposition of a duty upon the reviewing physician in this context, arbitrary coverage decisions will no doubt continue to result in the grave consequences underlying the current matter." (Opening Br. at 22.) Therefore, she says, the public policy principles inherent in analogous New Jersey cases strongly suggest that a duty should be imposed on MES and Dr. Beighe in this case. Furthermore, she points out, unlike the pre-employment examinees, "Mr. Skelcy pa[id] premiums in exchange for coverage of medically necessary treatments with

the expectation that treatment would not be arbitrarily withheld." (*Id.* at 20.)

We sympathize with Mrs. Skelcy and share the sense of injustice prompted by the UnitedHealth Defendants' decision to delay her husband's treatment until it was too late to save his life. That does not mean, however, that, under New Jersey law, either MES or Dr. Beighe owed a duty of care to her husband.[6] The cases cited by Mrs. Skelcy demonstrate how New Jersey courts have liberally, but not heedlessly, extended remedies to non-patients injured by the actions or inaction of physicians. Mrs. Skelcy is correct that a traditional doctor-patient relationship or special duty is not required to maintain a cause of action for negligence against a ***144** physician in New Jersey, but we think she is likely wrong that New Jersey courts would impose a duty on facts such as the ones here. There is a clear and common thread running through *Beadling, Ranier*, and *Reed* that is absent here—each of those cases involved personal interactions with or affirmative acts by a physician that induced the injured party to foreseeably and reasonably rely on the physician to discover or disclose serious illnesses. While none of those cases found that a physician-patient relationship existed, they each relied upon the existence of *some* "relationship between the parties" that could be inferred from the parties' interactions and that entitled the injured party to rely on the physician's competency. *Reed,* 764 A.2d at 443 (internal quotation marks omitted).

The facts of this case are different in at least two significant ways. First, Mr. Skelcy had absolutely no interaction of any kind with Dr. Beighe. In fact, he apparently had no awareness that Dr. Beighe even existed, let alone that she was performing services connected to his insurance claim. All Dr. Beighe did in connection with Mr. Skelcy's case was to review medical records and answer questions posed by the UnitedHealth Defendants. That difference undermines Mrs. Skelcy's claims against MES and Dr. Beighe, since *Reed* was clear that the "non-delegable duty" of care owed by a physician stems from the trust a patient places in the doctor after a relationship arises through personal interactions, in that case a physical examination. *Id.; see also Nolan v. First Colony Life Ins. Co.,* 345 N.J.Super. 142, 784 A.2d 81, 86 (N.J.Super.Ct.App.Div.2001) (holding that *Reed's* reasoning has little purchase in a "commercial setting" where a healthcare professional reviewed a plaintiff's blood test results but did not form a relationship of "trust or reliance" with the injured party). Second, even assuming that Mr. Skelcy relied on Dr. Beighe's professional competence, which he did not, it was not the sort of reliance that New Jersey courts have protected in the past. In *Beadling, Ranier,* and *Reed,* New Jersey courts protected a person's ability to safely rely on a physician's implied or express representations when making medical decisions, such as selecting an appropriate course of treatment. But the reliance interest claimed here is completely distinct. Mr. Skelcy did not rely on Dr. Beighe to help him understand his physical condition or determine an appropriate course of treatment; if he had relied on Dr. Beighe at all, it was to help him get reimbursed for his desired course of treatment.

We thus doubt that the New Jersey Supreme Court would recognize a duty of care on these terribly sad facts.

III. CONCLUSION

For the foregoing reasons, we will affirm the District Court's dismissal of the claims against MES and Dr. Beighe.

All Citations

620 Fed.Appx. 136

Footnotes

* This disposition is not an opinion of the full court and, pursuant to I.O.P. 5.7, does not constitute binding precedent.

1 We recount the facts as alleged by the non-movant, Mrs. Skelcy, accepting them as true. *Fowler v. UPMC Shadyside,* 578 F.3d 203, 210 (3d Cir.2009).

2 To determine whether the prescribed treatment was medically necessary for Mr. Skelcy, Dr. Beighe was presented with seven questions upon which to base her review:

1. Is this an FDA approved use of the requested medication(s)/service(s)?

2. Is this type of therapy “standard of care” for this disease/disease state?
3. Is this specific therapy “standard of care” for this patient's disease/disease state?
4. Is the clinical data from the prevailing peer-reviewed published medical literature adequate to conclude that the requested medication(s)/service(s) is effective in treating the member's condition? [I]f no-please go to question 5.
5. Are there at least two articles in the peer-reviewed literature that show that the proposed therapy is more likely to benefit the member than the standard of care, or other available therapies?
6. Are alternative therapies possible?
7. Is there sufficient data for your opinion?

(App. at 128–29.) The questions do not require or even encourage the reviewing physician to take a member's specific condition, treatment history, or a treating physician's recommendations into account. Dr. Beighe was instead asked simply to answer the non-specific, generic questions about the disease with which Mr. **Skelcy** was afflicted.

3 The District Court, having disposed of Mrs. **Skelcy's** claims against MES and Dr. Beighe on Rule 12(b)(6) grounds, did not address Dr. Beighe's argument that she was not subject to the Court's personal jurisdiction.

4 The District Court had jurisdiction under 28 U.S.C. § 1332. We have appellate jurisdiction under 28 U.S.C. § 1291. We exercise plenary review over a dismissal under Rule 12(b)(6). *Pearson v. Sec'y Dep't of Corr.,* 775 F.3d 598, 601 (3d Cir.2015). “To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to ‘state a claim to relief that is plausible on its face.’ ” *Ashcroft v. Iqbal,* 556 U.S. 662, 678, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009) (quoting *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 570, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007)).

5 Mrs. **Skelcy** also briefly cites a somewhat related collection of cases in which New Jersey courts have held a professional liable to non-client third parties who reasonably and foreseeably relied on the professional's skill and care in the performance of a professional undertaking. *See Snyder v. Am. Ass'n of Blood Banks,* 144 N.J. 269, 676 A.2d 1036, 1054 (1996) (holding that the American Association of Blood Banks owes a duty of ordinary care to persons receiving blood or blood products from its members, including the plaintiff who had no direct contact with the defendant but who contracted AIDS from a tainted unit of blood collected by one of its members); *Petrillo v. Bachenberg,* 139 N.J. 472, 655 A.2d 1354, 1361–62 (1995) (holding that an attorney for a seller of real estate has a duty not to provide misleading information to potential buyers who the attorney knows, or should know, will rely on that information); *Carter Lincoln–Mercury, Inc., Leasing Div. v. EMAR Grp., Inc.,* 135 N.J. 182, 638 A.2d 1288, 1297–99 (1994) (holding that an insurance broker engaged to obtain insurance on behalf of a prospective insured owes a duty to a loss-payee subsequently named on the acquired policy to place the insurance with a financially stable insurance carrier); *H. Rosenblum, Inc. v. Adler,* 93 N.J. 324, 461 A.2d 138, 154 (1983) (holding the auditor of a corporation liable to all those whom the auditor should reasonably foresee as recipients from the audited company of its financial statements for its proper business purposes, provided that the recipients rely on the statements pursuant to those business purposes), *superseded by statute,* N.J. Stat. Ann. 2A:53A–25, *as recognized in Cast Art. Indus., LLC v. KPMG, LLP,* 209 N.J. 208, 36 A.3d 1049 (2012); *Safer v. Estate of Pack,* 291 N.J.Super. 619, 677 A.2d 1188, 1192 (N.J.Super.Ct.App.Div.1996) (holding that a physician has a duty to warn a patient's immediate family members of avoidable harm from genetically transmissible diseases).

6 Our holding is strictly limited to the claims contained in Mrs. **Skelcy's** complaint. We do not opine whether entities and physicians could be liable as aiders and abettors in a scheme designed to deny insurance claims in bad faith.

--- N.Y.S.2d ----, 2008 WL 4356120 (N.Y.A.D. 2 Dept.), 2008 N.Y. Slip Op. 07081

Supreme Court, Appellate Division, Second Department, New York.
Lewis J. BAZAKOS, appellant,
v.
Philip LEWIS, respondent,
et al., defendant.
Sept. 23, 2008.

CARNI, J.

*1 The issue presented for our consideration is as follows: When a physician conducts a medical examination in the context of a personal injury action on behalf of an alleged tortfeasor or his or her insurer and, in the course of doing so, affirmatively injures the examinee, should the examinee's cause of action against the examining physician to recover damages for that injury be characterized as one to recover damages for medical malpractice, or rather, one to recover damages for "simple" negligence? [FN1] For the reasons that follow, we conclude that the cause of action is to be characterized as one to recover damages for simple negligence.

In 1998, the plaintiff, Lewis J. Bazakos, allegedly was injured when the vehicle that he was driving was "rear-ended" by another vehicle. After the accident, Bazakos commenced an action against the other driver, seeking to recover damages for his injuries.

On November 27, 2001, Bazakos was required to appear at the offices of the defendant Philip Lewis, an orthopedic surgeon licensed to practice medicine in New York, who had been selected to perform a statutory medical examination (*see* CPLR 3102[a]; 3121; 22 NYCRR 202.17) on behalf of the alleged tortfeasor in connection with the lawsuit. According to Bazakos, during the statutory medical examination, Lewis "took [his] head in his hands and forcefully rotated it while simultaneously pulling." In addition, according to Bazakos, this "physical action caused [him] personal injury."

Approximately two years and eleven months after the statutory medical examination took place, Bazakos commenced the instant action against Lewis. Alleging that Lewis "committed negligence toward" him during the statutory medical examination, Bazakos sought to recover damages for the alleged injuries caused by that "negligence ."

Lewis then moved pursuant to CPLR 3211(a)(5) to dismiss the complaint insofar as asserted against him as time-barred. In support of his motion, Lewis asserted that while Bazakos might have alleged that the instant action was one to recover damages for negligence, and hence, subject to a three-year statute of limitations (*see* CPLR 214[5]), the action was, in actuality, one to recover damages for medical malpractice, which is subject to a 2 1/2 -year statute of limitations (*see* CPLR 214-a). In opposition, Bazakos asserted that he was never in a physician-patient relationship with Lewis because he only saw Lewis in the context of a statutory medical examination, and contended that it necessarily followed that his claim sounded in negligence, as opposed to medical malpractice.

In the resultant order, the Supreme Court agreed with Lewis that the instant action was "founded on medical malpractice." Accordingly, the court granted Lewis's motion to dismiss the complaint. We reverse.

[1] It is well settled that the essence of a medical malpractice action is the existence of the duty which arises from the physician-patient relationship (*see Caso v. St. Francis Hosp.*, 34 A.D.3d 714, 825 N.Y.S.2d 127; *Mendelson v. Clarkstown Med. Assoc.*, 271 A.D.2d 584, 707 N.Y.S.2d 638; *Lippert v. Yambo*, 267 A.D.2d 433, 700 N.Y.S.2d 848; *Chaff v. Parkway Hosp.*, 205 A.D.2d 571, 613 N.Y.S.2d 237). "[M]alpractice in the statutory sense describes *the negligence of a professional toward the person for whom he rendered a service, and ... an action for malpractice springs from the correlative rights and duties assumed by the parties through the relationship. On the other hand, the wrongful conduct of the professional in rendering services to his client resulting in injury to a party outside the relationship is simple negligence* " (*Cubito v. Kreisberg*, 69 A.D.2d 738, 742, 419 N.Y.S.2d 578, *affd* 51 N.Y.2d 900, 434 N.Y.S.2d 991, 415 N.E.2d 979) (emphasis added). Contrary to Lewis's contention, the determination as to whether an action sounds in medical malpractice does not depend upon the need for expert testimony (*see Payette v. Rockefeller Univ.*, 220 A.D.2d 69, 74, 643 N.Y.S.2d 79; *Stanley v. Lebetkin*, 123 A.D.2d 854, 507 N.Y.S.2d 468; *but see Miller v. Albany Med. Ctr. Hosp.*, 95 A.D.2d 977, 464 N.Y.S.2d 297; *Hale v. State of New York*, 53 A.D.2d 1025, 386 N.Y.S.2d 151; *Mossman v. Albany Med. Ctr. Hosp.*, 34 A.D.2d 263, 311 N.Y.S.2d 131).

*2 Cast in this light, the time has come to acknowledge the essential nature of the relationship inherent in the performance of a statutory medical examination, pursuant to 22 NYCRR 202.17, by a physician retained and paid by a defendant's insurance carrier to assist in the defense of a personal injury action and the duty that flows to a party outside that relationship-in this case a personal injury plaintiff.[FN2] It is beyond cavil that a statutory medical examination is an adversarial process. The examinee's attendance is compelled by rule of law (*see* 22 NYCRR 202.17), and his or her engagement and interaction with the examining physician is nonconsensual. Indeed, because of the inherently adversarial nature of these types of examinations, this Court long ago recognized the examinee's right to be examined in the presence of his or her attorney (*see Ponce v. Health Ins. Plan of Greater N.Y.*, 100 A.D.2d 963, 475 N.Y.S.2d 102). In stark contrast, the physician-patient relationship is characterized by the confidentiality and trust necessary to facilitate the securing of adequate diagnosis and treatment (*see* CPLR 4504; *Matter of Grand Jury Investigation in N.Y. County*, 98 N.Y.2d 525, 749 N.Y.S.2d 462, 779 N.E.2d 173). Critical to a finding of a physician-patient relationship is the consensual nature essential to the formation of the relationship. "The relationship is created when the professional services of a physician are rendered to and accepted by another person for the purposes of medical or surgical treatment" (*Lee v. City of New York*, 162 A.D.2d 34, 36, 560 N.Y.S.2d 700 ["The physician patient-relationship is a consensual one"]).

Here, there is no dispute that Bazakos did not expect, seek, or receive medical treatment or diagnosis from Lewis. Nor does Lewis contend that Bazakos consulted him as a health care provider.[FN3] Under similar circumstances, this Court recently recognized that the touchstone of the formation of a physician-patient relationship giving rise to a medical malpractice cause of action is the expectation and receipt of medical services by the plaintiff for a medical condition (*see Sosnoff v. Jackman*, 45 A.D.3d 568, 845 N.Y.S.2d 391, *lv dismissed* 10 N.Y.3d 885, 860

N.Y.S.2d 481, 890 N.E.2d 244). Likewise, in refusing to apply the medical malpractice statute of limitations to a participant in an experimental diet study, the Appellate Division, First Department, in *Payette v. Rockefeller Univ.* (220 A.D.2d 69, 72, 643 N.Y.S.2d 79), stated:

"[N]one of the circumstances essential to a cause of action in malpractice, essentially the existence of a physician-patient relationship, are present in the instant matter. In her complaint, plaintiff makes no claim of [the defendant's] malpractice in furnishing medical treatment. It is also clear that plaintiff did not consult [the defendant] as a health care provider. Nor did she undergo, as part of any medical treatment, the procedures she complains of, i.e., the multiple injections of isotopes of iodine, which she contends were three times the amount approved by [the defendant's] Board of Directors in its protocol. The fact that medical doctors examined and evaluated plaintiff and made notations in [the defendant's] hospital chart as to plaintiff's medical reaction to the diet does not, by itself, indicate the existence of a physician-patient relationship."

