Who is Actually Calling the Shots? Watch Out, They May Not Be Liable: Irvin v. Smith

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WHO IS ACTUALLY CALLING THE SHOTS?
WATCH OUT, THEY MAY NOT BE LIABLE: IRVIN v. SMITH

I. INTRODUCTION

The medical field has undergone tremendous changes with the advent of new medical technologies over the years. Today, a doctor can communicate with both patients and colleagues across the country via telephones, e-mail, cellular phones, and fax machines. Rural doctors, who were once limited to their own expert knowledge or reference to medical handbooks, now can quickly consult with specialized doctors who can help in patient evaluations. With these increases in technology, however, traditional physician-patient relationships are no longer easily defined. Since a physician-patient relationship is a prerequisite for professional malpractice claims against doctors, “courts face new challenges in drawing the line between non-liability and a duty of care.”

Some courts are reluctant to find a physician-patient relationship between a patient and a consulting doctor who has been contacted by the treating physician via telephone. In those cases, courts have found the consultation to be merely “informal” because the consultant’s involvement with the patient was only to answer a colleague’s inquiry. Many of these courts reason that finding such a relationship would “stifle communication, education, and professional association, all to the detriment of the patient.” Most courts agree that while a formal consultation is required for a physician-patient relationship, the consultation does not have to include direct patient contact.
Courts have analyzed the consultant’s level of involvement when considering the existence of a formal consultation. Recently, the Kansas Supreme Court, in Irvin v. Smith, refused to extend the physician-patient relationship between a consulting physician and the patient despite the consultant’s high level of involvement in the patient’s case. The Kansas Supreme Court reasoned that a formal consultation requires a personal examination of the patient.


II. FACTS AND HOLDING

Ashley Irvin was born with a condition known as hydrocephalus, which causes a build up of cerebrospinal fluid in the skull. Left untreated, the excess fluid would exert too much pressure on the brain and kill a hydrocephalic. However, the surgical placement of a ventriculoperitoneal or “VP” shunt will drain the excess fluid from the skull into the abdomen where it is reabsorbed into the body.

At age two, Ashley had a “VP” shunt surgically placed by Dr. Edwin MacGee, a neurosurgeon. As long as the “VP” shunt worked properly, Ashley was able to live a normal life. However, twice in her early childhood, Ashley had to undergo surgery to keep the shunt working properly.

On October 15, 1995, twelve-year-old Ashley was taken to Bob Wilson Memorial Hospital in Ulysses, Kansas after experiencing a number of symptoms, including neck and back pain, nausea, and seizures. Three days later, Ashley was then transported by life flight to St. Luke’s Hospital in Kansas City, Missouri for an examination by Dr. MacGee to determine if Ashley’s shunt was working properly. X-rays were taken of Ashley’s chest and abdomen, which were examined by an unidentified radiologist and Dr.
Karen Divelbliss.\textsuperscript{19} The radiologist told Dr. MacGee that two inches of the shunt tubing remained in the abdomen.\textsuperscript{20} Additionally, Dr. Divelbliss’s official reading of the x-ray showed nothing wrong with the shunt.\textsuperscript{21} Therefore, Ashley was sent home on October 21, and Dr. MacGee informed Ashley’s pediatrician, Dr. Michael Shull, in Garden City, Kansas that the shunt appeared to be working properly.\textsuperscript{22}

On November 12, Ashley again began experiencing neck and back pain, nausea, and seizures.\textsuperscript{23} She was admitted to St. Catherine’s Hospital in Garden City, Kansas.\textsuperscript{24} Dr. Shull examined Ashley and ordered x-rays to be taken of Ashley’s chest and abdomen to again rule out a shunt malfunction.\textsuperscript{25} The radiologist at St. Catherine’s examined the x-rays and reported that there was no malfunction.\textsuperscript{26} Although the radiologist reported that no abnormalities were present in the x-rays, Dr. Shull was still worried about a possible shunt malfunction.\textsuperscript{27} Therefore, Dr. Shull ordered an MRI of Ashley’s brain to check for increased intracranial pressure.\textsuperscript{28} The MRI, however, was negative.\textsuperscript{29}

On November 13, Dr. Shull consulted Dr. MacGee regarding Ashley’s symptoms.\textsuperscript{30} Dr. MacGee expressed his opinion that the shunt was working properly and instructed Dr. Shull to prescribe hydration and seizure control medication to help alleviate her symptoms.\textsuperscript{31} Yet, Ashley continued to experience the symptoms despite the medication.\textsuperscript{32} Dr. Shull contacted Dr. Smith, a pediatric intensivist at Wesley Medical Center in Witchita, Kansas.\textsuperscript{33} Dr. Shull informed Dr. Smith of Ashley’s condition, her present symptoms, and the possibility of a shunt malfunction.\textsuperscript{34} On November 14, with Dr. Smith’s approval, Dr. Shull ordered Ashley’s transfer from St. Catherine’s
Hospital to Wesley Medical Center in Wichita, Kansas and ordered additional x-rays to be sent with Ashley to Wesley Medical Center.\footnote{35}

