# LAW & MEDICINE

*What Every Physician Should Know*

**Victor R. Cotton, MD, JD**

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INSIDE THIS ARTICLE



# THE DOCTOR-PATIENT RELATIONSHIP

All malpractice related liability begins and ends with the doctor-patient relationship. The importance of this statement can be more fully appreciated by starting with an overview of the medical malpractice system.

Technically speaking, malpractice is nothing more than negligence that occurs in the performance of a profession. And, negligence is a very simple area of the law. In order to sue someone successfully for negligence, or to sue a physician for malpractice, the plaintiff (i.e., the patient), must prove four things:

- Duty Owed – the existence of an obligation or responsibility
- Duty Breached – failure to deliver on the obligation
- Causation – a link between breach and damage
- Damages – loss of bodily function, lost wages, medical bills, pain and suffering

Every medical malpractice lawsuit is about the same four elements and the plaintiff must prove each of them in order to win. The corollary is that a physician who has been sued for medical malpractice (and thus becomes the defendant) must defeat any one of the four elements in order to prevail.

Although there are technically four elements, the whole system actually hinges on the first element, the duty owed. For, once the duty is established and its scope defined, it is relatively easy to assess whether it was breached and whether this caused the patient's injuries.

***The first element of negligence, the duty owed, is the only element that matters at the bedside.***

The duty owed element, is thus the key to the whole system. It is the element on which malpractice attorneys focus most of their attention, and it is the only element that matters to a clinician. In fact, a clinician who understands the duty owed element does not need to worry about the other three elements.

## GENERAL OBLIGATION TO OUR FELLOW MAN

The American legal system does not impose any general duty upon us with respect to helping our fellow man. In other words, the mere fact that another person happens to be in need, whether he is ill, has been injured, or simply has a

flat tire at the roadside, does not create an obligation for a passerby to help him. This is true everywhere in America, and it is true even if assistance could be rendered easily and would avert great loss.

### Case #1

*Dr. A is driving his car. Along the highway, he comes across a motor vehicle accident. The accident has just occurred, there are no emergency vehicles on the scene and it is obvious that people have been seriously injured. And, the events take place in a state where Dr. A is licensed to practice medicine.*

Analysis

Dr. A is not required to stop or assist in anyway, and he cannot be successfully sued if he chooses to not do so. The law is clear: Simply being a physician, being available, and being in the area of persons who are in need does not create a duty to help those persons. This is true even if Dr. A is a licensed, board certified trauma surgeon and the persons at the roadside are in great need.

***Simply being a physician, being available, and being in the area of persons who are in need does not create a duty to help those persons.***

Although the American Medical Association's position is that physicians have an ethical duty to assist whenever feasible in such a situation, this does not create a legal duty. Ironically, many physicians will no longer place a license plate on their car that indicates they are a doctor. The concern is that a license plate which displays the letters "MD" will alert persons at the scene of an accident that the driver is a physician, and thus make him the target of a lawsuit. But, this concern is misplaced. Simply being a physician does not create an obligation, regardless of one's license plate.

An additional concern regarding motor vehicle accidents is the physician's obligation under a Good Samaritan Law. The Good Samaritan Laws vary slightly from state to state, but they all share the same basic elements:

- They do not require physicians to assist in any way. Physicians remain free to choose whether to become involved;
- They apply only if the physician's involvement is voluntary (as opposed to being paid to be in attendance);
- They apply only if the situation is an emergency (and not merely a routine medical problem); and,
- They provide an added layer of legal protection, but the physician can still be sued for malpractice (and thus it remains legally safer not to become involved in the first place).

***Good Samaritan laws do not require a physician to assist in any way.***

In short, a physician who voluntarily chooses to assist at the scene of an emergency (i.e., be a Good Samaritan) will almost always receive the protection afforded by the Good Samaritan laws. However, from a legal perspective, it is safer to not become involved at all. Of course, for those of us who feel morally compelled to assist, the Good Samaritan Laws provide a valuable protection.

## Creation of the Duty

A legal duty does not exist simply because one person has a medical need and the other person is a physician. Something more is required. Specifically, the two of them must be in a doctor-patient relationship. It is the doctor-patient relationship that creates the critical link, the duty, and with it the first element of negligence.

In order to sue a physician successfully for medical malpractice, the patient must prove four elements, the first of which is duty owed. In order to establish this duty, all that the person must do is demonstrate that he was in a doctor-patient relationship with the defendant physician. Once he does that, the first element of a malpractice lawsuit is established. But, if he cannot do so, then he has no case against the physician.