*3 Thus, the threshold and dispositive issue is whether a physician-patient relationship exists between the examinee and the physician. The relationship defines the duty. The duty does not define the relationship. Put another way, the threshold determination of whether a physician-patient relationship exists is based upon the expectations of the parties during the course of the encounter. The Court of Appeals has recognized for more than a century that no physician-patient relationship arises from an examination rendered at the request and on behalf of an adversary in the litigation context (*see People v. Sliney*, 137 N.Y. 570, 33 N.E. 150). This Court recently held that "[a] physician-patient relationship does not exist where the examination is conducted solely for the purpose of rendering an evaluation for an insurer" (*Savarese v. Allstate Ins. Co.*, 287 A.D.2d 492, 493, 731 N.Y.S.2d 226).

Here, there is no "patient" at all in this relationship-only an "examinee" compelled to participate because of the rules pertaining to pretrial discovery and disclosure in personal injury actions. The examining physician's duty not to affirmatively injure the examinee during the evaluation is adequately and appropriately embraced within a simple negligence cause of action. The examining physician is not engaged in diagnosis and treatment on the *examinee's* behalf. The evaluation is performed for the benefit of the defendant, defense counsel, and the defendant's insurance carrier, not the examinee. Thus, the examining physician has no duty to the *examinee* even to so much as properly evaluate and report upon the injuries, disabilities, or injury causation issues extant in the litigation (*see Savarese v. Allstate Ins. Co.*, 287 A.D.2d 492, 731 N.Y.S.2d 226). Indeed, it is well settled that an examining physician has no duty to an examinee to properly diagnose any condition revealed during the examination (*see LoDico v. Caputi*, 129 A.D.2d 361, 517 N.Y.S.2d 640 [examining physician not liable to examinee for failure to properly diagnose a brain tumor]).

Wishing to avoid liability for having failed to properly diagnose a brain tumor during the plaintiff's statutory neurological examination, the examining neurologist in *LoDico* submitted an affidavit averring that "he examined the plaintiff at the request of the workers' compensation carrier; that the examination was not conducted for the purpose of treatment or diagnosis; and, therefore, there was no physician-patient relationship sufficient to support a claim for medical malpractice" (*LoDico v. Caputi*, 129 A.D.2d at 363, 517 N.Y.S.2d 640). The Appellate Division, Fourth Department, agreed. Yet the defendant in this case, secure in the knowledge that the

statute of limitations for medical malpractice has expired, contends that his conduct constituted medical treatment or bore a substantial relationship to medical treatment so as to receive the benefit of the shorter medical malpractice period of limitations. We find it irreconcilable that, on the one hand, the examining physician should have the benefit of asserting the absence of a physician-patient relationship when he or she seeks to avoid medical malpractice liability for negligently failing to diagnose, yet, on the other, when it suits his or her purpose, assert that he or she was "diagnosing" or "treating" the examinee through "hands on" manipulation so as to obtain the benefit of the shorter period of limitations.

*4 Notwithstanding the absence of a physician-patient relationship, Lewis seeks the protection provided by the shorter period of limitations contained within CPLR 214-a. A review of the legislative history of CPLR 214-a makes it clear that the period of limitations for medical malpractice actions was shortened as part of a comprehensive legislative overhaul to deal with "the critical threat to the health and welfare of the State by way of diminished *delivery of health care services* " and to "assure the public the basic protection to which all *patients* are entitled" (Mem of State Exec Dept, 1975 McKinney's Session Laws of NY, at 1599; Governor's Mem approving L 1975, ch 109, 1975 McKinney's Session Laws of NY, at 1739-1740)(emphasis added). [FN4] Indeed, in 1985 the Court of Appeals instructed that the analysis of whether a particular claim sounds in negligence or medical malpractice must be cast in the light of the legislative intent in shortening the Statute of Limitations in order to maintain " 'the adequate delivery of health care services' " (*Bleiler v. Bodner*, 65 N.Y.2d 65, 68, 489 N.Y.S.2d 885, 479 N.E.2d 230, quoting Mem of State Exec Dept, 1975 McKinney's Session Laws of NY, at 1601-1602).[FN5] The shortening of the medical malpractice period of limitations clearly did not have, as one of its salutary purposes, the intent of providing a significant litigation advantage to physicians not engaged in providing health care services, but instead engaged in business relationships structured to provide expert witness services to insurance carriers in the defense of personal injury litigation.

[2] Lewis's provision of the statutory medical examination service to his client, the insurance carrier, which allegedly resulted in injury to the plaintiff, with whom he had no physician-patient relationship, is simple negligence (*see Cubito v. Kreisberg*, 69 A.D.2d 738, 742, 419 N.Y.S.2d 578, *affd* 51 N.Y.2d 900, 434 N.Y.S.2d 991, 415 N.E.2d 979). A physician-patient relationship does not exist where, as here, the examination is conducted solely for the purpose of rendering an evaluation as a litigation support service for an insurer (*see Savarese v. Allstate Ins. Co.*, 287 A.D.2d 492, 493, 731 N.Y.S.2d 226). To the extent that any prior decisions of this Court hold or indicate to the contrary (*see Evangelista v. Zolan*, 247 A.D.2d 508, 669 N.Y.S.2d 325), they are not to be followed.

Accordingly, we find that the instant action, which was commenced less than three years after the statutory medical examination, is not time-barred (*see* CPLR 214). The order of the Supreme Court is reversed, on the law, and the motion of the defendant Philip Lewis pursuant to CPLR 3211(a)(5) to dismiss the complaint insofar as asserted against him as time-barred is denied.

PRUDENTI, P.J. and SKELOS, J., concur.

COVELLO, J., dissents and votes to affirm the order appealed from with the following memorandum, in which SANTUCCI, J., concurs.

When a physician performs what is commonly known as an "independent medical examination" (hereinafter IME),[FN1] and, in the course of doing so, affirmatively injures the examinee, the examinee's cause of action against the IME physician to recover damages for that injury should be characterized as one to recover damages for medical malpractice. Indeed, well-reasoned and long-standing case law from this and other appellate courts supports this conclusion. In light of this precedent, as well as principles of stare decisis, I must respectfully dissent.

*5 As the majority notes, it is fundamental that in order to maintain a cause of action to recover damages for medical malpractice, the plaintiff must have been in a physician-patient relationship with the defendant physician (*see* *Jacobs v. Mostow*, 306 A.D.2d 439, 761 N.Y.S.2d 500; *White v. Southside Hosp.*, 281 A.D.2d 474, 475, 721 N.Y.S.2d 678; *von Ohlen v. Piskacek*, 277 A.D.2d 375, 717 N.Y.S.2d 221; *Heller v. Peekskill Community Hosp.*, 198 A.D.2d 265, 603 N.Y.S.2d 548; *Lee v. City of New York*, 162 A.D.2d 34, 37, 560 N.Y.S.2d 700; *Murphy v. Blum*, 160 A.D.2d 914, 915, 554 N.Y.S.2d 640; *Hickey v. Travelers Ins. Co.* ., 158 A.D.2d 112, 116, 558 N.Y.S.2d 554). After all, "malpractice, in its strict sense, means the negligence of a member of a profession in his [or her] relations with his [or her] client or patient" (*Cubito v. Kreisberg*, 69 A.D.2d 738, 742, 419 N.Y.S.2d 578, *affd* 51 N.Y.2d 900, 434 N.Y.S.2d 991, 415 N.E.2d 979).

It has been said that a physician-patient relationship, which is a consensual relationship, would exist where a physician's "professional services" are "rendered and accepted by another person for the purposes of medical or surgical treatment" (*Heller v. Peekskill Community Hosp.*, 198 A.D.2d at 265, 603 N.Y.S.2d 548; *see* *Lee v. City of New York*, 162 A.D.2d at 36, 560 N.Y.S.2d 700; *United Calendar Mfg. Corp. v. Huang*, 94 A.D.2d 176, 179, 463 N.Y.S.2d 497; *see also* *Sosnoff v. Jackman*, 45 A.D.3d 568, 571, 845 N.Y.S.2d 391). Yet, when it comes to IMEs, a person is being examined because, as the majority puts it, he or she has been "compelled" to attend the examination. Indeed, various statutes and regulations require a person whose condition is at issue to submit to a medical examination demanded by a third party, such as: a party against whom the person has commenced a personal injury action (*see* CPLR 3121[a]; 22 NYCRR 202.17[a]); the person's no-fault insurance carrier (*see* 11 NYCRR 65-1.1[d], 65-3.5[d]); or the person's employer's workers' compensation insurance carrier (*see* 12 NYCRR 300.2[d][1]). Thus, it is obvious that the examinee is not seeing the IME physician-who has been retained by a third party for that party's benefit-for the purpose of being healed through medical or surgical treatment.

Considering all of this, one might be inclined to conclude that an IME physician can never be in a physician-patient relationship with the examinee. [FN2] However, certain cases from this Court (*see* *Evangelista v. Zolan*, 247 A.D.2d 508, 669 N.Y.S.2d 325), and the other departments of the Appellate Division (*see* *Smith v. Pasquarella*, 201 A.D.2d 782, 607 N.Y.S.2d 489 [Third Department]; *Violandi v. City of New York*, 184 A.D.2d 364, 584 N.Y.S.2d 842 [First

Department]; *Twitchell v. MacKay*, 78 A.D.2d 125, 434 N.Y.S.2d 516 [Fourth Department]), support the proposition that the examinee and the IME physician are indeed in a physician-patient relationship. This relationship, though, is only a "limited" one, and merely imposes a duty upon the IME physician to conduct the IME in a manner that does not affirmatively injure the examinee.[FN3] Thus, if the IME physician improperly manipulates the examinee during the examination, and the examinee suffers injury as a result, the examinee's cause of action against the IME physician to recover damages for that injury is one to recover damages for medical malpractice.

*6 In *Twitchell*, the plaintiff examinee alleged that the defendant IME physician improperly manipulated his injured knee during the course of the examination (*see Twitchell v. MacKay*, 78 A.D.2d at 126, 129, 434 N.Y.S.2d 516). The Court concluded that the case was "a medical malpractice case" (*id.*). In support of its determination, the Court found as follows:

"[The examinee] would have us apply the narrow test of treatment by a physician, or examination for the purposes of treatment, in order to find that a case involved medical malpractice instead of simple negligence. We decline to do so. Such an interpretation is too constricting and fails to recognize the realities of the relationship that arise, however briefly, when a physician is in the process of exercising his [or her] profession and utilizing the skills which he [or she] has been taught in examining, diagnosing, treating or caring for another person.

Here, [the examinee] went to [the IME physician], albeit at the request of [the examinee's disability insurance carrier], for the purposes of an examination. The [examinee] knew that he was seeing a doctor and must have been aware of the fact that the doctor, after the examination, would express his medical judgment to [the carrier. The IME physician] was acting as a doctor and in doing so he agreed to perform his common-law duty to use reasonable care and his best judgment in exercising his skill, and the law implies that he represented his skill to be such as is ordinarily possessed by physicians in the community. Thus, if he carried out his function in a negligent or improper fashion the fact remains that the legal concept for any malfeasance or misfeasance by [the IME physician] would quite properly fall under the label of medical malpractice"

(*Twitchell v. MacKay*, 78 A.D.2d at 128-129, 434 N.Y.S.2d 516). The Court was aware of the principle that a cause of action to recover damages for medical malpractice does not lie in the absence of a physician-patient relationship (*see Lee v. City of New York*, 162 A.D.2d at 37, 560 N.Y.S.2d 700; *Murphy v. Blum*, 160 A.D.2d at 915, 554 N.Y.S.2d 640; *Hickey v. Travelers Ins. Co.*, 158 A.D.2d at 116, 558 N.Y.S.2d 554), as the examinee there argued that "there [could] be no claim for medical malpractice" because "no physician patient-relationship existed" (*Twitchell v. MacKay*, 78 A.D.2d at 127, 434 N.Y.S.2d 516). The Court also noted that a "relationship ... arise[s]" whenever a physician is "examining [and] diagnosing ... another person" (*Twitchell v. MacKay*, 78 A.D.2d at 128, 434 N.Y.S.2d 516). Under these circumstances, it is clear that the Court determined that a physician-patient relationship existed between the examinee and the IME physician. It is also clear that the Court found that this relationship only placed a duty on the IME physician to avoid conducting the examination "in a negligent or improper fashion," and that a breach of this duty causing injury would provide the examinee with a cause of action

"fall[ing] under the label of medical malpractice" (*Twitchell v. MacKay*, 78 A.D.2d at 129, 434 N.Y.S.2d 516; *see also LoDico v. Caputi*, 129 A.D.2d 361, 363, 517 N.Y.S.2d 640 [indicating that a cause of action to recover damages for medical malpractice would lie if an examinee "suffered ... bodily injury during the course of" an IME]).

*7 In *Violandi v. City of New York* (184 A.D.2d 364, 584 N.Y.S.2d 842), the plaintiff examinee, a police officer who was injured in the line of duty, submitted to an IME that was conducted at the request of the New York City Police Department (*see Violandi v. City of New York*, 184 A.D.2d at 364, 584 N.Y.S.2d 842). He took issue with the defendant IME physician's recommendation that he be returned to light duty (*see Violandi v. City of New York*, 184 A.D.2d at 364-365, 584 N.Y.S.2d 842). Although *Violandi* did not involve the situation involved in the instant case, that is, one involving an affirmative injury during an IME, the Court, citing *Twitchell*, stated, albeit in dicta, that a "doctor-patient ... relationship would certainly exist" if, "during [the] examination," there was "physical manipulation" that "exacerbate[d] the [underlying] injury" (*Violandi v. City of New York*, 184 A.D.2d at 364, 584 N.Y.S.2d 842). The Court therefore recognized that, to some degree, a physician-patient relationship exists between the examinee and the IME physician.

In *Smith v. Pasquarella* (201 A.D.2d 782, 607 N.Y.S.2d 489), the plaintiff examinee alleged that during the IME, the defendant IME physician, among other things, "forc[ed][her] injured leg into a position that caused undue and excessive pain," and also "moved [her] foot in a manner that was likely to aggravate her injury" (*Smith v. Pasquarella*, 201 A.D.2d at 782-783, 607 N.Y.S.2d 489). Although the Court did not specifically state that the examinee and the IME physician were in some sort of physician-patient relationship, the Court, citing *Twitchell*, concluded that even though the examination "was not conducted during the course of treatment," the abovementioned "conduct" could "constitute[ ] malpractice" (*Smith v. Pasquarella*, 201 A.D.2d at 783, 607 N.Y.S.2d 489), which, once again, can only occur in the context of a physician-patient relationship (*see Lee v. City of New York*, 162 A.D.2d at 37, 560 N.Y.S.2d 700; *Murphy v. Blum*, 160 A.D.2d at 915, 554 N.Y.S.2d 640; *Hickey v. Travelers Ins. Co.*, 158 A.D.2d at 116, 558 N.Y.S.2d 554).