Dr. Smith admitted Ashley at Wesley Medical Center with the x-rays, but at trial, he testified that he could not recall whether he looked at the x-rays or not.\footnote{36} The x-rays showed Ashley’s shunt required repair because the “tip” of the shunt was embedded in her abdomen wall.\footnote{37} Dr. Smith did admit at trial that he would have known the shunt required repair had he looked at the x-rays, but was under the belief that a radiologist at Garden City had already examined the x-rays and found no repair necessary.\footnote{38} However, no radiologist at Garden City had read the additional x-rays that were sent with Ashley.\footnote{39}

On November 14, Dr. Smith called Dr. Gilmartin on the telephone to obtain a “neurological consult.”\footnote{40} Dr. Smith believed Dr. Gilmartin, a child neurologist, would be “the best consultant to use to help evaluate Ashley.”\footnote{41} Dr. Smith discussed Ashley’s condition and symptoms with Dr. Gilmartin, and both agreed a shuntogram, a procedure that “involves the injection of a radioactive isotope into the shunt to check for shunt blockage”, and an EEG should be ordered.\footnote{42} Dr. Smith and Dr. Gilmartin both agreed that Ashley’s symptoms did not require an immediate shuntogram because Ashley appeared stable, alert and conscious between seizures.\footnote{43} Therefore, Dr. Smith and Dr. Gilmartin planned to do the shuntogram the following morning, November 15.\footnote{44}

On the morning of November 15, Ashley’s condition was stable; she was alert, awake, and verbal.\footnote{45} However at 8:45 a.m., before the shuntogram or EEG were performed, Ashley’s condition deteriorated requiring resuscitation and intubation.\footnote{46} Then, over two hours later, at 11:30 a.m., Ashley’s pupils became dilated and unresponsive to light.\footnote{47} Finally, the shuntogram was performed revealing the tip of the shunt was embedded in the abdomen wall.\footnote{48} Surgery was then performed to correct the shunt malfunction.\footnote{49} However, it
was too late for Ashley. Ashley had already suffered an ischemic brain injury due to the lack of oxygen to her brain before the shuntogram procedure was performed. Ashley’s permanent and severe brain damage keeps her from walking, speaking, or carrying out any daily functions. She has to be fed through a tube and requires full-time care.

Ashley and her parents (together “Irvin”) filed an action in Sedgwick County District Court against Dr. MacGee, Neurology/Neurosurgery P.C., Dr. Smith, Dr. Gilmartin, and Wesley Medical Center. Irvin later added St. Luke’s Radiological Group, Dr. Divelbliss, and Columbia/HCA Healthcare Corporation. Dr. Divelbliss was granted a motion to dismiss for lack of personal jurisdiction, and Irvin voluntarily dismissed her claim against Dr. Divelbliss’s employer, St. Luke’s Radiological Group. The district court accepted Dr. Gilmartin’s argument that he owed no duty to Ashley since a physician-patient relationship was not established, and therefore, the court granted his motion for summary judgment.

In March 1999, Irvin’s first case was tried before a jury in Sedgwick County against Columbia/HCA Healthcare Corporation, Dr. Smith, and Wesley Medical Center. The trial resulted in a directed verdict in favor of Columbia/HCA Healthcare Corporation and a hung jury for Dr. Smith and Wesley Medical Center. After the trial, Irvin settled her claims against Wesley Medical Center.

In November 1999, Irvin’s second jury trial against St. Luke’s and Dr. Divelbliss resulted in a verdict of $1,770,391.08. However, Irvin sought the same damages as those claimed in the Sedgwick County action and therefore, filed a motion for additur or in the alternative a motion for a new trial. The district court granted the motion for the new trial and vacated the verdict.