Thus, if an individual is not a physician's patient, the physician does not (legally) owe the person anything with respect to his healthcare and that person can never successfully sue the physician for malpractice. But, once he becomes the physician's patient, the situation changes entirely.

The first critical question, then, with respect to potential malpractice exposure, is a simple one: Is the person in question actually your patient? The entire system hinges on the answer, which can be readily ascertained by application of the following legal principle: A doctor-patient relationship is established when a doctor has professional contact with a patient.

***A doctor-patient relationship is established when a doctor has professional contact with a patient.***

The contact can occur anywhere at any time. It can be in person or over the phone. It can be direct or via a mes-

sage relayed through an assistant or nurse. It is independent of whether any payment is requested or made. As soon as one person assumes the role of doctor and another person assumes the role of patient, a doctor-patient relationship, and the accompanying legal duty, is created. In addition, a doctor-patient relationship can be formed vicariously, through the actions of other people. For example, residents, interns, nurse practitioners, nurses and even office staff can form doctor-patient relationships for the supervising physician when they attend to a person's needs. This is true even if the case was not discussed with the attending physician.

## Case # 2

*Mr. X has been suffering from abdominal pain and decides to see a doctor. He does not have a physician, so he calls Dr. A's office and asks for a new patient appointment. Because Dr. A is very busy, the next new patient appointment is three weeks hence, which Mr. X agrees to take. Mr. X provides Dr. A's office with some general information about himself - his name, address, and phone number. The next day Dr. A's office sends Mr. X an appointment confirmation letter in the mail.*

*Unfortunately, over the next week, Mr. X's abdominal pain significantly worsens. He eventually goes to the emergency room and is diagnosed as having ruptured an abdominal aortic aneurysm. He is taken to the operating room, but subsequently dies of complications.*

*Everyone involved agrees that if Dr. A had seen Mr. X sooner, the diagnosis could have been made and his death averted. In addition, Mr. X did contact Dr. A's office and Dr. A did agree to see him. However, because of the scheduling backlog, Mr. X was not seen in a timely manner, the diagnosis was not made, and he died.*

### Analysis

Mr. X was not Dr. A's patient and Dr. A is not legally responsible for his death. It is tempting to look at this situation and conclude that it is a classic a case of a "delay in diagnosis."

However, from a medical-legal perspective, a "delay in diagnosis" cannot occur unless the physician was under some obligation to make a timely diagnosis. Put another way, there first must be a duty owed. As outlined above, duties are created by the establishment of a doctor-patient relationship and that requires professional contact between doctor and patient. In this case, there was some contact in that Mr. X called Dr. A's office, spoke to his staff, and scheduled an appointment.

But, neither Dr. A's staff nor Dr. A crossed the line and formed a doctor-patient relationship. No one counseled Mr. X, offered medical advice, ordered tests, made a diagnosis, prescribed medication, or treated him in any way. As such, Mr. X was not Dr. A's patient, Dr. A did not owe him a duty and Mr. X cannot successfully sue Dr. A for medical malpractice.

***Simply scheduling an appointment does not create a doctor-patient relationship.***

With that as the background, what then is our obligation to a new patient who schedules an appointment but then fails to keep it? Nothing. There is no duty whatsoever. Although we are free to contact these persons and ask them to reschedule, we are under no obligation to do so.

## Case #3

*In addition to the facts of the preceding case, at the time Mr. X schedules an appointment, Dr. A's staff asks him to have his old records sent to the office. Mr. X contacts his former physician to have the records forwarded, and they arrive within a few days.*

*In anticipation of the appointment, Dr. A looks through the records and realizes that Mr. X may have an enlarging aneurysm. Dr. A instructs his staff to call Mr. X and have him come to the office immediately. Unfortunately, Dr. A's staff misplaces the chart and never calls. A few days later Mr. X ruptures the aneurysm and dies.*

### Analysis

Mr. X was not Dr. A's patient and Dr. A is not legally responsible for his death. In this case Dr. A had the records, made the diagnosis and knew that Mr. X needed immediate medical attention. He even made an effort to help. But, due to an error, never contacted Mr. X. Although this is a tragedy, it does not form a doctor-patient relationship.