Finally, a decade ago, this Court decided *Evangelista v. Zolan* (247 A.D.2d 508, 669 N.Y.S.2d 325), which the Supreme Court relied upon here, and which is factually indistinguishable from the instant case. In *Evangelista*, the plaintiff examinee alleged, similar to what Bazakos alleges, that the defendant IME physician, in examining his injured shoulder, "so wrenched and twisted [that shoulder] that he was caused further damage" (*Evangelista v. Zolan*, 247 A.D.2d at 509, 669 N.Y.S.2d 325). Two years and eight months later, the examinee commenced an action against the IME physician, seeking to recover damages caused by the alleged aggravation of the underlying injury (*id.*). The IME physician then moved to dismiss the complaint as time-barred, and this Court, concluding that the examinee's claim "sounded in medical malpractice," determined that the motion was properly granted (*Evangelista v. Zolan*, 247 A.D.2d at 509-510, 669 N.Y.S.2d 325). As this Court found:

"During a physical examination in which a doctor is to provide an independent medical assessment of the [examinee's] condition and make recommendations for future treatment, the doctor impliedly contracts to utilize the same professional skills in examining the [examinee] at the insurance carrier's request as he [or she] would have in examining [the examinee] for

treatment purposes. At the least, a physician has a duty not to injure a patient during his [or her] physical examination, and the breach of such a professional duty gives rise to a cause of action for medical malpractice"

*8 (*Evangelista v. Zolan*, 247 A.D.2d at 509, 669 N.Y.S.2d 325 [citations and internal quotation marks omitted]). Although this Court did not explicitly find that the examinee and the IME physician were in a physician-patient relationship, this Court did cite *Twitchell*, as well as cases such as *Lee*, *Murphy*, and *Hickey* (*see* *Evangelista v. Zolan*, 247 A.D.2d at 509, 669 N.Y.S.2d 325), which, as indicated above, set forth the principle that a cause of action to recover damages for medical malpractice does not lie in the absence of a physician-patient relationship (*see* *Lee v. City of New York*, 162 A.D.2d at 37, 560 N.Y.S.2d 700; *Murphy v. Blum*, 160 A.D.2d at 915, 554 N.Y.S.2d 640; *Hickey v. Travelers Ins. Co.*, 158 A.D.2d at 116, 558 N.Y.S.2d 554). This Court, being cognizant of that principle, necessarily determined, upon holding that the examinee's cause of action against the IME physician was one to recover damages for medical malpractice, that the examinee and the IME physician were in a physician-patient relationship. That relationship, though, was clearly limited to the extent that the IME physician only had a "duty not to injure" the examinee during the IME (*Evangelista v. Zolan*, 247 A.D.2d at 509, 669 N.Y.S.2d 325).[FN4]

The majority states that "the threshold determination of whether a physician-patient relationship exists is based upon the expectations of the parties during the course of the encounter." The expectations of an examinee and an IME physician fully justify the imposition of a limited physician-patient relationship that merely places a duty on the IME physician to perform the examination in a manner that does not affirmatively injure the examinee. On one hand, as indicated above, the examinee does not expect the IME physician to treat his or her underlying condition. In addition, as also indicated above, the examinee, who knows that the IME physician is evaluating his or her condition for some third party's benefit, does not expect to benefit in some other manner from the IME physician's evaluation. This explains why courts have refused to saddle IME physicians with duties to properly advise or treat the examinee (*see e.g.* *Murphy v. Blum*, 160 A.D.2d at 914-915, 554 N.Y.S.2d 640). However, as courts have recognized, the IME physician, whose diagnostic conduct falls within the statutory definition of "practice of the profession of medicine," [FN5] impliedly promises that in performing the examination, he or she will exercise his or her medical skills just as carefully as if the examinee was his or her own patient (*see* *Evangelista v. Zolan*, 247 A.D.2d at 509, 669 N.Y.S.2d 325; *Twitchell v. MacKay*, 78 A.D.2d at 128-129, 434 N.Y.S.2d 516). Thus, as courts have also recognized, the examinee, who can never be compelled to submit to an IME that poses a significant risk of harm (*see* *Marino v. Pena*, 211 A.D.2d 668, 668-669, 622 N.Y.S.2d 63; *Lefkowitz v. Nassau County Med. Ctr.* ., 94 A.D.2d 18, 21-22, 462 N.Y.S.2d 903), can expect that, when the examination is conducted, the IME physician will exercise his or her medical skills just as carefully as they would be exercised had he or she been subjecting his or her own patient to that very same examination (*see* *Evangelista v. Zolan*, 247 A.D.2d at 509, 669 N.Y.S.2d 325; *Twitchell v. MacKay*, 78 A.D.2d at 128-129, 434 N.Y.S.2d 516). Implying a limited physician-patient relationship that places a duty on the IME physician to perform the examination in accordance with good and accepted medical practice, and hence, not affirmatively injure the examinee, is therefore perfectly consistent with the parties' expectations.

*9 Aside from the persuasive reasoning of the cases discussed above, principles of stare decisis also preclude me from concurring in the majority's determination to characterize causes

of action against IME physicians who affirmatively injure examinees as causes of action to recover damages for negligence. The majority has decided to depart from this Court's holding 10 years ago in *Evangelista,* which, as discussed above, is on point. Yet, the doctrine of stare decisis, which provides guidance and consistency in future cases by recognizing that settled legal questions should not be reexamined every time they are presented (*see* *People v. Bing*, 76 N.Y.2d 331, 337-338, 559 N.Y.S.2d 474, 558 N.E.2d 1011), requires this Court to adhere to prior holdings in controlling cases except under "compelling circumstances" (*Eastern Consol. Props. v. Adelaide Realty Corp.*, 95 N.Y.2d 785, 787, 710 N.Y.S.2d 840, 732 N.E.2d 948; *Cenven, Inc. v. Bethlehem Steel Corp.*, 41 N.Y.2d 842, 843, 393 N.Y.S.2d 700, 362 N.E.2d 251). However, I am not convinced that "compelling circumstances" warrant a departure from this Court's holding in *Evangelista.*

Principles of stare decisis do not preclude a court from revisiting a holding that is "out of step with the times and the reasonable expectations of members of society" (*People v. Hobson*, 39 N.Y.2d 479, 489, 384 N.Y.S.2d 419, 348 N.E.2d 894). Alluding to that principle, the majority announces that "the time has come to acknowledge the essential nature of the relationship" between an examinee and an IME physician. Yet, those "relationships" have existed since 1962, the year that CPLR 3121(a), which authorizes IMEs, was enacted (*see* L 1962, ch 308). Thus, when this Court decided *Evangelista,* it certainly understood the nature of those relationships, and, despite that, essentially determined that an examinee and an IME physician are in a limited physician-patient relationship.

Principles of stare decisis also do not preclude a court from revisiting an incorrect holding (*see* *People v. Hobson*, 39 N.Y.2d at 488-489, 384 N.Y.S.2d 419, 348 N.E.2d 894). To the extent that the majority is concluding that *Evangelista* was incorrectly decided, I do not agree, for reasons previously discussed.[FN6]

Finally, to accept the majority's characterization of a cause of action against an IME physician who affirmatively injures an examinee as one sounding in negligence will lead to a curious result, to wit, that physicians committing the same negligent act and causing the same injury will be treated differently. Indeed, if an IME physician and a treating physician each conduct the same examination, depart from good and accepted medical practice in the same regard, and affirmatively injure the examinee in the same manner, the treating physician will enjoy the benefit of a shortened statute of limitations, while the IME physician will not.

For all of the foregoing reasons, Bazakos's cause of action against Lewis should be characterized as one to recover damages for medical malpractice, and consequently, the instant action was not timely commenced (*see* CPLR 214-a). Accordingly, I would affirm the order of the Supreme Court granting Lewis's motion to dismiss the complaint insofar as asserted against him as time-barred (*see* CPLR 3211[a][5]).

*10 ORDERED that the order is reversed, on the law, with costs, and the motion of the defendant Philip Lewis pursuant to CPLR 3211(a)(5) to dismiss the complaint insofar as asserted against him is denied.

FN1. The applicable Uniform Rules for Trial Courts (22 NYCRR 202.17) describe the physician as the “examining medical provider.” Personal injury lawyers representing both plaintiffs and defendants, as well as physicians, have adopted the phrase “Independent Medical Examination” or “IME” as a term of art to identify and describe such examination.

FN2. In this setting, the physician's client is the defendant, defense counsel, or the defendant's insurance carrier, which selects, retains, and compensates the physician. Frequently, in order to prepare a defense in the pending litigation, the defendant's attorney or his insurance carrier also direct and define the nature, scope, and focus of the evaluation. There are circumstances when medical examination physicians transcend the statutory medical examination relationship and expressly or implicitly create a physician-patient relationship by providing diagnostic treatment and advice upon which the examinee relies (*see Hickey v. Travelers Ins., Co.,* 158 A.D.2d 112, 558 N.Y.S.2d 554). In such a case, the physician's diagnostic and treatment advice to the *patient,* not the defendant, defense counsel, or the defendant's insurance company, transforms the relationship, and thus the duty, into one sounding in medical malpractice (*see Lawliss v. Quellman,* 38 A.D.3d 1123, 832 N.Y.S.2d 328; *Hickey v. Travelers Ins. Co.,* 158 A.D.2d 112, 558 N.Y.S.2d 554). However, that did not occur here.

FN3. It is noteworthy that the American Board of Independent Medical Examiners promulgates “Guidelines of Conduct” for its members. Guideline 3(d) requires the examining physician to “advise the examinee that no treating physician-patient relationship will be established” (ABIME Guidelines of Conduct [American Board of Independent Medical Examiners], http://www.abime.org/node/21 [accessed February 19, 2008]).

FN4. Lewis incorrectly characterizes the legislation as “seeking to limit causes of action against physicians.” That may be an ancillary result. Nevertheless, the clear legislative intent was to facilitate the provision of diagnostic and treatment health care services to *patients,* not to provide a litigation benefit to physicians engaged outside of the health care delivery system and actually in the business of providing litigation support services to insurance carriers. It is no secret that many examining physicians limit their engagements to performing statutory medical examinations and do not maintain any significant level of engagement in the treatment and diagnosis of patients in the health care delivery system.

FN5. The Court of Appeals also recognized that the legislative intent included the concern that “ ‘the health and welfare of the people of this State are gravely threatened by the inability of health care providers to get malpractice insurance at reasonable rates' “ (*Bleiler v. Bodnar,* 65 N.Y.2d at 68, 489 N.Y.S.2d 885, 479 N.E.2d 230, quoting Mem of State Exec Dept, 1975 McKinney's Session Laws of NY, at 1601-1602).

FN1. Neither CPLR 3121(a), nor section 202.17 of the Uniform Rules for Trial Courts, which authorize medical examinations of parties who have placed their physical or mental condition in issue, characterize such examinations as “independent medical examinations .” Nevertheless,

whereas certain courts, lawyers, and physicians refer to such examinations as independent medical examinations, I shall describe such examinations as IMEs, in an effort to avoid any confusion.

FN2. There clearly is no such rule, though. In this regard, the majority recognizes, as other courts have, that if an IME physician proceeded to treat or advise the examinee, and the examinee detrimentally relied on that treatment or advice, a physician-patient relationship, which can either be expressly created or implied (*see* *Lee v. City of New York*, 162 A.D.2d at 36, 560 N.Y.S.2d 700), would be implied (*see* *Lawliss v. Quellman*, 38 A.D.3d 1123, 1124, 832 N.Y.S.2d 328; *Forrester v. Zwanger-Pesiri Radiology Group*, 274 A.D.2d 374, 374-375, 710 N.Y.S.2d 620; *Heller v. Peekskill Community Hosp.*, 198 A.D.2d at 266, 603 N.Y.S.2d 548; *Hickey v. Travelers Ins. Co.*, 158 A.D.2d at 116, 558 N.Y.S.2d 554). Accordingly, if, in such a situation, the IME physician negligently treated or advised the examinee, and the examinee suffered injury as a result, the examinee's cause of action against the IME physician to recover damages for that injury would be characterized as one to recover damages for medical malpractice (*see* *Lee v. City of New York*, 162 A.D.2d at 36, 560 N.Y.S.2d 700; *Hickey v. Travelers Ins. Co.*, 158 A.D.2d at 115, 558 N.Y.S.2d 554).

FN3. Courts in other jurisdictions that have considered the issue presented here have determined that such a limited relationship and duty exists. For example, in *Harris v. Kreutzer* (271 Va. 188, 199-203, 624 S.E.2d 24), the Supreme Court of Virginia concluded that during an IME, there is a "limited physician/patient relationship" that only vests the IME physician with a duty "to examine the [examinee] without harming [him or] her in the conduct of the examination." Similarly, in *Dyer v. Trachtman* (470 Mich. 45, 53-54, 679 N.W.2d 311), the Supreme Court of Michigan concluded that during an IME, there is a "limited physician-patient relationship" that places a duty on the IME physician "to conduct the examination in such a way as not to cause harm." Finally, it is worth noting that the American Medical Association (hereinafter AMA) Code of Ethics provides that "[d]espite" an IME physician's "ties to a third party," a "limited patient-physician relationship should be considered to exist" between an IME physician and the examinee (AMA Code of Medical Ethics, Ethical Op. 10.03).

FN4. In *Savarese v. Allstate Ins. Co.* (287 A.D.2d 492, 493, 731 N.Y.S.2d 226), the plaintiff examinee, who was the subject of various IMEs, essentially took issue with the IME physicians' diagnoses and recommendations to her insurance company, which stopped paying her certain benefits. She commenced an action against the IME physicians, seeking to recover damages for medical malpractice (*see* *Savarese v. Allstate Ins. Co.*, 287 A.D.2d at 492-493, 731 N.Y.S.2d 226). However, this Court determined that the IME physicians were entitled to summary judgment dismissing the complaint (*id.*). In support of its determination, this Court, which noted that "[n]o action to recover damages for medical malpractice arises absent a physician-patient relationship," stated that such a "relationship does not exist where [an] examination is conducted solely for the purpose of rendering an evaluation for an insurer" (*id.*). While the majority relies on this statement in support of its decision today, *Savarese* involved a situation where an examinee took issue with diagnoses and recommendations that IME physicians made and reported to the third party that retained them (*see* *Savarese v. Allstate Ins. Co.*, 287 A.D.2d at 493, 731 N.Y.S.2d 226). Thus, it is clear that *Savarese* is factually distinguishable from both *Evangelista* and the instant case, which involve situations where examinees were affirmatively injured as a result of physical manipulation by IME physicians. Moreover, in *Savarese*, this Court did not, as it does today, overrule its prior holding in *Evangelista.* For these reasons, *Evangelista* has always been viable, at least up until the instant case.

FN5. “The practice of the profession of medicine” is statutorily defined as “ *diagnosing*, treating, operating or prescribing for *any human disease, pain, injury, deformity or physical condition* ” (Education Law § 6521 [emphasis added]).