50. Id.
51. Id.
52. Id.
53. Id.
54. Id.
55. Id.
56. Id.
57. Id.
58. Id.
59. Id.
60. Id.
61. Id.
62. Id.
63. Id.
Irvin subsequently settled with St. Luke’s and Dr. Divelbliss for the full amount of the verdict.64

In January 2000, Irvin’s third jury trial against Dr. Smith in Sedgwick County resulted in a verdict of no fault on the part of Dr. Smith.65 Irvin’s motion for a new trial was denied.66 Irvin then appealed this verdict and the dismissal of Dr. Gilmartin.67 Dr. Smith also filed a cross-appeal.68 The Kansas Supreme Court found the district court did not err in refusing to grant Irvin’s motion for a new trial.69 Further, while affirming the district court’s decisions, the Kansas Supreme Court noted Smith’s cross-appeals were moot.70

The Kansas Supreme Court also rejected Irvin’s argument that the district court erred in granting summary judgment in favor of Dr. Gilmartin.71 The Kansas Supreme Court agreed with the district court’s finding that no physician-patient relationship existed between Gilmartin and Irvin.72 Without a physician-patient relationship, Dr. Gilmartin owed no duty to Irvin, one of the basic elements of a medical malpractice case.73 The Kansas Supreme Court noted that finding a physician-patient relationship between Dr. Gilmartin and Irvin would discourage telephone consultations, which is against the public’s interest since these calls are used on a frequent basis in the medical field.74

III. LEGAL BACKGROUND

Nearly a century and a half ago, courts recognized negligence in the medical field as a separate tort.75 Prior to this recognition, medical malpractice was solely a contract action.76 Today medical malpractice is a “civil action for damages resulting from the negligence of a physician in treating a patient.”77

64. Id.
65. Id.
66. Id.
67. Id. at 940.
68. Id.
69. Id. at 947.
70. Id.
71. Id. at 942-43.
72. Id. at 940, 943.
73. Id. at 940.
74. Id. at 943.
77. Id.
The elements of a medical malpractice claim are: 1) a duty, 2) a breach of the duty, 3) causation, and 4) damages. In order to establish the element of duty, one must prove the existence of a physician-patient relationship. Absent such a relationship, a physician cannot be held liable for medical malpractice. The existence of a physician-patient relationship requires mutual knowledge and consent. In *St. John v. Pope*, the Texas Supreme Court provided a good description of the circumstances under which a duty arises in medical malpractice. The court distinguished the duty under ordinary negligence from the duty required for a claim in medical malpractice. Under a general negligence theory, people have a duty to refrain from negligently injuring others even though no prior relationship exists. However, physicians do not owe a duty to “exercise their particular talents, knowledge, and skill on behalf of every person they encounter in the course of the day.” Additionally, the court noted that physicians are not even required to render their services to everyone who asks for care. Furthermore, the duty only exists when a physician consents to a physician-patient relationship, though this consent may be express or implied. Since consent may be implied, a physician does not need to directly deal with a patient for a duty to exist. Additionally, the “physician-patient relationship does not require the formalities of a contract.”

An increasing number of courts have found physician-patient relationships even when the physician has had no personal contact with the patient. These courts have noted that indirect contact with a patient will not preclude a physician-patient relationship. Therefore, some courts are now willing to impose liability on consulting doctors. However, the consulting doctor’s

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78. Id.
79. Id. at 752-53.
80. Id. at 753.
81. *St. John*, 901 S.W.2d at 423; *Adams*, 270 Kan. at 835; *Reynolds*, 277 Ill.App.3d at 85; *Lopez*, 852 S.W.2d at 306.
82. *St. John*, 901 S.W.2d at 420.
83. Id. at 423.
84. Id.
85. Id.
86. Id.
87. Id.
88. Id. at 424.
89. Id.
91. *Adams*, 270 Kan. At 835; *Lecion*, 65 S.W.3d at 704; *St. John*, 901 W.E.2d at 424; *Lopez*, 852 S.W.2d at 305; *Dougherty*, 826 S.W.2d at 674-75; *Cogswell*, 249 A.D.2d at 866-67.
92. *Adams*, 270 Kan. At 837; *Lecion*, 65 S.W.3d at 715; *Dougherty*, 826 S.W.2d at 672, 674.
level of involvement in the patient’s case often determines whether a duty is created. 93

In Oliver v. Brock, the consultant’s level of involvement was not enough for a physician-patient relationship to be created. 94 The Alabama Supreme Court found the consulting physician did not take any part in the treatment of the patient. 95 The physician had never seen the patient and never requested to serve as a consultant in the patient’s treatment. 96 The attending physician had generally described Oliver’s injuries and treatment during a telephone conversation which was originated to discuss another patient’s treatment. 97 The consulting doctor did not offer any treatment advice, but merely agreed with the treating doctor’s opinion. 98 The court found the conversation to be merely gratuitous and affirmed summary judgment in the physician’s favor. 99