***Simply having medical records, even if you look through the records, does not create a doctor-patient relationship.***

The critical element of professional contact is again missing. Dr. A never advised, examined, recommended or treated Mr. X in any way. Although Dr. A knew that Mr. X was in danger and even made an attempt to help, that is not enough. Without professional contact there is no relationship and without a relationship there is no legal obligation or liability.

## Case #4

*Mr. X again calls Dr. A's office and asks to be seen. He is told that the next new patient appointment is in three weeks. He attempts to negotiate with the scheduler in an effort to be seen earlier and explains that his pain is such that he does not want to wait three weeks.*

*The scheduler, in an effort to be helpful, asks about his pain. Mr. X explains that his previous doctor believed it was due to an ulcer, treated him with Prilosec, and that it did help. The scheduler tells Mr. X to stay on the Prilosec, and if the pain worsens, to call back as she might be able to find an earlier appointment for him. The next week Mr. X's aneurysm ruptures and he dies.*

### Analysis

Mr. X was Dr. A's patient and Dr. A may be held partially responsible for his death. Dr. A's scheduler, acting under Dr. A's authority and control, triaged Mr. X. She asked about his problem, made an assessment and gave a recommendation. That is sufficient to create a doctor-patient relationship.

It does not matter that Dr. A was not personally involved or even aware of the conversation. His scheduler, who works on his behalf and represents him, was involved and that is all that is needed. When a staff person gives medical advice, it creates a doctor-patient relationship for the supervising physician.

***When a staff person gives medical advice, it creates a doctor-patient relationship for the supervising physician.***

As such, the only persons giving medical advice in a physician's office should be the people whom the physician instructs to give medical advice. In addition, physician offices should not triage new patients. Although it is legally permissible to do so, it creates unmanageable liability – a duty to a person who has never been seen and may never be seen - and is thus an unwise approach.

Of course, in this example, refusing to help Mr. X also creates a dilemma. He is in pain, but cannot be seen for several weeks. Although it is unwise to give medical advice, it is inappropriate simply to hang up the phone. In such a situation, there are two legally viable approaches. The first is to tell him to call his former physician and the second is to have him go to the emergency room.

A case could be made that those approaches also constitute medical advice which forms a doctor-patient relationship, but the argument is weak. The advice is nothing more than the same recommendation that any lay person would give to someone who was in pain: "Call your doctor" or "Go to the emergency room." Because the advice is simply a general suggestion to seek medical care, rather than specific medical advice, it is not sufficient to form a doctor-patient relationship.

Although triage creates a doctor-patient relationship, simple screening questions do not. This means that we can ask about patients' insurance coverage, their ability to pay, any other physicians whom they may have seen, or whether they have a history of opioid dependency, without forming a doctor-patient relationship. And, based on the answers, we can decide whether to see the person.

***Screening questions, such as asking about a patient's insurance coverage, do not create a doctor-patient relationship.***

Although the person is being asked for medical information, he is not being offered any advice or treatment. The questions are designed simply to determine whether the physician wishes to see the person. The interaction therefore does not form a doctor-patient relationship.

## Case #5

*Dr. A is a cardiologist. Dr. B sees him in the hallway and asks for a quick opinion on an EKG. Dr. A looks at the tracing and tells Dr. B that it shows atrial fibrillation, and that he should consider using digoxin. Dr. B thanks him, writes that he discussed the case with Dr. A in the patient's chart, and proceeds to give digoxin.*

*Unfortunately, Dr. A's quick read on the EKG was incorrect and the digoxin causes the patient to decompensate. Although Dr. B, as the treating physician, is clearly in a compromised legal position, the question is whether Dr. A is also in jeopardy.*

### Analysis

This person was not Dr. A's patient and Dr. A is not legally responsible for her bad outcome. It is commonly believed that because Dr. A's name is in the chart, he is thereby legally responsible. But, this is irrelevant. All that matters is whether he was in a doctor-patient relationship, whether he had contact with the patient.

***It is impossible to create liability simply by writing a physician's name in the patient's chart.***

Although he discussed the case in a "curbside" consult, he was not formally consulted; he did not see the patient; he did not examine the patient; he did not write a note in the chart; he did not write the order for the digoxin; he

did not have professional contact; and, he was therefore not in a doctor-patient relationship.

The physician must have professional contact with the **patient**, not with another doctor. As such, giving a friendly opinion to another physician who then treats the patient is not sufficient to form a doctor-patient relationship, even if the friendly advice turns out to be wrong. The contact must be more direct.