FN6. While the majority's decision is predicated, in part, upon the conclusion that the legislative history underlying CPLR 214-a shows that the Legislature intended that only treating physicians receive the benefit of a shortened statute of limitations, the legislative history of CPLR 214-a does not necessarily support that conclusion. CPLR 214-a, which was enacted in 1975 (*see* L 1975, ch 109, § 6), shortened the statute of limitations on “[a]n action for medical ... malpractice” from three to two and one-half years (CPLR 214-a). At the time, there had been a “crisis in the medical profession” because insurance companies were withdrawing, or threatening to withdraw, from this State's medical malpractice insurance market (*Bleiler v. Bodnar*, 65 N.Y.2d 65, 68, 489 N.Y.S.2d 885, 479 N.E.2d 230). Thus, as the majority points out, the Executive Department, which supported the enactment of CPLR 214-a, explained that the statute, and certain others, were being enacted in an effort to prevent a cessation of the delivery of “health care services” (Governor's Program Bill Mem, Bill Jacket, L 1975 ch 109, at 1, 9). Treating physicians obviously provide, and IME physicians obviously do not provide, such services. However, it should be noted that the Executive Department, which did not suggest that it was of the opinion that only certain types of physicians should get the benefit of a shortened statute of limitations, explained that “even aside from” this goal, a shortened statute of limitations was being supported because of “special interests involved and other considerations connected with the skilled nature of the work” of “the medical professional” (Governor's Program Bill Mem, Bill Jacket, L 1975 ch 109, at 3), which includes both treating and IME physicians. Finally, it should be pointed out that the Legislature, which was certainly aware of the relationships between examinees and IME physicians, chose not to define the term “medical malpractice” in a manner that excluded claims against IME physicians. Indeed, the term was not defined at all (*see* *Bleiler v. Bodnar*, 65 N.Y.2d at 68, 489 N.Y.S.2d 885, 479 N.E.2d 230).

formance, attempted promoting a sexual performance by a child, third-degree attempted criminal sexual act, and two counts of endangering the welfare of a child. On appeal the Supreme Court, Appellate Division, 54 A.D.3d 684, 862 N.Y.S.2d 803, affirmed, and leave to appeal was granted.

Holding: The Court of Appeals held that evidence that defendant came "dangerously near" committing his intended crimes was sufficient to support conviction.

Affirmed.

Criminal Law ⇨44

Evidence that defendant came "dangerously near" committing his intended crimes was sufficient to support conviction for, inter alia, attempted use of a child in a sexual performance; evidence that defendant engaged in extensive preparations and traveled to the intended crime scene showed that he was close to achieving his illegal goal.

Larkin, Axelrod, Ingrassia & Tetenbaum, LLP, Newburgh (Kathleen v. Wells of counsel), for appellant.

Francis D. Phillips, II, District Attorney, Middletown (Andrew R. Kass of counsel), for respondent.

OPINION OF THE COURT

MEMORANDUM.

The order of the Appellate Division should be affirmed.

The defendant came "dangerously near" the commission of crimes when he arrived at the location of what he thought would be a sexual rendezvous with an underage boy. The proof of defendant's intent and extensive preparation followed by his travel to the intended crime scene showed that he was close to achieving his illegal goal and justified his convictions for attempt (*People v. Naradzay,* 11 N.Y.3d 460, 872 N.Y.S.2d 373, 900 N.E.2d 924 [2008]).

The appellant's other contentions lack merit.

Chief Judge LIPPMAN and Judges CIPARICK, GRAFFEO, READ, SMITH, PIGOTT and JONES concur.

On review of submissions pursuant to section 500.11 of the Rules of the Court of Appeals (22 NYCRR 500.11), order affirmed, in a memorandum.

12 N.Y.3d 631

Lewis J. BAZAKOS, Respondent,

v.

Philip LEWIS, Appellant, et al., Defendants.

Court of Appeals of New York.

June 24, 2009.

Background: Plaintiff in personal injury suit brought action against physician designated by the adverse party to conduct independent medical examination (IME) of plaintiff, seeking to recover for injuries allegedly sustained during examination. The Supreme Court, Nassau County, R. Bruce Cozzens, Jr., J., dismissed complaint. Plaintiff appealed. The Supreme Court, Appellate Division, 56 A.D.3d 15, 864 N.Y.S.2d 505, reversed. Physician appealed.

Holding: The Court of Appeals, Smith, J., held that plaintiff's claim was governed by

the two-year, six-month statute of limitations for professional malpractice actions.

Reversed.

Lippman, C.J., filed dissenting opinion in which Pigott and Jones, JJ., joined.

1. Health ⚿811

A claim against a doctor for his alleged negligence in performing an independent medical examination (IME) is a claim for malpractice, governed by the two-year, six-month statute of limitations for professional malpractice actions. McKinney's CPLR 214–a, 3121.

2. Health ⚿576

The relationship between a doctor performing an independent medical examination (IME) and the person he is examining may fairly be called a limited physician-patient relationship. McKinney's CPLR 3121.

3. Health ⚿709(1)

An independent medical examination (IME) physician, acting at the behest of a third party, is not liable to the examinee for damages resulting from the conclusions the physician reaches or reports. McKinney's CPLR 3121.

4. Health ⚿709(1)

The limited relationship between an examinee and a physician performing an independent medical examination (IME) imposes a duty on the physician to perform the examination in a manner not to cause physical harm to the examinee. McKinney's CPLR 3121.

Kopff, Nardelli & Dopf LLP, New York City (Peter C. Kopff and Martin B. Adams of counsel), for appellant.

Ralph A. Hummel, Woodbury, for respondent.

633 **OPINION OF THE COURT**

SMITH, J.

[1] We hold that a claim against a doctor for his alleged negligence in performing an independent medical examination (IME) is a claim for malpractice, governed by CPLR 214–a's two-year-and-six-month statute of limitations.

I

Lewis Bazakos, plaintiff in this case, was also the plaintiff in a previously-brought action arising out of an automobile accident. In that action, Bazakos was required, pursuant to CPLR 3121, to undergo an examination, commonly called an IME, by a doctor designated by the adverse party. The person Bazakos sued designated Dr. Philip Lewis, and Lewis examined Bazakos on November 27, 2001.

On October 15, 2004, approximately 2 years and 11 months later, Bazakos commenced this action against Lewis. The complaint alleges that Lewis injured Bazakos during the IME when he "took plaintiff's head in his hands and forcefully rotated it while simultaneously pulling."

Lewis moved to dismiss the case as barred by the statute of limitations. Supreme Court granted the motion (2006 N.Y. Slip Op. 30401[U]), relying on the Appellate Division, Second Department's decision in *Evangelista v. Zolan*, 247 A.D.2d 508, 669 N.Y.S.2d 325 (2d Dept. 1998). On Bazakos's appeal, the Appellate Division, with two Justices dissenting, overruled *Evangelista* and reversed Supreme Court, holding the action to be timely (*Bazakos v. Lewis*, 56 A.D.3d 15, 864 N.Y.S.2d 505 [2d Dept.2008]). The Appellate Division majority concluded that, because the doctor performing an IME

and the person undergoing it do not have a physician-patient relationship, the action was not "for medical ... malpractice" (CPLR 214–a) and was therefore governed by the three-year statute applicable to personal injury actions generally (CPLR 214[5]). The dissenting Justices, relying on *Evangelista* and *Twitchell v. MacKay,* 78 A.D.2d 125, 434 N.Y.S.2d 516 (4th Dept. 1980), argued that a "limited" physician-patient relationship exists between the examining doctor at an IME and the person examined, and that the action should therefore be considered one for malpractice (56 A.D.3d at 24, 864 N.Y.S.2d 505).

The Appellate Division granted Lewis leave to appeal, certifying the question of whether its order was properly made. We answer the question in the negative and reverse.

II

Bazakos's argument, which the Appellate Division accepted, is a simple one: He says that medical malpractice is a breach of a doctor's duty to provide his or her patient with medical care meeting a certain standard; that Lewis was not Bazakos's doctor, and Bazakos was not Lewis's patient; and that therefore the negligence of which Lewis is accused cannot be medical malpractice. He points out that the relationship between the doctor and the person the doctor examines at an IME is essentially adversarial; the person examined is required by law to submit to a procedure performed for the benefit of a party seeking to defeat that person's legal claim. The Appellate Division majority quoted the observation in *Payette v. Rockefeller Univ.,* 220 A.D.2d 69, 72, 643 N.Y.S.2d 79 (1st Dept.1996) that "the existence of a physician-patient relationship" is "essential to a cause of action in malpractice" (56 A.D.3d at 19, 864 N.Y.S.2d 505).

There is some logic to Bazakos's position, but the result he seeks would be an arbitrary one. Bazakos, like any medical malpractice plaintiff, claims he was injured because a doctor failed to perform competently a procedure requiring the doctor's specialized skill; Lewis, like any medical malpractice defendant, is called upon to defend his performance of professional duties. This case is not like *Payette*, in which a volunteer participant in a diet study at Rockefeller University complained of the University's "alleged negligent creation and implementation of its diet research program" (220 A.D.2d at 72, 643 N.Y.S.2d 79). The act on which Bazakos's lawsuit is based—Lewis's manipulation of a body part of a person who came to his office for a physical examination—constitutes "medical treatment by a licensed physician," and the negligent performance of that act is not ordinary negligence, but a prototypical act of medical malpractice (*Weiner v. Lenox Hill Hosp.,* 88 N.Y.2d 784, 788, 650 N.Y.S.2d 629, 673 N.E.2d 914 [1996], quoting *Bleiler v. Bodnar,* 65 N.Y.2d 65, 72, 489 N.Y.S.2d 885, 479 N.E.2d 230 [1985]). We see no good reason why the statute of limitations should be longer than it would be if Lewis were accused of making exactly the same error on a patient who came to him for consultation or care.

CPLR 214–a, creating a statute of limitations for certain forms of professional malpractice that is six months shorter than the ordinary personal injury statute, was part of a package of legislation passed in 1975 in response "to a crisis in the medical profession posed by the withdrawal and threatened withdrawal of insurance companies from the malpractice insurance market" (*Bleiler,* 65 N.Y.2d at 68, 489 N.Y.S.2d 885, 479 N.E.2d 230). The purpose of the legislative package was to enable "health care providers to get malpractice insurance at reasonable rates"

(*id.*, quoting Mem. of State Exec. Dept., 1975 McKinney's Session Laws of N.Y., at 1601–1602). It is unlikely, in our judgment, that the Legislature would have found less reason to make insurance available to doctors performing IMEs than to those practicing medicine in more traditional contexts, or that it intended any distinction between the two.

[2–4] We agree with the dissenting Justices at the Appellate Division that the relationship between a doctor performing an IME and the person he is examining may fairly be called a "limited physician-patient relationship"—indeed, this language is used in an American Medical Association opinion describing the ethical responsibilities of a doctor performing an IME (AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics, Ops on Patient–Physician Privilege E–10.03). As the Michigan Supreme Court has explained, this relationship:

> "is not the traditional one. It is a limited relationship. It does not involve the full panoply of the physician's typical responsibilities to diagnose and treat the examinee for medical conditions. The IME physician, acting at the behest of a third party, is not liable to the examinee for damages resulting from the conclusions the physician reaches or reports. The limited relationship that we recognize imposes a duty on the IME physician to perform the examination in a manner not to cause physical harm to the examinee." (*Dyer v. Trachtman,* 470 Mich. 45, 49–50, 679 N.W.2d 311, 314–315 [2004].)

Bazakos's claim here is that Lewis breached his duty "to perform the examination in a manner not to cause physical harm to the examinee." That is a claim for medical malpractice, and it is governed by the two-year-and-six-month statute of limitations. Therefore, Bazakos's lawsuit was not timely.

Accordingly, the order of the Appellate Division should be reversed, with costs, the order of Supreme Court reinstated and the certified question answered in the negative.

Chief Judge LIPPMAN (dissenting).

During a physical exam compelled by the court upon the application of plaintiff's adversary in separate personal injury litigation (*see* CPLR 3102[a]; 22 NYCRR 202.17), defendant Dr. Lewis, the examiner designated by plaintiff's adversary to perform the exam, is alleged to have "[taken] plaintiff's head in his hands and forcefully rotated [636] it while simultaneously pulling." Some 2 years and 11 months later, plaintiff commenced this action alleging that Lewis's manipulation of his head caused him injury. The complaint purports to sound in ordinary negligence. Defendant, however, contends that what is alleged is not simple negligence but medical malpractice. The distinction relied on by defendant, although not marked by a "rigid analytical line"—medical malpractice being but a form of negligence (*Scott v. Uljanov,* 74 N.Y.2d 673, 674, 543 N.Y.S.2d 369, 541 N.E.2d 398 [1989]; *see Weiner v. Lenox Hill Hosp.,* 88 N.Y.2d 784, 787–788, 650 N.Y.S.2d 629, 673 N.E.2d 914 [1996])—is here of pivotal import since plaintiffs claim would be timely as one for simple negligence (*see* CPLR 214), but would be barred under the shorter limitations period applicable to claims for medical malpractice (*see* CPLR 214–a).

Contrary to the impression that might be produced by the majority writing, the issue of whether allegedly tortious conduct is for statute of limitations purposes to be deemed medical malpractice or ordinary negligence is not new to this Court. Nor is it one whose disposition is ungoverned

by settled principles. We have held clearly and repeatedly that "[c]onduct may be deemed malpractice, rather than negligence, when it 'constitutes *medical treatment* or bears a substantial relationship to the rendition of *medical treatment* by a licensed physician' " (*Scott,* 74 N.Y.2d at 674–675, 543 N.Y.S.2d 369, 541 N.E.2d 398, quoting *Bleiler v. Bodnar,* 65 N.Y.2d 65, 72, 489 N.Y.S.2d 885, 479 N.E.2d 230 [1985] [emphasis added]; *accord Weiner,* 88 N.Y.2d at 787–788, 650 N.Y.S.2d 629, 673 N.E.2d 914). Here, although Lewis may have employed medical techniques in examining plaintiff, it is plain that no medical treatment was intended or in fact provided. The exam was conducted simply as a disclosure device in litigation and, indeed, one whose benefit inured not to the examinee but to the examinee's adversary. Bereft of any medical treatment rationale or application, Lewis's conduct during his examination of plaintiff is not amenable to description as medical malpractice within the meaning of CPLR 214–a.

This conclusion, of course, is entirely consistent with the purpose of CPLR 214–a's abbreviated limitations period, which was not to afford those providing litigation support services a measure of protection against liability, but to address the threat to the health and welfare of New Yorkers posed by the "inability of *health care providers* to get malpractice insurance at reasonable rates" and to help assure that "the adequate delivery of *health care services* " would not be impaired (Mem. of State Exec. Dept. in Support of L. 1975, ch. 109, 1975 McKinney's Session Laws of N.Y., at 1601–1602 [emphasis added]).