However, almost twenty-five years after the Oliver decision, the Arizona Court of Appeals, in Diggs v. Arizona Cardiologists, Ltd., held that a cardiologist had a duty of care to the patient when the cardiologist offered an “informal consult.” 100 In Diggs, the cardiologist consulted with an emergency room physician regarding a patient with severe chest pains. 101 After the consultation, the emergency room physician released the patient, who then died of a heart attack three hours later. 102 The court noted that generally a physician who provides an informal consult does not have a duty of care to the patient. 103 However, in this case, the court found the cardiologist voluntarily undertook a duty of care to the patient because the cardiologist’s opinion, his interpretation of the electrocardiogram (EKG), was the primary factor that led the ER doctor to rule out a myocardial infarction. 104 Further, the court relied on the Restatement (Second) of Torts section 324A and found that the consulting doctor undertook to give treatment advice to the attending doctor knowing that he would rely on this advice. 105 Therefore, the court found that,

95. Id. at 5.
96. Id. at 4.
97. Id.
98. Id.
99. Id. at 4-5.
100. Diggs, 198 Ariz. at 198.
101. Id. at 200.
102. Id.
103. Id. at 203.
104. Id. at 202.
105. Id.
even though no contractual patient-physician relationship existed between the cardiologist and the patient, the cardiologist owed a duty of reasonable care.106

Typically, as the Diggs court noted, no physician-patient relationship exists between the patient and the consultant if the consultant informally offers his or her opinion to another physician.107 In Hill v. Kokosky, the Michigan Court of Appeals held that a physician-patient relationship did not exist between the patient and the consulting physician.108 In Hill, the treating physician discussed the patient’s pregnancy difficulties in numerous telephone conversations with a consulting physician.109 The consulting doctor gave his opinion based on the patient’s case history as related to him by the treating physician.110 However, the consulting physician did not see the patient, examine her, or view her chart.111 The court stated that the physician’s opinions were “not in the nature of prescribed course of treatment” but were “recommendations to be accepted or rejected” by the treating physician.112 The court compared the medical advice offered by the consultant to information one might find in a medical treatise or article.113 Therefore, the court found no physician-patient relationship existed because the consulting doctor had such a limited and remote connection with the patient’s case.114

In NBD Bank v. Barry, the Michigan Court of Appeals held that no evidence supported a physician-patient relationship between the patient and consulting physician.115 In NBD Bank, the treating physician contacted the consulting doctor on multiple occasions to seek his opinion regarding treatment alternatives for the patient.116 However, the consulting doctor did not agree to treat the patient or to be a consultant on the case.117 Further, the court found the treating doctor was free to accept or reject the consulting doctor’s recommendations, and therefore, the consulting physician owed no duty of care to the patient.118

In Reynolds v. Decatur Memorial Hosp., the Illinois Appellate Court held no physician-patient relationship existed between the patient and a doctor who

106. Id. at 203.
107. Id.
109. Id. at 302.
110. Id.
111. Id.
112. Id. at 304.
113. Id. at 305.
114. Id. at 305-306.
116. Id. at 370.
117. Id. at 373
118. Id.
gave an informal opinion over the telephone.\textsuperscript{119} The court noted the doctor merely answered an inquiry from a colleague, was not contacted again, and charged no fee.\textsuperscript{120} The court stated the consultant was not asked to provide a service for the patient, conduct lab tests, review test results, or commit himself to further involvement with the patient.\textsuperscript{121} Therefore, the Illinois Appellate Court reasoned that finding a physician-patient relationship under the circumstances in the case would have “a chilling effect upon the practice of medicine. It would stifle communication, education and professional association, all to the detriment of the patient.”\textsuperscript{122}

Similarly in \textit{Corbet v. McKinney}, the physician’s consultation with the patient’s treating doctor was insufficient to establish the requisite relationship and duty of care.\textsuperscript{123} The Missouri Court of Appeals noted that the consulting physician merely offered a recommendation for treatment.\textsuperscript{124} The court stated that merely undertaking to advise the patient’s treating doctor as to general patient care is not enough for a physician-patient relationship.\textsuperscript{125} Instead, the court noted that undertaking to examine, diagnose, or treat the patient will give rise to a relationship.\textsuperscript{126} However, the court found no evidence that the physician contracted to provide medical services, examined the patient, or diagnosed the patient.\textsuperscript{127}

In \textit{Ingber v. Kandler}, the New York Appellate Court, held that the consulting physician gave an informal opinion to a fellow physician, and therefore no physician-patient relationship existed.\textsuperscript{128} The court noted that the consulting physician did not have any contact with the patient, never saw any records relating the case, and did not even know the patient’s name.\textsuperscript{129}

The Texas Court of Appeals, in \textit{Lopez v. Aziz}, also found no physician-patient relationship to exist between the patient and an OB-GYN specialist consulted by phone by the patient’s treating physician.\textsuperscript{130} The consultant did not bill the patient or treating physician, did not prepare any reports or conduct any lab tests, did not accept any work relating to the patient’s case, and never contacted or examined the patient.\textsuperscript{131} The treating doctor acknowledged that