***A "curbside" consult creates no liability for the consulted physician.***

However, it is important distinguish an informal curbside consult like the one in this example, from situations where a physician is formally involved in EKG interpretation. For example, it is common for hospitals to have a cardiologist interpret every EKG that is done in the facility. And, in a similar way, radiologists read X-rays, and pathologists interpret tissue specimens.

These scenarios are not curbside consults. These persons are formally involved in the care of the patient and other clinicians rely on the accuracy of their opinions. In these situations, the involved individuals are in a doctor-patient relationship, albeit limited, and they are legally responsible for the opinions that they render.

Although one could argue that these physicians had no contact with the patient, they play an integral role in the patient's care and the rule of "contact" must therefore be modified slightly. In its restated form, the "contact" can be with the entire patient, as it usually is. Or, in the case of a pathologist, it can be "contact" with a piece of the patient. For a radiologist, it is "contact" with an image of the patient. And, for a cardiologist, it is "contact" with an electrical tracing of the patient. In all three cases, the persons are formally involved with the patient's care and have an obligation to deliver an acceptable level of performance.

Of course, the mere fact that a cardiologist reads an EKG does not mean that he must then assume all cardiac care of the patient. It simply obligates him to interpret and handle that particular EKG in a clinically competent manner.

## Case #6

*Dr. A is at his brother's wedding reception. A distant relative approaches him, explains her medical problem, and asks for his opinion as to how she should adjust her medication.*

**Analysis**

The setting is irrelevant; the individual is offering herself as a patient. And, if Dr. A chooses to assume the role of physician, the two of them will form a doctor-patient relationship for which Dr. A will then be responsible. Although Dr. A is permitted to do this, it is generally inadvisable because the setting dramatically limits his ability to practice medicine at an acceptable level.

Specifically, he cannot take a very detailed history; he does not have any records; he cannot perform an adequate physical examination; he cannot order any tests; he does not have reliable follow-up; he is not being paid; and, he is fully liable for the advice that he gives. Although permissible, this is not the type of doctor-patient relationship that most of us should be seeking to enter.

***Physicians should avoid the possibility of inadvertently entering into a doctor-patient relationship.***

In order to avoid any potential for confusion or liability, Dr. A should avoid forming a doctor-patient relationship here. He can do so by simply refusing to enter into the role of physician. This does not mean that he must ignore the person or be impolite in any way.

However, he should avoid giving specific medical advice, ordering tests or writing prescriptions. To that end, one of the following phrases will allow him to address the situation politely without incurring any legal worries:

- "It doesn't sound serious to me, but you really need to talk to your doctor;"
- "Without being your doctor, it's really hard for me to tell;" or
- "I think you're on the right track, but please realize that I'm not your doctor and I really wouldn't want you to rely on what I think."

## Case #7

*Dr. A goes away on vacation and Dr. B agrees to cover his practice. The next day, one of Dr. A's patients develops a problem and calls. Her call is forwarded to Dr. B.*

**Analysis**

The person on the phone is Dr. B's patient and he should handle the call accordingly.

The analysis of Dr. B's obligation begins, as always, by determining whether he is in a doctor-patient relationship. And, this hinges on the element of professional

contact. In this example, Dr. B never saw the person, never before talked to her, and never treated her. So, it is tempting to conclude that he is not in a doctor-patient relationship, and therefore has no obligation.

*When you cover for me, you are me with respect to my doctor-patient relationships.*

However, Dr. A did see and treat this person. She is Dr. A's patient. And, when Dr. B agreed to cover for Dr. A, this person became his patient. She is not "kind of" Dr. B's patient or "sort of" Dr. B's patient. She is Dr. B's patient and he must care for her accordingly. Of course, when Dr. A returns, Dr. B's obligation ends.

Physicians commonly make the mistake of thinking that we are not fully responsible for a person like this by virtue of the fact that we are "just covering." There is no legal basis for this position. When we cover for another physician, we are "covering" his legal obligations with respect to all of his patients until he returns.

### Case #8

*Mr. X enrolls with a managed care company and picks Dr. A, a solo practitioner, as his primary care physician. Six months later, Mr. X has not seen or called Dr. A.*

**Analysis**

Mr. X is not Dr. A's patient and Dr. A has no legal duty to him. The critical element of professional contact is missing. Without contact, there can be no relationship. And, without a relationship there is no duty. Dr. A is not required to seek Mr. X or pursue him in any way. If Mr. X needs medical care, he has the responsibility of contacting Dr. A.