637 While the majority supposes it unlikely that the Legislature "would have found less reason" (majority op. at 635, 883 N.Y.S.2d at 788, 911 N.E.2d at 850) to extend similar protection to doctors not engaged in the provision of medical treatment, the basis for the supposition is far from evident. Indeed, there would appear to be ample reason to treat the two groups of practitioners quite differently. The risks facing a medical clinician diagnosing and treating a patient are of an entirely different order of magnitude than those ordinarily encountered by a medical examiner in a nontreatment context. The situation at bar is illustrative of this disparity. It is conceded that Dr. Lewis's duty towards his examinee was no more extensive than that of refraining from harming him during the exam; he had no medical duty competently to diagnose, inform or, indeed, to treat the subject of his exam. Such an extraordinarily limited scope of professional responsibility stands in sharp contrast to the enormous risks and obligations routinely encountered by physicians providing actual patient care and treatment. While a shortened limitations period may, at the time of CPLR 214–a's enactment, reasonably have been thought necessary to the continued insurability of the latter group of medical practitioners on economically feasible terms, there exists no plausible argument that parity of protection was ever thought necessary to the insurability of practitioners not engaged in the provision of medical treatment.

The majority's embrace of the novel and highly problematic notion that there may be medical malpractice in the absence of medical treatment evidently proceeds from the conviction that the same conduct by a doctor should not be deemed malpractice in one context and negligence in another. Yet, in postulating that a medical examiner, such as defendant, undertakes a limited duty to the examinee not involving " 'the full panoply of the physician's typical responsibilities to diagnose and treat' " (majority op. at 635, 883 N.Y.S.2d at 788, 911 N.E.2d at 850, quoting *Dyer v. Trachtman,* 470 Mich. 45, 50, 679 N.W.2d 311, 314 [2004]), the majority must accept what it

purports to reject, namely, that what will be malpractice in the context of ongoing medical treatment may not, no matter how glaring the breach, be malpractice in the context of an exam understood by the parties thereto to have no medical treatment objective. Indeed, most of what would be malpractice in the former context is not even actionable in the latter.

Context cannot be consigned to irrelevance, even in the case of what would be "prototypical malpractice." We have held as much. In *Weiner,* where the defendant hospital, intent on having 638 its negligence deemed malpractice so as to avail itself of the medical malpractice limitations period, urged that the failure of its physician properly to supervise blood collection could not be viewed except as a breach of his obligations as a physician, we replied,

> "although the Hospital correctly points out that a physician must supervise the process of blood collection (*see, e.g.,* 10 NYCRR 58–2.1[s]; 58–2.2[a]), this requirement does not resolve the question of whether the challenged conduct 'bears a substantial relationship to the rendition of medical treatment' to a particular patient, which remains the determinative question on appeal" (*Weiner,* 88 N.Y.2d at 788, 650 N.Y.S.2d 629, 673 N.E.2d 914, quoting *Bleiler v. Bodnar,* 65 N.Y.2d at 72, 489 N.Y.S.2d 885, 479 N.E.2d 230).

Here, of course, there was actual contact between plaintiff and physician, but that factual distinction between this case and *Weiner* is one that should possess no dispositive significance. Propinquity, particularly in what is essentially an adversarial situation between an examiner and his or her subject, is not to be confounded with medical treatment. Here, as in *Weiner,* there was no treatment, and that should be "determinative."

While I agree that Lewis in undertaking to examine plaintiff assumed a duty not to harm him in the process, the breach of such a duty would not sound in medical malpractice. The very limited duty arising in this situation bears not the slightest resemblance to the very much more comprehensive set of responsibilities devolving upon a practitioner engaged in treatment—the defining set of responsibilities contemplated by the Hippocratic injunction to do no harm. The duty here implicated does not arise from what is reasonably susceptible of characterization as a doctor-patient relationship, i.e. a treatment relationship; it is simply an instance of the general obligation, frequently enforceable in tort, to refrain from causing foreseeable harm. That is ordinary negligence. It is today denominated "medical malpractice" only by dint of an exercise in judicial artifice untethered to any law or to the actual nature of the transaction known euphemistically as an "independent" medical examination. These exams, far from being independent in any ordinary sense of the word, are paid for and frequently controlled in their scope and conduct by legal adversaries of the examinee. They are emphatically not occasions for treatment, but are most often utilized to contest the examinee's claimed injury and to dispute the need for any treatment at all. Indeed, 639 according to the Guidelines of Conduct of the American Board of Independent Medical Examiners, the examiner at the exam should "advise the examinee that no treating physician-patient relationship will be established" (http://abime.org/node/21, accessed June 19, 2009). The majority's bare assertion that medical treatment is compatible with this context is merely a form of words. Describing the sliver of a duty that an examiner has during an exam not to harm the examinee as arising from a "limited physician-patient relationship" will

be recognized, given the reality it purports to describe, as no more than a device to avail a litigant of a statutory bar.

The cause of action the majority now recognizes for medical malpractice is not only stillborn in this action, but, I will venture, will never possess viability as an actual claim for relief. I am confident that the majority has not the slightest intention to open the vistas of malpractice so wide as to actually permit such claims in the absence of anything cognizable as treatment. What is involved then is simply the arbitrary creation of an exception for a group of practitioners who, as a group, neither seek nor are entitled to the protection properly afforded and reserved to those engaged in the delivery of medical care and treatment.

The well considered decision of the Appellate Division should be affirmed.

Order reversed, etc.

Judges CIPARICK, GRAFFEO and READ concur with Judge SMITH; Chief Judge LIPPMAN dissents and votes to affirm in a separate opinion in which Judges PIGOTT and JONES concur.

THE SUPREME COURT OF THE STATE OF ALASKA

TERRY L. SMITH, Appellant, v. PATRICK L. RADECKI, M.D., Appellee.	)	Supreme Court No. S-13171 Superior Court No. 4FA-06-02657 CI O P I N I O N No. 6505 – August 27, 2010

Appeal from the Superior Court of the State of Alaska, Fourth Judicial District, Fairbanks, Michael A. MacDonald, Judge.

Appearances: Terry L. Smith, pro se, Fairbanks, Appellant. Howard A. Lazar and Kendra E. Bowman, Delaney Wiles, Inc., Anchorage, for Appellee.

Before: Carpeneti, Chief Justice, Fabe, Winfree, Christen, and Stowers, Justices.

CHRISTEN, Justice.

I. INTRODUCTION

Terry Smith injured his back while working for CSK Auto, Inc. (CSK) and brought a workers' compensation claim. CSK arranged for Dr. Patrick Radecki to perform an independent medical examination to assess Smith's condition. Dr. Radecki examined Smith and reported that he had no physical injury resulting from the incident. But Smith later underwent an MRI which revealed several spinal problems, including a

Tarlov cyst. Smith filed suit against Dr. Radecki. His complaint included claims arising from Dr. Radecki's alleged failure to discover the existence of the cyst and Smith's earlier "failed" back surgery. In the alternative, Smith alleged that Dr. Radecki *did* discover his true back condition but failed to report it. The superior court granted Dr. Radecki's motion for summary judgment, ruling that Dr. Radecki and Smith did not have the requisite physician-patient relationship upon which to base a medical malpractice claim, and that Smith's claims were barred by the statute of limitations. Because we conclude that all of Smith's claims were dependent upon him having a physician-patient relationship with Dr. Radecki, and Smith did not have a physician-patient relationship with Dr. Radecki, we affirm the superior court's ruling. We do not reach the statute of limitations issue.

II. FACTS AND PROCEEDINGS

On March 29, 2001, Terry Smith injured his back while working as a delivery driver for CSK. Unloading cases of antifreeze from the bed of his truck, Smith "lifted and twisted" to remove two cases that were strapped together and immediately experienced "pain in his back and leg that took his breath away." Smith sought medical attention the next day and was treated for "acute muscle strain." He received temporary total disability benefits from March 30, 2001, through April 13, 2001.

When Smith's pain did not improve, additional assessments were performed which revealed abnormalities at L5 and possible degenerative disc disease at L4-5. He underwent a variety of treatments including medication, physical therapy, participation in a work hardening program, and epidural steroid injection.[1] Smith was given some

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[1] The epidural space is located outside the *dura mater* surrounding the spinal cord. 9 ATTORNEYS' TEXTBOOK OF MEDICINE § 58.20 (Roscoe N. Gray & Louise J. (continued...)

authorized time loss from work and then deemed partially disabled effective May 14, 2001. He returned to work in "a light duty capacity" from May 14 through July 8, 2001, but he continued to report symptoms including weakness, dizziness, disorientation, loss of consciousness, and pain. Smith began to miss work again and received additional temporary total disability benefits. But on August 14, 2001, Dr. Susan Klimow found Smith "medically stable."[2] Later that month Smith's treating doctors began to consider the possibility of psychological factors in his continuing complaints of pain, but physical interventions for his symptoms continued into 2003.[3]

CSK arranged for Dr. Patrick Radecki to perform an independent medical examination (IME) of Smith on July 25, 2003. Dr. Radecki's report states that prior to conducting the examination he informed Smith (1) "that the purpose of the examination was to address specific injuries or conditions, as outlined by [CSK's insurance carrier]," (2) that the IME was "not a substitute for his/her personal physician(s) or health care," and (3) that "[n]o physician/patient relationship exists or is sought." Smith did not dispute that he received this statement describing the scope of Dr. Radecki's engagement.

The report Dr. Radecki prepared reflects his conclusion that Smith suffered from "[m]ild degenerative disc disease" in his "lumbar spine, including minimal disc

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[1](...continued)
Gordy eds., 1999). The goal of the epidural steroid injection procedure is to reduce nerve root inflammation. 2 RICHARD M. PATTERSON, LAWYERS' MEDICAL CYCLOPEDIA § 16.9[E][2] (6th ed. 2009). Smith may have also undergone radiofrequency ablation, a procedure in which heat is created by ionic vibration at the tip of a needle and applied to painful neural tissue. 4 *id.* § 29.15a.

[2] Smith was referred to Dr. Klimow for evaluation and treatment of lumbar strain by Dr. John Duddy, an orthopedic surgeon who had treated Smith.

[3] Pages are missing from the record of Smith's medical history; it is unclear exactly what treatment he received between August of 2001 and April of 2003.

bulge which [was] not . . . symptomatic," and exhibited "nonphysiologic pain behavior and multiple nonphysiologic responses to physical maneuvers . . . that should not cause pain, typical of psychogenic pain disorder, severe in nature." In his report Dr. Radecki stated that "there is no objective evidence of permanent partial impairment that can be said to have been caused by the March 29, 2001, incident," advised against further physical or pharmacological interventions, and suggested psychological treatment and weight loss.

Smith again reported severe pain symptoms during subsequent vocational rehabilitation and underwent an MRI at Fairbanks Memorial Hospital on November 8, 2004. The MRI revealed disc desiccation at the L5-S1, L4-L5, and L3-L4 levels, displacement of the left S1 nerve root, L5 limbus vertebra, and a small sacral Tarlov cyst.[4]

On December 17, 2004, Smith filed a workers' compensation claim for ongoing medical bills and temporary total disability during recovery from anticipated back surgery. The claim alleged that the anticipated surgery would address pain arising from Smith's 2001 work-related injury. CSK controverted the claim, relying principally upon Dr. Radecki's conclusions that: (1) Smith was medically stable as of July of 2003; (2) Smith had no permanent impairment resulting from the 2001 injury; and (3) Smith did not require further medical treatment.

Smith filed suit against Dr. Radecki in the superior court in October 2006. His complaint included 18 claims that we group into three categories: (1) claims arising

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[4] "[A] perineural cyst found in the radicles of the lower spinal chord; it is usually productive of symptoms." STEDMAN'S MEDICAL DICTIONARY 389 (25th ed. 1990).

from Dr. Radecki's alleged failure to discover and properly treat his back condition;[5] (2) claims associated with the alternative theory that Dr. Radecki *did* discover the nature of Smith's back condition but did not report these findings to Smith;[6] and (3) claims that are actually prayers for relief when read in context.[7]

Dr. Radecki moved for summary judgment on the grounds that Smith's claims were: (1) barred by the statute of limitations; and (2) precluded by the lack of a physician-patient relationship and corresponding duty of care. Dr. Radecki asked the superior court to "construe each of plaintiff's allegations as sounding in medical malpractice" and argued that "for plaintiff to succeed on any of [his] claims, there must have been a physician/patient relationship." Smith's opposition to the motion did not respond to the contention that Smith's claims should be treated as a malpractice allegation, but it did reiterate Smith's entire list of claims.

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[5] Claims in the first category include gross negligence, "failure to diagnose" (argued as two separate counts), "failure to use due care," misdiagnosis, "[f]ailure to provide appropriate treatment for a medical condition; [i]mproper diagnosis," "[l]ack of informed consent," "negligen[t] concealment of injury," battery, and "breach of duty." Smith's abandonment claim also falls into the first category: it alleges that Dr. Radecki "failed to attend and care for" Smith and that he failed to notify Smith of his withdrawal from the physician-patient relationship.

[6] The claims in the second category include "[f]ailure to advise of diagnosis," fraud, "[f]alse [r]epresentation," and spoliation of evidence. These claims are premised on the theory that Dr. Radecki discovered, but failed to report, the Tarlov cyst and that he discovered, but failed to report, that Smith's earlier surgery had been unsuccessful.

[7] These include "[i]nterference [with] medical treatment," "[i]nterference [with] employment contract," and emotional distress. In these claims Smith addresses the ways in which Dr. Radecki's diagnosis disrupted his access to continuous treatment paid for by CSK's workers' compensation insurance.

The superior court granted summary judgment, ruling that Dr. Radecki did not owe Smith a duty of care and that the statute of limitations barred his claims. The court's order did not distinguish between Smith's claims, impliedly treating them all as variously-stated claims for medical malpractice. Smith moved for reconsideration of the order granting summary judgment, but the superior court denied his motion and entered final judgment in favor of Dr. Radecki. Smith appeals.

III. STANDARD OF REVIEW

We review a grant of summary judgment "de novo, affirming if the record presents no genuine issue of material fact and if the movant is entitled to judgment as a matter of law. All reasonable inferences are drawn in favor of the nonmovant in this examination."[8]

We review questions of law using the de novo standard, "apply[ing] our independent judgment to questions of law, adopting 'the rule of law most persuasive in light of precedent, reason, and policy.' "[9]

IV. DISCUSSION

Dr. Radecki argues that he did not owe a duty of care to Smith because he did not have a physician-patient relationship with Smith. Dr. Radecki examined Smith only once, and only in the context of conducting an IME. His report reflects the fact that Smith was informed of the limited nature of their professional relationship.

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[8] *Beegan v. State, Dep't of Transp. & Pub. Facilities*, 195 P.3d 134, 138 (Alaska 2008) (citing *Matanuska Elec. Ass'n v. Chugach Elec. Ass'n*, 152 P.3d 460, 465 (Alaska 2007)).

[9] *Jacob v. State, Dep't of Health & Soc. Servs.*, 177 P.3d 1181, 1184 (Alaska 2008) (quoting *Guin v. Ha*, 591 P.2d 1281, 1284 n.6 (Alaska 1979)).

Alaska Statute 09.55.540 defines the standard of care for malpractice actions based upon the negligent or willful misconduct of health care practitioners. We have previously held that the duty to meet this standard of care arises specifically from the existence of a physician-patient relationship.[10] We have not previously considered whether the performance of an IME creates a physician-patient relationship between a doctor and an examinee or whether such an examination otherwise gives rise to a duty of care owed to the examinee.