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  \item \textsuperscript{119} Reynolds, 277 Ill.App.3d at 80.
  \item \textsuperscript{120} \textit{Id.} at 85.
  \item \textsuperscript{121} \textit{Id.}
  \item \textsuperscript{122} \textit{Id.} at 86.
  \item \textsuperscript{123} \textit{Corbet v. McKinney}, 980 S.W.2d 166, 168-69 (Mo. Ct. App. 1998).
  \item \textsuperscript{124} \textit{Id.} at 171.
  \item \textsuperscript{125} \textit{Id.} at 169-70.
  \item \textsuperscript{126} \textit{Id.} at 169.
  \item \textsuperscript{127} \textit{Id.} at 171.
  \item \textsuperscript{128} \textit{Ingber v. Kandler}, 128 A.D.2d 591, 591-92 (N.Y. 1987).
  \item \textsuperscript{129} \textit{Id.} at 592.
  \item \textsuperscript{130} \textit{Lopez}, 852 S.W.2d at 304.
  \item \textsuperscript{131} \textit{Id.} at 306.
\end{itemize}
he was ultimately responsible for the patient’s treatment and was free to accept
or reject the consultant’s opinion. 132 Further, the court noted the consultant’s
comments were not binding, and he had no authority or control of the course of
the patient’s treatment. 133 The court found the consulting physician merely
answered a professional inquiry of a colleague. 134

Although most courts have found that an informal consultation does not
give rise to a physician-patient relationship, courts have struggled with the
complex question of when a consultant’s opinion becomes formal. Many
courts find informal consults when the physician has not committed to further
involvement with patient, charged the patient or the treating doctor, or retained
control of the patient’s treatment. 135 Often formal consults involve a physician
attempting to evaluate, diagnose, or treat a patient. 136

In Cogswell v. Chapman, the New York Supreme Court, Appellate
Division, found that genuine issues of material fact existed as to whether the
ophthalmologist, who served as a courtesy/consulting physician at a hospital,
entered into a physician-patient relationship with the infant patient. 137 In
Cogswell, a physician’s assistant called the consulting ophthalmologist on the
telephone for advice regarding the infant patient. 138 After asking the
physician’s assistant a series of questions, the ophthalmologist advised him of
treatment management, including rest, Tylenol, and the possible need of
follow-up visits. 139 The physician assistant relayed this information to the ER
doctor who followed the ophthalmologist’s advice. 140

The court held that the ophthalmologist had more than an informal interest
in the patient’s condition, and an issue of fact existed as to the level of
involvement the ophthalmologist had in the patient’s treatment. 141 The court
noted that physical contact with the patient is not a requirement for a
physician-patient relationship. 142 The court also stated that if a physician
advises a patient over the telephone, and it is foreseeable that the patient would

132. Id. at 307.
133. Id. at 307
134. Id.
John, 901 S.W.2d at 424; Lopez, 852 S.W.2d at 306-307; Cogswell, 249 A.D. at 866-67; Bovara
136. Lection, 65 S.W.3d at 715.
137. Cogswell, 249 A.D.2d at 865-66.
138. Id. at 865.
139. Id. at 865-66.
140. Id. at 865.
141. Id. at 867.
142. Id. at 866.
rely on that advice, an implied physician-patient relationship can exist.\textsuperscript{143} Here, the ophthalmologist may have offered advice that would likely be followed since he had particular expertise in the field, and the ER doctor did not.\textsuperscript{144}

In \textit{Wheeler v. Yettie Kersting Memorial Hospital}, the court found that a physician-patient relationship was created when an on-call physician received information through a nurse’s phone call from the hospital regarding the status of a woman in labor.\textsuperscript{145} The on-call physician used this relayed information to conclude that the patient should be transferred to a hospital over ninety miles away.\textsuperscript{146} The patient began delivering the baby in breech before reaching the hospital and died due to suffocation.\textsuperscript{147} According to the court, the on-call physician established a physician-patient relationship with the patient because he evaluated the status of the patient’s labor and gave the approval for the patient’s transfer.\textsuperscript{148} Even though the doctor had no contact or connection with the patient other than one phone call from the nurse, the court relied on the fact that the doctor rendered his services to the patient and concluded he had a duty of care.\textsuperscript{149}

In \textit{Lection v. Dyll}, the Texas Court of Appeals held the trial court erred in granting summary judgment in favor of the physician.\textsuperscript{150} The court found genuine issues of fact existed as to whether a physician-patient relationship existed.\textsuperscript{151} In \textit{Lection}, the on-call neurologist spoke with the hospital emergency room physician over the telephone.\textsuperscript{152} The consulting neurologist diagnosed the emergency room patient’s condition over the phone and told the ER doctor that no other treatment was necessary and the patient could leave the hospital.\textsuperscript{153} The court found that the consulting doctor stated his medical opinion as to the treatment of the patient and the ER doctor relied on the consultant’s expertise and advice.\textsuperscript{154} Therefore, summary judgment was precluded.\textsuperscript{155}

In \textit{Adams v. Via Christi Reg’l Med. Ctr.}, the Kansas Supreme Court found a physician-patient relationship existed between the physician and patient.