### Case #9

*Mr. X sees Dr. A as a new patient. During the course of their visit, Mr. X refuses to provide Dr. A with anything more than a few details about his medical history and will not cooperate with an examination. He states that the only thing he needs is a prescription for Tylox.*

*When Dr. A refuses to write the prescription, Mr. X storms out of the office. The next day, Mr. X calls and wants to be seen again. Dr. A refuses.*

**Analysis**

Mr. X is not Dr. A's patient and Dr. A is not required to accept his call, see him in the office or care for him in any way.

In order to establish a doctor-patient relationship, there must be professional contact between a doctor and a patient. Here, Dr. A saw Mr. X in the office, so there has clearly been some contact. But, the contact must be between two persons, one of whom is playing the role of doctor and the other the role of patient.

*A doctor-patient relationship cannot be formed with someone who is unwilling to act like a patient.*

Here, Dr. A is clearly the "doctor." But, the question is whether Mr. X is actually a "patient." In order for him to be a "patient," he must play the role of a patient. This means that he must genuinely seek the assistance and advice of a physician. In this case, he has not done so. Although a variety of terms might be used to describe Mr. X, the word "patient" is probably not high on the list. Because Mr. X refuses to be a patient, he cannot form a doctor-patient relationship.

## Exception to the Rule

To this point, the entire analysis has been built upon the idea of contact. Contact creates the relationship, and the relationship creates the duty. The rule is a good one, and it works everywhere except the emergency room.

The reason that the rule does not work in the emergency room is a federal law, the Emergency Medical Treatment and Active Labor Act ("EMTALA"). This law is also commonly referred to as "COBRA," which is actually the budget bill which contained EMTALA. EMTALA is therefore the more accurate term, but the two acronyms are often used interchangeably and they refer to the same law.

*EMTALA creates a duty without the existence of a doctor-patient relationship.*

EMTALA is important because it creates a duty without the existence of a doctor-patient relationship. EMTALA states that a facility is obligated to treat any patient who presents to the emergency room with an "emergency medical condition."

This means that a person who presents to the emergency room with a heart attack must be evaluated and treated. The emergency room physician cannot turn him away on the basis that he does not have a preexisting doctor-patient relationship with the individual. A preexisting doctor-patient relationship is irrelevant; EMTALA creates the duty. And, because EMTALA is federal law, it applies everywhere in America.

*When the ER calls, consider yourself to be in a doctor-patient relationship.*

From a practical perspective, the safest way to view EMTALA is that it creates an obligation for the hospital, its emergency room physicians and also its on-call physicians for any patient who presents to the emergency room. The hospital cannot turn the patient away; the emergency room physician cannot refuse to see the patient; and, when contacted, an on-call physician cannot refuse to see the patient. All of these persons are obligated to evaluate and treat the effected individual independently of any preexisting doctor-patient relationship.

## Extent of the Duty

Once in a doctor-patient relationship, the physician owes the patient a duty, an obligation with respect to his healthcare. That duty is the standard of care. The standard of care is the legal duty that every doctor owes to every patient in every situation. There are no exceptions to the standard of care.

Accordingly, the following algorithm can be used as the initial approach to any medical malpractice dilemma:

- If a person is not your patient, you do not owe him anything with respect to his healthcare.
- Once he becomes your patient, you owe him a duty.
- And, that duty is always the standard of care.

## Ending a Doctor-Patient Relationship

At this juncture, we have established that a physician's duty to another person is created with the formation of a doctor-patient relationship. And, in a similar fashion, the duty ends with the dissolution of that relationship.

Although, a doctor-patient relationship is always formed in the same way – when a doctor has professional contact with a patient – the relationship can end in a number of different ways. The first way is as a result of inactivity. A doctor-patient relationship will cease to exist if it is not maintained by regular contact. There is not presently a law which specifies the exact amount of time required, so the situation will be governed by the circumstances and expectations of the involved persons.

In some cases, for a patient with diabetes who should be seen regularly, a physician could probably declare the relationship over if the patient makes no contact for one year. In other cases, where the patient's ongoing needs are less intensive, several years is probably more reasonable. But, again, there is no clear rule.

*A physician has the right to declare a doctor-patient relationship over if he has not had contact with the patient in two years.*

In an effort to balance all of these considerations, it is reasonable to conclude that a physician has the right to declare a doctor-patient relationship over if he has not had contact with a patient in two years. This means that the physician does not have to take a call from the patient, refill a prescription, or see him in the office.