Alaska Statute 09.55.540 requires that a party alleging medical malpractice in Alaska must prove:

> (1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing;
>
> (2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and
>
> (3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

In *M.A. v. United States*, we held that the duty to meet the standard of care specified in AS 09.55.540 is dependent upon the existence of a physician-patient relationship.[11] *M.A.* involved a minor's parents who alleged that their child's physician owed an independent duty of care to them. We held that the source of a physician's duty

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[10] *M.A. v. United States*, 951 P.2d 851, 856 (Alaska 1998) (holding that "the source of a physician's duty to provide reasonably competent care lies in the unique nature of the physician-patient relationship").

[11] *Id.*

to provide reasonably competent medical care lies in the unique nature of the physician-patient relationship, and that a physician owes no comparable duty of care where no physician-patient relationship exists.[12] Dr. Radecki relied on *M.A.* in his motion for summary judgment to support his argument that he did not owe a duty of care to Smith.

Decisions from the majority of other states support Dr. Radecki's assertion that Smith's medical malpractice claim should fail as a matter of law for lack of a duty of care. These jurisdictions have concluded that an IME performed at the behest of a third party does not give rise to a physician-patient relationship or to potential for medical malpractice liability.[13] Courts adopting this rule rely principally upon the desire not to chill the willingness of doctors to act as expert witnesses in workers' compensation cases.[14] In these states, the duty of care for providing a correct diagnosis runs to the IME physician's employer rather than the patient.[15]

Given these authorities, the starting point for analyzing what duty Dr. Radecki owed to Smith must be the scope of work Dr. Radecki agreed to perform. Dr. Radecki expressly advised Smith at the outset of the IME that no physician-patient

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[12] *Id.*

[13] *See, e.g.*, *Hafner v. Beck*, 916 P.2d 1105, 1107-08 (Ariz. App. 1995); *Felton v. Schaeffer*, 229 Cal. App. 3d 229, 235-36 (Cal. App. 1991); *Martinez v. Lewis*, 969 P.2d 213, 219-20 (Colo. 1998); *Peace v. Weisman*, 368 S.E.2d 319, 320-21 (Ga. App. 1988); *Henkemeyer v. Boxall*, 465 N.W.2d 437, 439 (Minn. App. 1991); *Ervin v. Am. Guardian Life Assurance Co.*, 545 A.2d 354, 358 (Pa. Super. 1988); *Johnston v. Sibley*, 558 S.W.2d 135, 137 (Tex. App. 1977); *Joseph v. McCann*, 147 P.3d 547, 551-52 (Utah App. 2006); *Rand v. Miller*, 408 S.E.2d 655 (W. Va. 1991); *Erpelding v. Lisek*, 71 P.3d 754, 760 (Wyo. 2003).

[14] *See, e.g.*, *Hafner*, 916 P.2d at 1107; *Martinez*, 969 P.2d at 219.

[15] *See, e.g.*, *Hafner*, 916 P.2d at 1106; *Felton*, 229 Cal. App. 3d at 235.

relationship would be undertaken and that the purpose of the examination was limited to the specific injuries or conditions identified by CSK's insurance carrier. We recognize that IME physicians examine and interact directly with examinees, but we disagree with Smith's argument that they thereby establish physician-patient relationships with examinees. Physicians conducting IMEs at the behest of third parties assume a fundamentally different role from a diagnosing or treating physician; typically, a physician conducting an IME is not selected by the examinee, is not hired by the examinee, does not report to the examinee, and does not provide treatment to the examinee. We are not persuaded that a physician who performs an IME undertakes a traditional physician-patient relationship or owes an examinee the duty of care that attends such a relationship.

Smith argues that even if he and Dr. Radecki did not have a traditional physician-patient relationship, we should rule that they had a limited physician-patient relationship giving rise to a duty to correctly diagnose Smith's condition. Smith supports this argument two ways. First, he argues that Dr. Radecki is a member of the American Medical Association (AMA) and the AMA's ethical guidelines state that a limited physician-patient relationship is established when an IME is performed. Second, he argues that a growing body of case law from other states recognizes a limited duty of care exists when IMEs are performed. We do not find either argument to be persuasive.

Smith argues that Dr. Radecki's membership in the AMA makes him susceptible to Smith's medical malpractice claim because the AMA's professional standards describe a "limited patient-physician relationship" in the context of an IME. The phrase Smith quotes comes from the AMA's ethics guidelines, a non-binding code

for ethical behavior by member physicians.[16] Smith offers no authority for the implied argument that these guidelines bear on the scope of IME physicians' legal liability in Alaska. Moreover, taken in context, the statement Smith relies upon does not support his claim in this instance. AMA ethics opinion 10.03 outlines the duty of IME physicians to: (1) be objective; (2) maintain examinee confidentiality; (3) disclose conflicts of interest; (4) inform examinees of the limited nature of the relationship arising from the IME; and (5) make patients aware of abnormalities discovered during the exam.[17] Smith did not present any evidence that Dr. Radecki failed to abide by any of these standards. Thus, even if we were to consider ethics opinion 10.03 to create a duty of care, it would not support Smith's claim against Dr. Radecki.

As for Smith's second argument, we acknowledge that courts in several other states have held that physicians owe a limited duty of care in an IME setting.[18] For example, the Tennessee Court of Appeals held that a limited physician-patient relationship exists when an IME is conducted, such that the physician has a duty not to

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[16] *History of AMA Ethics*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/history-ama-ethics.shtml (last visited July 16, 2010).

[17] *Opinion 10.03 - Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations*, AM. MED. ASS'N (Dec. 1999), http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1003.shtml.

[18] *See, e.g.*, *Green v. Walker*, 910 F.2d 291, 296 (5th Cir. 1990); *Betesh v. U.S.*, 400 F. Supp. 238, 246-47 (D.D.C. 1974); *Ritchie v. Krasner*, 211 P.3d 1272, 1280-81 (Ariz. App. 2009); *Keene v. Wiggins*, 69 Cal. App. 3d 308, 313 (Cal. App. 1977); *Webb v. T.D.*, 951 P.2d 1008, 1013-14 (Mont. 1997); *Hoover v. Williamson*, 203 A.2d 861, 863-64 (Md. 1964); *Reed v. Bojarski*, 764 A.2d 433, 443-44 (N.J. 2001); *Johnston*, 558 S.W. 2d at 137.

injure the patient during the examination.[19] Similar decisions have been reached by courts in New York,[20] Colorado,[21] and Michigan.[22] The Michigan court described the limited duty as:

> . . . not the traditional one. It is a limited relationship. It does not involve the full panoply of the physician's typical responsibilities to diagnose and treat the examinee for medical conditions. *The IME physician, acting at the behest of a third party, is not liable to the examinee for damages resulting from the conclusions the physician reaches or reports*. The limited relationship that we recognize imposes a duty on the IME physician to perform the examination in a manner not to cause physical harm to the examinee.[23]

Other courts have held that physicians have limited duties of care encompassing the duty to discover[24] and warn an examinee[25] of conditions which pose

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[19] *Gentry v. Wagner*, No. M2008-02369-COA-R3-CV, 2009 WL 1910959 (Tenn. App. June 30, 2009).

[20] *Bazakos v. Lewis*, 911 N.E.2d 847, 850 (N.Y. 2009) (holding that such a limited relationship encompasses a duty not to injure, but no duty to correctly diagnose).

[21] *Slack v. Farmers Ins. Exch.*, 5 P.3d 280, 283-84 (Colo. 2000).

[22] *Dyer v. Trachtman*, 679 N.W.2d 311, 314-15 (Mich. 2004).

[23] *Id.* (emphasis added).

[24] *Webb v. T.D.*, 951 P.2d 1008, 1013-14 (Mont. 1997) (health care provider retained by third party to perform IME owes duty to patient to: (1) discover conditions posing "imminent danger" to examinee and take reasonable steps to alert examinee; and (2) assure advice to examinee meets standard of care for provider's profession; IME provider does not "have the same duty of care that a physician has to his or her own patient").

[25] *Id.*; *see also Green v. Walker*, 910 F.2d 291, 296 (5th Cir. 1990) (physician who performs pre-employment medical examination for employer has affirmative duty (continued...)

an "imminent danger" to the examinee's health, and to provide correct information to a patient about his condition in the event the IME physician "gratuitously undertakes to render services which he should recognize as necessary to another's bodily safety."[26]

Though we acknowledge this growing body of case law, we also recognize that it is not implicated by the evidence Smith offered. Smith did not present admissible evidence that Dr. Radecki failed to diagnose a condition that posed imminent harm, that Dr. Radecki knew of and concealed an imminently dangerous condition,[27] that Dr. Radecki went beyond his role as an IME physician and gratuitously rendered medical advice directly to Smith,[28] or that Dr. Radecki injured Smith during the course of the

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[25](...continued)
to act in keeping with training and expertise and must inform patient of conditions posing imminent danger); *Betesh v. United States*, 400 F. Supp. 238, 246-47 (D.D.C. 1974) (army physicians who discovered abnormality in chest X-ray during selective service screening exam had affirmative duty to notify examinee of need for further medical attention); *Reed v. Bojarski*, 764 A.2d 433, 443-44 (N.J. 2001) (physician retained to perform pre-employment physical has affirmative, non-delegable duty to inform patient of potentially serious medical condition).

[26] *Hoover v. Williamson*, 203 A.2d 861, 863 (Md. 1964) (plaintiff may not ordinarily recover for malpractice without express doctor/patient relationship, but "one who gratuitously undertakes to render services which he should recognize as necessary to another's bodily safety, and leads the other in reasonable reliance on the services to refrain from taking other protective steps, or to enter on a dangerous course of conduct, 'is subject to liability to the other for bodily harm resulting from the actor's failure to exercise reasonable care to carry out his undertaking' ").

[27] *Cf. Webb*, 951 P.2d at 1013-14; *see also Green*, 910 F.2d at 296; *Betesh*, 400 F. Supp. at 246-47; *Reed*, 764 A.2d at 443-44.

[28] *Cf. Hoover*, 203 A.2d at 863.

examination itself.[29] Dr. Radecki's examination of Smith consisted of a review of Smith's medical records and a brief physical examination that was further limited by Smith himself.[30] Dr. Radecki delivered copies of his report to Smith's employer and legal representative and had no further direct contact with Smith. In sum, even if we were to recognize the limited duty that has been imposed by courts in other states, such a duty would not extend to actions taken by Dr. Radecki in this case.[31]

The superior court did not err in concluding that Dr. Radecki did not have a physician-patient relationship with Smith that would allow for liability for medical malpractice. This conclusion is fatal to the first category of Smith's claims, all of which expressly allege medical malpractice. To the extent Smith's second category of claims is premised upon the theory that Dr. Radecki willfully failed to disclose information he discovered during the IME, Smith's claims fail because he offered no admissible evidence to raise a genuine issue of material fact that Dr. Radecki discovered the cyst or that Smith's earlier surgical procedure was unsuccessful. Nor did Smith explain why, in the absence of

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[29] *Cf. Gentry v. Wagner*, No. M2008-02369-COA-R3-CV, 2009 WL 1910959, at *7-8 (Tenn. App. June 30, 2009).

[30] Smith refused to remove a lumbosacral corset for the examination and "forcefully decline[d] examination of the area, even with the corset left on," declined to perform range of motion tests, and refused to do a pelvic rotation movement.

[31] We agree with Smith that the absence of a physician-patient relationship does not *immunize* a physician performing an IME from all tort liability, and we do not rule out the possibility that a physician could be liable for conduct committed during an IME that is both tortious and not dependent upon a physician-patient relationship. Indeed, at oral argument before the superior court, Dr. Radecki's counsel acknowledged that an IME physician has "a duty to act carefully and reasonably." But the absence of a physician-patient relationship is fatal to Smith's medical malpractice claims.

a physician-patient relationship, Dr. Radecki would have had a duty to report these conditions to Smith if he had discovered them.[32]

V. CONCLUSION

We AFFIRM the superior court's order granting summary judgment in favor of Dr. Radecki on the issue of duty.

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[32] Smith does not argue on appeal that the superior court erred by treating all of his original claims as a single count of medical malpractice without explanation, nor did he argue this point below. It would have been preferable for the superior court to address Smith's claims individually or memorialize its implied conclusion that all of Smith's claims are variously phrased medical malpractice claims. But because our independent review of the record leads us to conclude that Smith's complaint was correctly interpreted as asserting multiple claims of medical malpractice, the superior court's error was harmless in this instance.

Supreme Court of California, In Bank.
Olga TUNKL, as Executrix of the Estate of Hugo Tunkl, Deceased, Plaintiff and Appellant,
v.
The REGENTS OF the UNIVERSITY OF CALIFORNIA, Defendant and Respondent.
L. A. 26984.

July 9, 1963.

Action by hospital patient against charitable hospital for negligence. The patient died, and his surviving wife, as executrix, was substituted as plaintiff. The Superior Court, Los Angeles County, Jerold E. Weil, J., entered judgment for the defendant and plaintiff appealed. The Supreme Court, Tobriner, J., held that release from liability for future negligence imposed as condition for admission to charitable research hospital was invalid, under statute prohibiting agreements exempting a person from his own fraud, willful injury to another, or violation of law, on ground that the agreement affected the public interest.

Reversed.

Opinion, 23 Cal.Rptr. 328, vacated.

West Headnotes

[1] Release 331 2

331 Release
331I Requisites and Validity
331k2 k. Subject-Matter. Most Cited Cases
Release from liability for future negligence as condition of admission to charitable research hospital was invalid, under statute prohibiting agreements exempting a person from willful injury or violation of law, on ground that agreement between hospital and patient affected public interest. West's Ann.Civ.Code, § 1668; West's Ann.Health & Safety Code, §§ 1400-1421, 32000-32508.

[2] Contracts 95 108(2)

95 Contracts
95I Requisites and Validity
95I(F) Legality of Object and of Consideration
95k108 Public Policy in General
95k108(2) k. Particular Contracts. Most Cited Cases
Public policy does not oppose private, voluntary transactions in which one party, for a consideration, agrees to shoulder a risk which the law would otherwise have placed upon the other party.

[3] Release 331 2

331 Release
331I Requisites and Validity
331k2 k. Subject-Matter. Most Cited Cases
Hospital's selectivity as to patients it would accept did not negate its public aspect or public interest therein and did not permit it to contract, as condition of admission of patient, to release itself from liability for future negligence. West's Ann.Civ.Code, § 1668; West's Ann.Health & Safety Code, §§ 1400-1421, 32000-32508.

[4] Release 331 2

331 Release
331I Requisites and Validity
331k2 k. Subject-Matter. Most Cited Cases
That hospital was a charitable hospital did not make release of hospital from liability for future negligence as condition of admission of patient valid. West's Ann.Civ.Code, § 1668; West's Ann.Health & Safety Code, §§ 1400-1421, 32000-32508.

[5] Charities 75 45(2)

75 Charities
75II Construction, Administration, and Enforcement
75k45 Rights, Duties, and Liabilities of Charitable Societies and Trustees

75k45(2) k. Liability for Torts. Most Cited Cases
Charitable hospital which accepted selected patients from public at large was not permitted to exempt itself from negligence of its employees, as opposed to its own negligence, toward patient as condition of admitting patient. West's Ann.Civ.Code, § 1668; West's Ann.Health & Safety Code, §§ 1400-1421, 32000-32508.