\textsuperscript{143} Id.
\textsuperscript{144} Id. at 867.
\textsuperscript{146} Id. at 35.
\textsuperscript{147} Id. at 36.
\textsuperscript{148} Id. at 40.
\textsuperscript{149} Id. at 39-40.
\textsuperscript{150} Lection, 65 S.W.3d at 696.
\textsuperscript{151} Id. at 707.
\textsuperscript{152} Id. at 705.
\textsuperscript{153} Id. at 705-706.
\textsuperscript{154} Id. at 715.
\textsuperscript{155} Id.
although the physician did not speak directly with the patient, had not seen, talked to, or treated the patient in four years. In *Adams*, the patient’s mother contacted the family physician to seek advice about her pregnant daughter’s abdominal pain. The physician advised the mother to take her daughter to the emergency room if the pain worsened, and to see a doctor the next day. The court found that the doctor’s “undertaking to render medical advice as to the patient’s condition gave rise to a physician-patient relationship.” The court reasoned that it was immaterial that the physician had not seen the patient for several years, did not speak directly with the patient, or that he no longer provided obstetrical care. The fact that the physician gave the mother his medical opinion over the phone gave rise to a physician-patient relationship. The court further noted that even if the prior relationship between the daughter and physician had extinguished since the physician had not seen her for four years, the medical advice given to her mother had renewed a relationship. The court distinguished this case from others because the doctor took some action to give medical assistance.

In *Bovara v. St. Francis Hosp.*., the Illinois Appellate Court held that genuine issues of fact existed as to whether a physician-patient relationship existed. In *Bovara*, the court noted that a physician who provides a service for a patient may have a duty to the patient. In *Bovara*, the consulting physicians reviewed angiogram film and communicated to the cardiologist that the recipient was a candidate for coronary angioplasty. The patient died during the procedure. The court held the consulting physicians may have established a physician-patient relationship with the patient since they provided a service for the patient and should have known their medical opinion would be passed on to the patient.

Other courts have adopted clear-cut tests to determine when a consulting doctor may have a duty to the patient. These cases often involve on-call doctors who have not physically examined a patient. In *Millard v. Corrado*,

157. *Id.* at 826.
158. *Id.*
159. *Id.* at 837.
160. *Id.* at 836.
161. *Id.* at 837.
162. *Id.*
163. The doctor told her the daughter was experiencing nothing unusual and dissuaded the mother from promptly seeking medical attention. *Id.*
165. *Id.* at 147.
166. *Id.* at 145.
167. *Id.* at 146.
168. *Id.* at 147-48.
the Missouri Appellate Court held a physician-patient relationship can arise if
the physician is contractually obligated to provide assistance in the patient’s
diagnosis and treatment and does so.\footnote{169} In an Ohio Appellate Court case,
\textit{McKinney v. Schlatter}, the court held “that a physician-patient relationship can
exist by implication between an emergency room patient and an on call
physician who is consulted by the patient’s physician but who has never met,
spoken with, or consulted the patient when the on call physician (1)
participates in the diagnosis of the patient’s condition, (2) participates in or
prescribes a course of treatment for the patient, and (3) owes a duty to the
hospital, staff or patient for whose benefit he is on call.”\footnote{170} The Michigan
Appellate Court recently adopted the \textit{McKinney} test in \textit{Oja v. Kin}.\footnote{171}

Although the \textit{Millard} and \textit{McKinney} courts provided well-defined tests to
determine when a physician-patient relationship exists, these tests apply only
to physicians with contractual obligations. Numerous state courts have begun
to set forth criteria to enable one to distinguish between informal and formal
consults, but a fuzzy line still exists between non-liability and a duty of care in
many states. In \textit{Irvin v. Smith} the Kansas Supreme Court drew a solid line
between non-liability and a duty of care, but in doing so nearly erased the
consulting doctor’s duty of care.