Of course, in most cases, it is easiest to simply resume the relationship and begin seeing the person again. But, the point is that we do not have to do so. Therefore, if an unfamiliar patient calls seeking assistance, and the physician learns that he has not seen the person in more than two years, he is not obligated to assist the person in any way. Again, he is permitted to do so and many times will. But, because there is no longer a doctor-patient relationship, there is no obligation to the individual.

There is sometimes a question as to what measures the physician must take to end a relationship with a patient whom he has not seen in several years. And the answer is that nothing is required. The lack of contact itself ends the relationship. No letter, notification or documentation is necessary.

*If there is doubt about whether a person is actually our patient, we must always err on the safe side, and care for him as if he is.*

However, if there is doubt about when the person was last seen, treated, examined or advised, we should always err on the safe side, assume that he is our patient, and care for him accordingly. This prevents the undesirable situation of not caring for someone who turns out to be our responsibility.

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The second way that a doctor-patient relationship can end is by the choice of the patient. In other words, the patient unilaterally decides to stop seeing or "fire" his doctor. A patient is permitted to fire his doctor at any time for any reason, and without any advance notice.

The patient is not required to do anything formal such as notifying the physician in writing. The patient might tell us in person that they are not coming back, in which case we should document his decision in the record.

The patient might tell us indirectly, such as by replacing us with another physician. If a family doctor learns that his patient is now seeing another family doctor, he has the right to assume that he has been replaced and that the relationship is over. Of course, he may also continue to care for the patient in the event that he periodically returns.

## Case #10

*Mr. X has been seeing Dr. A for many years. Mr. X calls Dr. A and informs him that he will not be returning for care.*

Analysis

Mr. X has terminated his doctor-patient relationship with Dr. A. This ends the ongoing duty of care owed by Dr. A. Other than transferring Mr. X's records upon request and maintaining the confidentiality of his healthcare information, Dr. A owes Mr. X no further duty. Mr. X has been very clear and direct.

## Case #11

*Mr. X had been seeing Dr. A as his primary care physician. Dr. A learns that, for the past three months, Mr. X has been seeing Dr. B, who is also a primary care physician in the same town.*

Analysis

Mr. X has effectively terminated his doctor-patient relationship with Dr. A. By establishing a doctor-patient relationship with another primary care physician, Dr. A's role has been rendered obsolete.

***A physician who has been "replaced" by the patient has the right to consider the relationship to be over.***

Although not as obvious as in the preceding case, Mr. X's behavior sends a message that Dr. A will no longer be serving as his primary care physician. As such, Dr. A is under no further obligation to Mr. X.

## Case #12

*Mr. X has several medical problems and has been seeing Dr. A as his primary care physician. Dr. A learns that, for the past three months, Mr. X has also been seeing Dr. B, who is a cardiologist, and that Dr. B has been managing his hypertension.*

Analysis

Mr. X has not terminated his doctor-patient relationship with Dr. A. Although Dr. A may be offended that Mr. X has sought the opinion of a cardiologist, the behavior has not completely eliminated Dr. A's role. Unlike the preceding case, a cardiologist would generally not be serving all of Mr. X's healthcare needs, and therefore Dr. A's role as his primary care physician has not been rendered obsolete.

Mr. X did not inform Dr. A that he wanted to end their relationship and that conclusion cannot be reasonably inferred from his behavior. Of course, if Dr. A is offended, he has the right unilaterally to terminate the relationship.

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A patient can also end a relationship by misbehaving in a serious way, such as by cursing at the physician or his staff, or by levying threats against them. This type of behavior so irreparably fractures the relationship that it effectively and immediately terminates it.

In such a situation, the patient should be told to leave the office and be informed that he should never return. Then, the exact details of what the patient said and did should be documented, including every profane remark. Any judge, attorney or juror who thereafter reads that entry is highly unlikely to be sympathetic to the patient. It is therefore desirable to include as much detail as is possible in such a situation.

## Case #13

*Mr. X has been seeing Dr. A as his primary care physician. While waiting to be seen, Mr. X becomes frustrated with Dr. A's front desk staff and loudly curses at them. He will not quiet down when requested to do so. When Dr. A appears, Mr. X curses at him and threatens to harm someone physically if his paperwork is not straightened out.*

Analysis

Mr. X has terminated his doctor-patient relationship with Dr. A and should be told to leave the office immediately. Some degree of patient frustration is an unfortunate part of modern day medicine. As a result, simple complaining or expressions of dissatisfaction by a patient cannot be construed as an act of termination.