[6] Health 198H 819

198H Health
198HV Malpractice, Negligence, or Breach of Duty
198HV(G) Actions and Proceedings
198Hk815 Evidence
198Hk819 k. Burden of Proof. Most Cited Cases
(Formerly 204k8 Hospitals)
Patient suing hospital on theory of negligence must prove negligence.

***33 **441 *93** Caidin, Bloomgarden & Kalman and Newton Kalman, Beverly Hills, for plaintiff and appellant.

Edward I. Pollock, William Jerome Pollack and Morris L. Marcus, Los Angeles, amici curiae on behalf of plaintiff and appellant.

***94** Belcher, Henize & Fargo, Los Angeles, Leo J. Biegenzahn, West Covina, and William I. Chertok, Los Angeles, for defendant and respondent.

TOBRINER, Justice.

[1] This case concerns the validity of a release from liability for future negligence imposed as a condition for admission to a charitable research hospital. For the reasons we hereinafter specify, we have concluded that an agreement between a hospital ***34 **442** and an entering patient affects the public interest and that, in consequence, the exculpatory provision included within it must be invalid under Civil Code section 1668.

Hugo Tunkl Brought this action to recover damages for personal injuries alleged to have resulted from the negligence of two physicians in the employ of the University of California Los Angeles Medical Center, a hospital operated and maintained by the Regents of the University of California as a nonprofit charitable institution. Mr. Tunkl died after suit was brought, and his surviving wife, as executrix, was substituted as plaintiff.

The University of California at Los Angeles Medical Center admitted Tunkl as a patient on June 11, 1956. The Regents maintain the hospital for the primary purpose of aiding and developing a program of research and education in the field of medicine; patients are selected and admitted if the study and treatment of their condition would tend to achieve these purposes. Upon his entry to the hospital, Tunkl signed a document setting forth certain 'Conditions of Admission.' The crucial condition number six reads as follows: 'RELEASE: The hospital is a nonprofit, charitable institution. In consideration of the hospital and allied services to be rendered and the rates charged therefor, the patient or his legal representative agrees to and hereby releases The Regents of the University of California, and the hospital from any and all liability for the negligent or wrongful acts or omissions of its employees, if the hospital has used due care in selecting its employees.'

Plaintiff stipulated that the hospital had Selected its employees with due care. The trial court ordered that the issue of the validity of the exculpatory clause be first submitted to the jury and that, if the jury found that the provision did not bind plaintiff, a second jury try the issue of alleged malpractice. When, on the preliminary issue, the jury returned a verdict sustaining the validity of the executed release, the ***95** court entered judgment in favor of the Regents.[FN1] Plaintiff appeals from the judgment.

FN1. Plaintiff at the time of signing the release was in great pain, under sedation. and probably unable to read. At trial plaintiff

> contended that the release was invalid, asserting that a release does not bind the releasor if at the time of its execution he suffered from so weak a mental condition that he was unable to comprehend the effect of his act (Perkins v. Sunset Tel. & Tel. Co. (1909) 155 Cal. 712, 103 P. 190; Raynale v. Yellow Cab Co. (1931) 155 Cal.App. 90, 300 P. 991; 42 Cal.Jur.2d, Release s 20). The jury, however, found against plaintiff on this issue. Since the verdict of the jury established that plaintiff either knew or should have known the significance of the release, this appeal raises the sole question of whether the release can stand as a matter of law.

We shall first set out the basis for our prime ruling that the exculpatory provision of the hospital's contract fell under the proscription of Civil Code section 1668; we then dispose of two answering arguments of defendant.

We begin with the dictate of the relevant Civil Code section 1668. The section states: 'All contracts which have for their object, directly or indirectly, to exempt anyone from responsibility for his own fraud, or willful injury to the person or property of another, or violation of law, whether willful or negligent, are against the policy of the law.'

The course of section 1668, however, has been a troubled one. Although, as we shall explain, the decisions uniformly uphold its prohibitory impact in one circumstance, the courts' interpretations of it have been diverse. Some of the cases have applied the statute strictly, invalidating any contract for exemption from liability for negligence. The court in England v. Lyon Fireproof Storage Co. (1928) 94 Cal.App.562, 271 P. 532, categorically states, 'The court correctly instructed the jury that The defendant cannot limit its liability against its own negligence by contract, and any contract to that effect would be void.' (94 Cal.App. p. 575, 271 P. p. 537.) (To *****35 **443** the same effect: Union Constr. Co. v. Western Union Tel. Co. (1912) 163 Cal. 298, 314-315, 125 P. 242.)[FN2] The recent case of Mills v. Ruppert (1959) 167 Cal.App.2d 58, 62-63, 333 P.2d 818; however, apparently limits '(N)egligent * * * violation of law' exclusively to statutory law.[FN3] Other cases hold that ***96** the statute prohibits the exculpation of gross negligence only;[FN4] still another case states that the section forbids exemption from active as contrasted with passive negligence.[FN5]

> FN2. Accord, Hiroshima v. Bank of Italy (1926) 78 Cal.App. 362, 377-378, 248 P. 947; cf. Estate of Garcelon (1894) 104 Cal. 570, 589, 38 P. 414, 32 L.R.A. 595.

> FN3. To the same effect: Werner v. Knoll (1948) 89 Cal.App.2d 474, 201 P.2d 45; 15 Cal.L.Rev. 46 (1926). This interpretation was criticized in Barkett v. Brucato (1953) 122 Cal.App.2d 264, 277, 264 P.2d 978, and 1 Witkin, Summary of California Law 228 (7th ed. 1960). The latter states: 'Apart from the debatable interpretation of 'violation of law' as limited strictly to violation of statutes, the explanation appears to make an unsatisfactory distinction between (1) valid exemptions from liability for injury or death resulting from types of ordinary or gross negligence not expressed in statutes, and (2) invalid exemptions where the negligence consists of violation of one of the many hundreds of statutory provisions setting forth standards of care.'

> FN4. See Butt v. Bertola (1952) 110 Cal.App.2d 128, 242 P.2d 32; Ryan Mercantile Co. v. Great Northern Ry. Co. (D.Mont.1960) 186 F.Supp. 660, 667-668. See also Smith, Contractual Controls of Damages in Commercial Transactions, 12 Hastings L.J. 122, 142 (1960), suggesting that section 1668 permits exculpatory clauses for all but intentional wrongs, an interpretation which would render the term 'negligent * * * violation of law' totally

ineffective.

FN5. Barkett v. Brucato (1953) 122 Cal.App.2d 264, 277, 264 P.2d 978.

In one respect, as we have said, the decisions are uniform. The cases have consistently held that the exculpatory provision may stand only if it does not involve 'the public interest.'[FN6] Interestingly enough, this theory found its first expression in a decision which did not expressly refer to section 1668. In Stephens v. Southern Pacific Co. (1895) 109 Cal. 86, 41 P. 783, 29 L.R.A. 751, a railroad company had leased land, which adjoined its depot, to a lessee who had constructed a warehouse upon it. The lessee covenanted that the railroad company would not be responsible for damage from fire 'caused by any * * * means.' (109 Cal. p. 87, 41 P. p. 783.) This exemption, under the court ruling applied to the lessee's damage resulting from the railroad company's carelessly burning dry grass and rubbish. Declaring the contract not 'violative of sound public policy' (109 Cal. p. 89, 41 P. p. 784), the court pointed out '* * * As far as this transaction was concerned, the parties, when contracting, stood upon common ground, and dealt with each other as A. and B. might deal with each other with reference to any private business undertaking. * * *' (109 Cal. p. 88, 41 P. p. 784.) The court concluded 'that the interests***97** of the public in the contract are more sentimental than real' (109 Cal. p. 95, 41 P. p. 786; emphasis added) and that the exculpatory provision was therefore enforceable.

FN6. The view that the exculpatory contract is valid only if the public interest is not involved represents the majority holding in the United States. Only New Hampshire, in definite opposition to 'public interest' test, categorically refuses to enforce exculpatory provisions. The cases are collected in an extensive annotation in 175 A.L.R. 8 (1948). In addition to the California cases cited in the text and note 7 infra, the public interest doctrine is recognized in dictum in Sproul v. Cuddy (1955) 131 Cal.App.2d 85, 95, 280 P.2d 158; Basin Oil Co. v. Baash-Ross Tool Co. (1954) 125 Cal.App.2d 578, 594, 271 P.2d 122; Hubbard v. Matson Navigation Co. (1939) 34 Cal.App.2d 475, 477, 93 P.2d 846. Each of these cases involved exculpatory clauses which were construed by the court as not applicable to the conduct of the defendant in question.

In applying this approach and in manifesting their reaction as to the effect of the exemptive clause upon the public interest, some later courts enforced, and others invalidated*****36 **444** such provisions under section 1668. Thus in Nichols v. Hitchcock Motor Co. (1937) 22 Cal.App.2d 151, 159, 70 P.2d 654, 658, the court enforced an exculpatory clause on the ground that 'the public neither had nor could have any interest whatsoever in the subject-matter of the contract, considered either as a whole or as to the incidental covenant in question. The agreement between the parties concerned 'their private affairs' only.'[FN7]

FN7. See also Hischemoeller v. Nat. Ice etc. Storage Co. (1956) 46 Cal.2d 318, 328, 294 P.2d 433 (contract upheld as an 'ordinary business transaction between businessmen'); Mills v. Ruppert (1959) 167 Cal.App.2d 58, 62, 333 P.2d 818 (lease held not a matter of public interest); Inglis v. Garland (1936) 19 Cal.App.2d Supp. 767, 773, 64 P.2d 501 (same); cf. Northwestern Mutual Fire Ass'n v. Pacific Co. (1921) 187 Cal. 38, 41, 200 P. 934 (exculpatory clause in bailment upheld because of special business situation).

In Barkett v. Brucato (1953) 122 Cal.App.2d 264, 276, 264 P.2d 978, 987, which involved a waiver clause in a private lease, Justice Peters summarizes the previous decisions in this language: 'These cases hold that the matter is simply one of interpreting a contract; that both parties are free to contract; that the relationship of landlord and tenant does not affect the public interest; that such a provision af-

fects only the private affairs of the parties. * * *' (Emphasis added.)

On the other hand, courts struck down exculpatory clauses as contrary to public policy in the case of a contract to transmit a telegraph message (Union Constr. Co. v. Western Union Tel. Co. (1912) 163 Cal. 298, 125 P. 242) and in the instance of a contract of bailment (England v. Lyon Fireproof Storage Co. (1928) 94 Cal.App. 562, 271 P. 532). In Hiroshima v. Bank of Italy (1926) 78 Cal.App. 362, 248 P. 947, the court invalidated an exemption provision in the form used by a payee in directing a bank to stop payment on a check. The court relied in part upon the fact that 'the banking public, as well as the particular individual who may be concerned in the giving of any stop notice, is interested in seeing that the bank is held accountable for the ordinary and regular performance of its duties, and also in seeing that directions***98** in relation to the disposition of funds deposited in the bank are not heedlessly, negligently, and carelessly disobeyed, and money paid out contrary to directions given.' (78 Cal.App. p. 377, 248 P. p. 953.) The opinion in Hiroshima was approved and followed in Grisinger v. Golden State Bank (1928) 92 Cal.App. 443, 268 P. 425.[FN8]

> FN8. Exculpatory clauses were regarded as invalid, although without reference to the public interest doctrine, in Franklin v. Southern Pacific Co. (1928) 203 Cal. 680, 686, 265 P. 936, 59 A.L.R. 118 (common carrier); Dieterle v. Bekin (1904) 143 Cal. 683, 688, 77 P. 664 (bailment); George v. Bekins Van & Storage Co. (1949) 33 Cal.2d 834, 846, 205 P.2d 1037 (bailment, clause upheld as one for declaration of value and not complete exculpation); Hall-Scott Motor Car Co. v. Universal Ins. Co. (9th Cir. 1941) 122 F.2d 531, 533-534 (California law, clause upheld on ground that transaction not a bailment).

If, then, the exculpatory clause which affects the public interest cannot stand, we must ascertain those factors or characteristics which constitute the public interest. The social forces that have led to such characterization are volatile and dynamic. No definition of the concept of public interest can be contained within the four corners of a formula. The concept, always the subject of great debate, has ranged over the whole course of the common law; rather than attempt to prescribe its nature, we can only designate the situations in which it has been applied. We can determine whether the instant contract does or does not manifest the characteristics which have been held to stamp a contract as one affected with a public interest.

In placing particular contracts within or without the category of those affected with a public interest, the courts have revealed a rough outline of that type of transaction in which exculpatory provisions will *****37 **445** be held invalid. Thus the attempted but invalid exemption involves a transaction which exhibits some or all of the following characteristics. It concerns a business of a type generally thought suitable for public regulation.[FN9] The party seeking exculpation is engaged ***99** in performing a service of great importance to the public,[FN10] which is often a matter of practical necessity for some members of the public.[FN11] The party holds himself out as willing to perform this service for any member of the public who seeks it, or at least for any member coming within certain established standards.[FN12] As a result of the essential nature *****38 **446** of the ***100** service, in the economic setting of the transaction, the party invoking exculpation possesses a decisive advantage of bargaining strength against any member of the public who seeks his services.[FN13] In exercising a superior bargaining power the party confronts the public with a standardized adhesion contract of exculpation,[FN14] and makes no provision whereby a purchaser may pay additional reasonable fees and obtain protection***101** against negligence.[FN15] Finally, as a result of the transaction, the person or property of the purchaser is placed under the control of the seller,[FN16] subject to the risk of carelessness by the seller or his agents.

FN9. 'Though the standard followed does not always clearly appear, a distinction seems to be made between those contracts which modify the responsibilities normally attaching to a relationship which has been regarded in other connections as a fit subject for special regulatory treatment and those which affect a relationship not generally subjected to particularized control.' (11 So.Cal.L.Rev. 296, 297 (1938); see also Note 175 A.L.R. 8, 38-41 (1948).

In Munn v. Illinois (1877) 94 U.S. 113, 24 L.Ed. 77, the Supreme Court appropriated the common law concept of a business affected with a public interest to serve as the test of the constitutionality of state price fixing laws, a role it retained until Nebbia v. New York (1934) 291 U.S. 502, 54 S.Ct. 505, 78 L.Ed. 940, and Olsen v. Nebraska (1941) 313 U.S. 236, 61 S.Ct. 862, 85 L.Ed. 1305. For discussion of the constitutional use and application of the 'public interest' concept, see generally Hall, Concept of Public Business (1940); Hamilton, Affectation with a Public Interest, 39 Yale L.J. 1089 (1930).