\section*{IV. INSTANT DECISION}

\subsection*{A. Majority Opinion}

In \textit{Irvin v. Smith}, the Kansas Supreme Court asserted that one element of a
medical malpractice claim is a duty of care, which exists only if a physician-
patient relationship is found.\footnote{172} The court noted that the existence of a
physician-patient relationship is a question often left to a jury.\footnote{173} However, the
court added that summary judgment may be proper if a jury could draw only
one conclusion from the undisputed facts that no physician-patient relationship
exists.\footnote{174}

Once the court established that summary judgment could be proper, the
court discussed the circumstances in which it and other courts have found such
relationships to exist.\footnote{175} First, the court cited the Missouri Court of Appeals by
stating the relationship is generally created only where the physician

\begin{itemize}
  \item \footnote{169} Millard v. Corrado, 14 S.W.3d 42, 50-51 (Mo. Ct. App. 2000).
  \item \footnote{170} McKinney v. Schlatter, 118 Ohio App.3d 328, 336 (1997).
  \item \footnote{172} \textit{Irvin}, 31 P.3d at 940.
  \item \footnote{173} \textit{id.} at 940-41.
  \item \footnote{174} \textit{id.} at 940-41.
  \item \footnote{175} \textit{id.}.
\end{itemize}
personally examines the patient. 176 However, the court cited a number of cases, including one of its previous decisions, in which courts have found a physician-patient relationship even though the physician did not examine the patient but instead had merely indirect contact with the patient. 177 Yet, the court noted that a physician-patient relationship is not created when a physician gives merely an “informal opinion” to the treating physician. 178

The court cited its 2001 decision in Adams v. Via Christi Reg’l Med. Ctr. regarding the “foundational requirements for the existence of a physician-patient relationship.” 179 The court stated:

A physician-patient relationship is consensual. Thus, where there is no ongoing physician-patient relationship, the physician’s express or implied consent to advise or treat the patient is required for the relationship to come into being. Stated otherwise, the doctor must take some affirmative action with regard to treatment of a patient in order for the relationship to be established. 180

After examining case history, the court analyzed Irvin’s argument. 181 Irvin argued the facts show that Dr. Smith and Dr. Gilmartin engaged in a lengthy, detailed conversation about the condition, care, and treatment of Irvin. 182 This conversation provided Dr. Gilmartin with a “complete picture of Ashley Irvin’s presentation,” and Dr. Gilmartin testified that he believed Irvin’s condition was stable. 183 Dr. Gilmartin further testified that he “jointly developed a plan for the evaluation of Ashley Irvin” and assumed primary responsibility for performing the shuntogram on November 15, 1995. 184 The Kansas Court noted certain facts it deemed important including: 1) Dr. Gilmartin was not an employee of the hospital; 2) Dr. Gilmartin was not on call the night he received a phone call from Dr. Smith; 3) Dr. Gilmartin never had involvement or contact with Ashley Irvin or her family prior to the November 14th call from Dr. Smith; and 4) Dr. Gilmartin had no contractual obligation to attend any patients at Wesley. 185

The court decided that Dr. Gilmartin had merely been asked to carry out a consultation on November 15, 1995. 186 Further, the court stated that this

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176. Id. (citing Millard v. Corrado, 14 S.W.3d 42 (Mo. Ct. App. 2000)).
177. Id.
178. Id.
179. Id.
180. Id.
181. Id. at 942.
182. Id.
183. Id.
184. Id.
185. Id.
186. Id.
consultation on the 15th would be a “formal consultation” because it included a full bedside review and physical examination of the patient. The court stated that Dr. Gilmartin had not spoken with Irvin or her parents, reviewed her hospital chart, nor examined Irvin on the 14th. The court additionally placed great emphasis on the facts that Dr. Gilmartin was informed of Irvin’s condition only by his conversation with Dr. Smith, that Dr. Gilmartin did not enter any orders in Irvin’s case, and that he took no other action than discussing the case with Dr. Smith in general terms. Finally the court reasoned that telephone conversations like that between Smith and Gilmartin take place frequently in the medical field. Therefore, discouraging such conversations, by creating a relationship between the physician and the patient, would be adverse to the both the patients’ and public’s interests.

The court additionally cited numerous cases which have rejected the extension of a duty to physicians who provide informal consultations. The court cited the Illinois Appellate court which stated that finding a physician-patient relationship in every conversation would “have a chilling effect upon the practice of medicine. It would stifle communication, education and professional association, all to the detriment of the patient.”

The Kansas Supreme Court analyzed a Michigan Appellate Court case, NBD Bank v. Barry, in which the court held a physician-patient relationship did not exist because the physician did not formally consult on the case. The court stated that the physician offered merely informal recommendations which the treating physician “was free to accept or reject.” In NBD, the consultant did not contact or examine the patient and reviewed the patient’s chart only once.