***Serious misbehavior by the patient immediately ends the doctor-patient relationship.***

On the other hand, this patient has clearly crossed the line. His repeated cursing and threats of physical harm have completely fractured his relationship with Dr. A and immediately ends their doctor-patient relationship. As such, Dr. A is under no further obligation to Mr. X. Of course, Dr. A is also free to forgive Mr. X and continue to see him as a patient, although that approach would be generally inadvisable.

In contrast, less egregious behavior, such as non-compliance with medications, missing appointments or not paying a bill does not terminate a doctor-patient relationship. Although the physician may choose to end these relationships, the mere fact that the patient is uncooperative not mean that he has fired his physician.

***Simple noncompliance by itself does not end a doctor-patient relationship.***

## Case #14

*Mr. X has been seeing Dr. A as his primary care physician. He experiences financial difficulty and does not pay a bill that he received from Dr. A. Several months later, he calls to schedule an appointment with Dr. A.*

### Analysis

Mr. X has not terminated his doctor-patient relationship with Dr. A. Dr. A should see Mr. X and attend to his needs in a proper fashion. The failure to make timely payment does not, in and of itself, terminate a doctor-patient relationship. Of course, the physician always has the right to terminate such a relationship unilaterally.

***A patient's failure to make timely payment does not, in and of itself, terminate a doctor-patient relationship.***

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The final way that a doctor-patient relationship can end is by the unilateral decision of the physician. That is, the physician "fires" the patient. From a medical-legal perspective, this is the most underutilized risk management tool.

Despite the best of intentions, there are some doctor-patient relationships that simply do not work. And, unfortunately, most physicians remain in these dysfunctional relationships long after it was in everyone's best interest that they ended.

***A doctor can unilaterally end his relationship with any patient at any time for almost any reason.***

When the time comes to make such a decision, the rules are very simple: A doctor can unilaterally end his relationship with any patient at any time for almost any reason. This means that a doctor can fire a patient for not paying his bill, for being noncompliant, for dishonesty, for being disruptive or disrespectful, or for altering a prescription. Of course, we are not required to fire these individuals, but we may.

However, a physician cannot fire a person because of a disability, such as being blind, being in a wheelchair, or having AIDS. Those persons are protected under the Americans with Disabilities Act. And, we cannot fire someone because of their race. But, a physician can fire a patient for just about any other reason.

The process for unilaterally ending a doctor-patient relationship is also very simple. The only requirements are to notify the patient, which we generally do in writing, and to provide them with sufficient time to find a new physician.

Although the exact amount of time is not specified by law, no authority currently recommends more than 30 days. In some cases, a physician might be able to reduce the timeframe to 15 or 20 days, especially if there are an abundance of other doctors in the community. But, the physician is always legally safe when he gives the patient 30 days to find a new doctor.

***The cleanest way to end a relationship with a patient is by use of a "form letter."***

In terms of notifying the patient, the best approach is a simple form letter, a copy of which should be kept with the patient's medical record.

October 18, 2007

Dear Mr. Jones:

After consideration, I believe that it is in our mutual best interest to end our doctor-patient relationship.

Effective November 18, 2007, I will no longer be your physician. Please find a new physician who can assume your care. If you need my assistance with your healthcare or in finding a new physician, please contact my office.

Sincerely,

Victor R. Cotton, MD, JD

Some authors recommend that the termination letter include the reasons behind the physician's decision. This is not legally required and is undesirable on several accounts. First, by listing the specifics, the physician takes the risk of mistakenly including something which violates an obscure law or regulation, and the patient could use that against him.

Second, and more concerning is the possibility that that the list of reasons may provoke the patient. If the relationship is not working, the objective is to end it in a non-offensive and civil manner. There is nothing to be gained by telling the patient that he is dishonest, uncooperative and not particularly likeable. All that does is risk inflaming the situation into one of confrontation. As such, it is better simply to tell the patient that the physician has decided to end the relationship.

In the event that the patient asks for the reasons, confrontation can be avoided with a statement like the following: "We have been over this before. I think you know what the reasons are." This keeps the situation as collegial as is possible under the circumstances.

There is sometimes an issue as to the amount of effort that the physician must make in finding the patient a new doctor. The answer is none. Finding a new doctor is the patient's responsibility, and he is given 30 days to accomplish the task.