FN10. See New York Cent. Railroad Co. v. Lockwood (1873) 17 Wall. 357, 84 U.S. 357, 378-382, 21 L.Ed. 627; Millers Mut. Fire Ins. Ass'n v. Parker (1951) 234 N.C. 20, 65 S.E.2d 341; Hiroshima v. Bank of Italy (1926) 78 Cal.App. 362, 377, 248 P. 947; cf. Lombard v. Louisiana (1963) 373 U.S. , 83 S.Ct. 1122 (Douglas, J., concurring) (holding that restaurants cannot discriminate on racial grounds, and noting that '(p)laces of public accommodation such as retail stores, restaurants, and the like render a 'service which has become a public interest' * * * in the manner of the innkeepers and common carriers of old.'); Charles Wolff Packing Co. v. Court of Industrial Relations (1923), 262 U.S. 522, 43 S.Ct. 630, 67 L.Ed. 1103 ('public interest' as test of constitutionality of price fixing); German Alliance Ins. Co. v. Kansas (1914) 233 U.S. 389, 34 S.Ct. 612, 58 L.Ed. 1011 (same); Hamilton, Affectation with a Public Interest, 39 Yale L.J. 1089 (1930) (same); Arterburn, The Origin and First Test of Public Callings, 75 U.Pa.L.Rev. 411, 428 (1927) ('public interest' as one test of whether business has duty to serve all comers). But see Simmons v. Columbus Venetian Stevens Buildings (1958) 20 Ill.App.2d 1, 25-32, 155 N.E.2d 372, 384-387 (apartment leases, in which exculpatory clauses are generally permitted, are in aggregate as important to society as contracts with common carriers).

FN11. See Bisso v. Inland Waterways Corp. (1955) 349 U.S. 85, 91, 75 S.Ct. 629, 99 L.Ed. 911; New York Cent. Railroad Co. v. Lockwood, supra; Fairfax Gas & Supply Co. v. Hadary (4th Cir. 1945) 151 F.2d 939; Millers Mut. Fire Ins. Ass'n v. Parker (1951) 234 N.C. 20, 65 S.E.2d 341; Irish & Swartz Stores v. First Nat. Bank of Eugene (1960) 220 Or. 362, 375, 349 P.2d 814, 821: 15 U.Pitt.L.Rev. 493, 499-500 (1954); Note 175 A.L.R. 8, 16-17 (1948); cf. Charles Wolff Packing Co. v. Court of Industrial Relations (1923) 262 U.S. 522, 43 S.Ct. 630, 67 L.Ed. 1103 (constitutional law); Munn v. Illinois (1877) 94 U.S. 113, 24 L.Ed. 77 (same); Hall, Concept of Public Business 94 (1940) (same).

FN12. See Burdick, The Origin of the Peculiar Duties of Public Service Companies, 11 Colum.L.Rev. (1911) 514, 616, 743; Lombard v. Louisiana, supra, fn. 10. There is a close historical relationship between the duty of common carriers, public warehousemen, innkeepers, etc. to give reasonable service to all persons who apply, and

the refusal of courts to permit such businesses to obtain exemption from liability for negligence. See generally Arterburn, supra, fn. 10. This relationship has lead occasional courts and writers to assert that exculpatory contracts are invalid only if the seller has a duty of public service. 28 Brooklyn L.Rev. 357, 359 (1962); see Ciofalo v. Vic Tanney Gyms, Inc. (1961) 10 N.Y.2d 294, 220 N.Y.S.2d 962, 117 N.E.2d 925. A seller under a duty to serve is generally denied exemption from liability for negligence; (however, the converse is not necessarily true.) 44 Cal.L.Rev. 120 (1956); cf. Charles Wolff Packing Co. v. Court of Industrial Relations (1923) 262 U.S. 522, 538, 43 S.Ct. 630, 67 L.Ed. 1103 (absence of duty to serve public does not necessarily exclude business from class of those constitutionally subject to state price regulation under test of Munn v. Illinois); German Alliance Ins. Co. v. Kansas (1914) 233 U.S. 389, 407, 34 S.Ct. 612, 58 L.Ed. 1011 (same). A number of cases have denied enforcement to exculpatory provisions although the seller, had no duty to serve. See e. g., Bisso v. Inland Waterways Corp. (1955) 349 U.S. 85, 75 S.Ct. 629, 99 L.Ed. 911; Millers Mut. Fire Ins. Ass'n v. Parker (1951) 234 N.C. 20, 65 S.E.2d 341; cases on exculpatory provisions in employment contracts collected in 35 Am.Jur., Master & Servant, s 136.

FN13. Prosser, Torts (2d ed. 1955) 306: 'The courts have refused to uphold such agreements * * * where one party is at such obvious disadvantage in bargaining power that the effect of the contract is to put him at the mercy of the other's negligence.' Note 175 A.L.R. 8, 18 (1948): 'Validity is almost universally denied to contracts exempting from liability for its negligence the party which occupies a superior bargaining position.' Accord: Bisso v. Inland Waterways Corp. (1955) 349 U.S. 85, 91, 75 S.Ct. 629, 99 L.Ed. 911; Hiroshima v. Bank of Italy (1926) 78 Cal.App. 362, 377, 248 P. 947; Ciofalo v. Vic Tanney Gyms, Inc. (1961) 13 App.Div.2d 702, 214 N.Y.S.2d 99; (Kleinfeld, J. dissenting); 6 Williston, Contracts (Rev. ed. 1938) s 1751C; Note, The Significance of Comparative Bargaining Power in the Law of Exculpation (1937) 37 Colum.L.Rev. 248; 20 Corn.L.Q. 352 (1935); 8 U.Fla.L.Rev. 109, 120-121 (1955); 15 U.Pitt.L.Rev. 493 (1954); 19 So.Cal.L.Rev. 441 (1946); see New York Cent. Railroad Co. v. Lockwood (1873) 17 Wall. 357, 84 U.S. 357, 378-382, 21 L.Ed. 627; Fairfax Gas & Supply Co. v. Hadary (4th Cir. 1945) 151 F.2d 939; Northwestern Mutual Fire Ass'n v. Pacific Co. (1921) 187 Cal. 38, 43-44, 200 P. 934; Inglis v. Garland (1936) 19 Cal.App.2d Supp. 767, 773, 64 P.2d 501; Jackson v. First Nat. Bank of Lake Forest (1953) 415 Ill. 453, 462-463, 114 N.E.2d 721, 726; Simmons v. Columbus Venetian Stevens Buildings (1958) 20 Ill.App.2d 1, 26-32, 155 N.E.2d 372, 384-387; Hall v. Sinclair Refining Co. (1955) 242 N.C. 707, 89 S.E.2d 396; Millers Mut. Fire Ins. Ass'n v. Parker (1951) 234 N.C. 20, 65 S.E.2d 341; Irish & Swartz Stores v. First Nat. Bank of Eugene (1960) 220 Or. 362, 375, 349 P.2d 814, 821; 44 Cal.L.Rev. 120 (1956); 4 Mo.L.Rev. 55 (1939).

FN14. See Simmons v. Columbus Venetian Stevens Building (1958) 20 Ill.App.2d 1, 30-33, 155 N.E.2d 372, 386-387; Irish & Swartz Stores v. First Nat. Bank of Eugene (1960) 220 Or. 362, 376, 349 P.2d 814, 821; Note 175 A.L.R. 8, 15-16, 112 (1948) .

FN15. See 6A Corbin, Contracts (1962) s 1472 at p. 595; Note 175 A.L.R. 8, 17-18

(1948).

FN16. See Franklin v. Southern Pacific Co. (1928) 203 Cal. 680, 689-690, 265 P. 936, 59 A.L.R. 118; Stephens v. Southern Pacific Co. (1895) 109 Cal. 86, 90-91, 41 P. 783, 29 L.R.A. 751; Irish & Swartz Stores v. First Nat. Bank of Eugene (1960) 220 Or. 362, 377, 349 P.2d 814, 822; 44 Cal.L.Rev. 120, 128 (1956); 20 Corn.L.Q. 352, 358 (1935).

[2] While obviously no public policy opposes private, voluntary transactions in which one party, for a consideration, agrees to shoulder a risk which the law would otherwise have placed upon the other party, the above circumstances pose a different situation. In this situation the releasing party does not really acquiesce voluntarily in the contractual shifting of the risk, nor can we be reasonably certain that he receives an adequate consideration for the transfer. Since the service is one which each *****39 **447** member of the public, presently or potentially, may find essential to him, he faces, despite his economic inability to do so, the prospect of a compulsory assumption of the risk of another's negligence. The public policy of this state has been, in substance, to posit the risk of negligence upon the actor; in instances in which this policy has been abandoned, it has generally been to allow or require that the risk shift to another party better or equally able to bear it, not to shift the risk to the weak bargainer.

In the light of the decisions, we think that the hospital-patient contract clearly falls within the category of agreements affecting the public interest. To meet that test, the agreement need only fulfill some of the characteristics above outlined; here, the relationship fulfills all of them. Thus the contract of exculpation involves an institution suitable for, and a subject of, public regulation. (See Health & Saf.Code, ss 1400-1421, 32000-32508.) FN17 That the services of the hospital to those members of the public who are in special need of the particular skill of its staff and facilities constitute a practical and crucial necessity is hardly open to question.

FN17. '(P)roviding hospital facilities to those legally entitled thereto is a proper exercise of the police power of the county * * * as it tends to promote the public health and general welfare of the citizens of the county.' (Goodall v. Brite (1936) 11 Cal.App.2d 540, 548, 54 P.2d 510, 514; see Jardine v. City of Pasadena (1926) 199 Cal. 64, 248 P. 225, 48 A.L.R. 509.)

[3] ***102** The hospital, likewise, holds itself out as willing to perform its services for those members of the public who qualify for its research and training facilities. While it is true that the hospital is selective as to the patients it will accept, such selectivity does not negate its public aspect or the public interest in it. The hospital is selective only in the sense that it accepts from the public at large certain types of cases which qualify for the research and training in which it specializes. But the hospital does hold itself out to the public as an institution which performs such services for those members of the public who can qualify for them. FN18

FN18. See Wilmington General Hospital v. Manlove (Del.1961) 174 A.2d 135, holding that a private hospital which holds itself out as rendering emergency service cannot refuse to admit a patient in an emergency and comment on the above case in 14 Stan.L.Rev. 910 (1962).

In insisting that the patient accept the provision of waiver in the contract, the hospital certainly exercises a decisive advantage in bargaining. The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital. The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract. As a result, we cannot but conclude that the instant agreement manifested the characteristics of the so-called adhesion contract. Finally, when the patient

signed the contract, he completely placed himself in the control of the hospital; he subjected himself to the risk of its carelessness.

In brief, the patient here sought the services which the hospital offered to a selective portion of the public; the patient, as the price of admission and as a result of his inferior bargaining position, accepted a clause in a contract of adhesion waiving the hospital's negligence; the patient thereby subjected himself to control of the hospital and the possible infliction of the negligence which he had thus been compelled to waive. The hospital, under such circumstances, occupied a status different than a mere private party; its contract with the patient affected the public interest. We see no cogent current reason for according to the patron of the inn a greater protection than the patient of the hospital; we cannot hold the innkeeper's performance affords a greater public service than that of the hospital.

*****40 **448** [4][5] We turn to a consideration of the two arguments urged by ***103** defendant to save the exemptive clause. Defendant first contends that while the public interest may possibly invalidate the exculpatory provision as to the paying patient, it certainly cannot do so as to the charitable one. Defendant secondly argues that even if the hospital cannot obtain exemption as to its 'own' negligence it should be in a position to do so as to that of its employees. We have found neither proposition persuasive.

As to the first, we see no distinction in the hospital's duty of due care between the paying and nonpaying patient. (But see Rest., Contracts, s 575(1)(b).) The duty, emanating not merely from contract but also tort, imports no discrimination based upon economic status. (See Malloy v. Fong (1951) 37 Cal.2d 356, 366, 232 P.2d 241; Rest., Torts, ss 323-324.) Rejecting a proposed differentiation between paying and nonpaying patients, we refused in Malloy to retain charitable immunity for charitable patients. Quoting Rutledge, J. in President & Directors of Georgetown College v. Hughes (1942) 76 U.S.App.D.C. 123, 130 F.2d 810, 827, we said: 'Retention (of charitable immunity) for the nonpaying patient is the least defensible and most unfortunate of the distinction's refinements. He, least of all, is able to bear the burden. More than all others, he has no choice. * * * He should be the first to have reparation, not last and least among those who receive it.' (37 Cal.2d p. 365, 232 P.2d p. 246.) To immunize the hospital from negligence as to the charitable patient because he does not pay would be as abhorrent to medical ethics as it is to legal principle.

Defendant's second attempted distinction, the differentiation between its own and vicarious liability, strikes a similar discordant note. In form defendant is a corporation. In everything it does, including the selection of its employees, it necessarily acts through agents. A legion of decisions involving contracts between common carriers and their customers, public utilities and their customers, bailees and bailors, and the like, have drawn no distinction between the corporation's 'own' liability and vicarious liability resulting from negligence of agents. We see no reason to initiate so far-reaching a distinction now. If, as defendant argues, a right of action against the negligent agent is in fact a sufficient remedy, then defendant by paying a judgment against it may be subrogated to the right of the patient against the negligent agent, and thus may exercise that remedy.

[6] ***104** In substance defendant here asks us to modify our decision in Malloy, which removed the charitable immunity; defendant urges that otherwise the funds of the research hospital may be deflected from the real objective of the extension of medical knowledge to the payment of claims for alleged negligence. Since a research hospital necessarily entails surgery and treatment in which fixed standards of care may not yet be evolved, defendant says the hospital should in this situation be excused from such care. But the answer lies in the fact that possible plaintiffs must prove negligence; the standards of care will themselves reflect the research nature of the treatment; the hospital will not become an in-

surer or guarantor of the patient's recovery. To exempt the hospital completely from any standard of due care is to grant it immunity by the side-door method of a contractual clause exacted of the patient. We cannot reconcile that technique with the teaching of Malloy.

We must note, finally, that the integrated and specialized society of today, structured upon mutual dependency, cannot rigidly narrow the concept of the public interest. From the observance of simple standards of due care in the driving of a car to the performance of the high standards of hospital practice, the individual citizen must be completely dependent upon the responsibility of others. The fabric of this pattern is so closely woven that the snarling of a single thread affects the whole. We cannot lightly accept a sought immunity from careless failure to provide the hospital service upon which many must depend. Even if the *****41 **449** hospital's doors are open only to those in a specialized category, the hospital cannot claim isolated immunity in the interdependent community of our time. It, too, is part of the social fabric, and prearranged exculpation from its negligence must partly rend the pattern and necessarily affect the public interest.

The judgment is reversed.

GIBSON, C. J., and TRAYNOR, SCHAUER, McCOMB, PETERS, and PEEK, JJ., concur.
CAL. 1963.
Tunkl v. Regents of University of Cal.
60 Cal.2d 92, 383 P.2d 441, 32 Cal.Rptr. 33, 6 A.L.R.3d 693

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Visit Date/Time: **December 29, 2008 14:30**

This is to acknowledge that I, an emergency department patient at University of Washington Medical Center, am leaving the hospital against the advice of the attending physician and the hospital authorities. I acknowledge the risks involved and I hereby release the attending physician at University of Washington Medical Center from any responsibility or liability for ill effects which may result from my action. I assume full responsibility for this action.

Witnessed by	Patient or Representative
Witnessed by	Relationship to Patient