*Finding a new doctor is the patient's responsibility.*

Although there is no obligation for the physician to help in this search, it is often advantageous to do so. The reason is that it expedites the process. Thus, the sooner that the patient finds another doctor, the sooner the physician's obligation ends. The 30 day period is the maximum extent of the physician's obligation. If the patient finds someone sooner, the physician's obligation ends. So, it thus makes some sense to assist in locating a replacement, even though it is not legally required.

The final issue relates to the preferred method of delivery. Although many authors recommend certified mail with return receipt, the only requirement is that the patient receives the letter. Therefore, it can be delivered by any method that works.

*Any delivery method that works is legally acceptable.*

It can be sent by certified mail, second day mail, regular mail, federal express or it can be handed it to the patient. Because many people will not sign for certified mail, regular mail with a follow up phone call, or personal delivery at the time of an office visit often works best, and is also the least expensive method. But, all that matters is delivery of the notice.

## Termination Dilemmas

There are several dilemmas that complicate the process of terminating a doctor-patient relationship. The first is the extent of the physician's obligation to the patient during the 30 day period. In other words, how much care must the physician provide during this period?

The answer can be derived from the fact that during the 30 days, the person is still the physician's patient. The two are in a doctor-patient relationship. And, as with all doctor-patient relationships, the physician's obligation is the standard of care.

*The doctor-patient relationship is a black-and-white, all-or-nothing phenomenon.*

During the 30 days, the patient should be viewed no differently than any other patient. The doctor-patient relationship is a black-and-white, all-or-nothing phenomenon. Accordingly, it is a mistake to assume that any patient is somehow owed a lesser degree of care.

The second dilemma arises when the patient cannot find a new doctor within the 30 days. From a legal perspective, that is the patient's problem. On the 31st day, the relationship ends. And, with it, so too does end any ongoing obligation on the part of the physician. Whether the patient is able to establish a relationship with a new physician is legally irrelevant.

The third dilemma arises when there are no available physicians within the local area and the patient is forced to drive a great distance to find someone who is willing to see them. That is unfortunate. But, the patient's geographic situation is not the physician's problem.

The only problem with such a situation is that if the patient cannot find a replacement, he may come to the emergency room. At that point, EMTALA applies (assuming he has an "emergency medical condition") and whoever happens to be on call has little choice but to take care of him. This is true even if the on-call physician just fired the patient. However, in such a case, although the physician would be required to treat the acute episode, he would have no obligation to take the individual back as a long-term patient.

The next dilemma arises when the patient is given 30 days notice and then is seen in the office three or four times during the 30 days. Some physicians believe that

the ongoing contact negates the termination; but, that is incorrect. The physician is not required to avoid the patient for 30 days. In fact, the obligation is to provide whatever care is appropriate during the 30 days.

But, regardless of what happens during the 30 days, the relationship will end on the 31st day. Once the physician serves the patient with the 30 day termination notice, nothing can stop the relationship from ending on the 31st day unless the physician decides to forgive the patient and take him back. And, that is something that should generally be avoided.

The next dilemma is whether firing a patient constitutes abandonment. Abandonment is a serious infraction that we certainly want to avoid. It occurs when a physician ceases providing care without adequate notice. The difference between proper termination of a doctor-patient relationship and abandonment of a doctor-patient relationship is the presence of notice. As long as the patient is given sufficient notice of the decision, he cannot be abandoned.

***As long as the patient is given sufficient notice, he cannot be abandoned.***

The last dilemma is whether it is ethical to terminate a doctor-patient relationship. Perhaps a better way of looking at this issue is to ask whether it is ethical to remain in a doctor-patient relationship where there is mistrust, poor communication, dishonesty, manipulation and defensiveness. Because these barriers badly interfere with the ability to practice medicine, there is a good argument that the ethical duty becomes that of termination for some of the more badly compromised relationships.

## Conclusion

A doctor-patient relationship creates the duty upon which the entire medical malpractice system is built. Although the rules defining its creation and termination are important, the most important rule is to remember that if there is ever any doubt about whether we are in a doctor-patient relationship, whether we are responsible, or whether we are covering, we always want to err on the side of assuming that we are responsible and take care of the patient accordingly.



Law & Medicine
P.O. Box 401
Hershey, PA 17033
Phone/Fax: (800) 808-8525
Email: info@lawandmed.com

www.lawandmed.com