The Kansas Supreme Court noted that an Illinois Appellate Court case, Reynolds v. Decatur Memorial Hosp., was similar to Irvin’s case and yet, the appellate court held there was no physician-patient relationship. In Reynolds, a pediatrician, Dr. Bonds, called Dr. Fulbright regarding a child patient with a high fever. Dr. Fulbright inquired whether the child had a stiff neck, and after Dr. Bonds reporting that the child did, Dr. Fulbright

187. Id.
188. Id. at 943.
189. Id.
190. Id.
191. Id.
192. Id.
193. Id.
194. Id.
195. Id.
196. Id.
197. Id. at 943-44.
recommended a spinal tap be performed. From the procedure the patient had incurred a spinal cord injury, which left him permanently quadriplegic. The appellate court decided Dr. Fulbright’s consultation was informal, and therefore no physician-patient relationship was created.

Therefore, the Kansas Supreme Court concluded that Dr. Gilmartin did not have a physician-patient relationship with Irvin and that summary judgment was correctly granted in Gilmartin’s favor.

B. Dissenting Opinion

Judge Lockett dissented from the majority’s opinion, contending the majority did not distinguish between the various types of physician consultants and instead excluded them all for public policy reasons. Judge Lockett disagreed with the majority’s statement that a formal consultation requires (1) a full bedside review of the case and (2) a physical examination of the patient. Lockett noted that the majority cited Millard v. Corrado for the proposition that “generally a physician-patient relationship requires a physician personally examining a patient,” but then acknowledged a contrary statement in Adams, a 2001 Kansas Supreme Court case, to the effect that indirect contract doesn’t preclude a physician-patient relationship. Lockett criticized the majority for ignoring this prior Kansas case law and basing its decision on public policy.

Lockett argued that the majority failed to note the difference between an informal opinion and a formal opinion. Lockett asserted that a distinction should be made between consulting doctors who merely offer suggestions to a treating physician and those who aid the treating physician in formulating a treatment plan for the patient. Lockett found Irvin’s argument convincing. Irvin asserted that Dr. Gilmartin developed a plan for the evaluation of Irvin jointly with the treating physician, Dr. Smith, and Dr. Gilmartin agreed to assume primary responsibility for performing the shuntogram. Further, Irvin argued that Dr. Gilmartin engaged in a very

198. Id. at 943.
199. Id.
200. Id. at 944.
201. Id.
202. Id. at 947.
203. Id. at 948-49.
204. Id. at 948.
205. Id.
206. Id. at 949.
207. Id.
208. Id.
209. Id.
detailed conversation regarding the condition, care, and treatment of Irvin which gave Dr. Gilmartin a complete picture of Irvin’s presentation.\footnote{210} Therefore, Irvin argued this was not an informal consultation, but rather, a formal consultation which gave rise to a physician-patient relationship between Irvin and Dr. Gilmartin.\footnote{211}

Lockett next examined the case law which the majority relied on in its opinion. Lockett disagreed with the majority’s analysis of \textit{Reynolds}.\footnote{212} In \textit{Reynolds}, the examining physician telephoned a second physician at home to seek advice in diagnosing a child.\footnote{213} The only participation by the second physician in the treatment of the child was his suggestion that a particular test be conducted to rule out the child’s illness.\footnote{214} The Illinois court held that this was merely an “informal opinion” and the second physician was just answering an inquiry from a colleague.\footnote{215} Therefore, no physician-patient relationship existed.\footnote{216}

Lockett did not agree that these facts were “strikingly similar” to Irvin’s case like the majority found.\footnote{217} Instead, Lockett noted that the facts in \textit{Bovara v. St. Francis Hosp.} were similar to Irvin’s case.\footnote{218} In \textit{Bovara}, the two consulting doctors reviewed an angiogram film and communicated to the cardiologist that the patient was a candidate for a coronary angioplasty.\footnote{219} In \textit{Bovara} the Illinois court limited its prior holding in \textit{Reynolds} by stating that a physician-patient relationship may exist if the physician performs a service for the care and treatment of a patient.\footnote{220} Further, the court decided a trier of fact may find that the doctors knew or should have known their medical opinion would be passed on to the patient and would be crucial to whether or not the angioplasty was performed.\footnote{221}

The majority also relied on \textit{NBD Bank v. Barry} in which the Michigan court found no physician-patient relationship because the consultations were merely informal.\footnote{222} However, Lockett noted that the consulting physician in \textit{NBD Bank} did not agree to treat the patient or to be a consultant on the case.\footnote{223}
Additionally, the attending physician was free to accept or reject the consulting doctors advice.\textsuperscript{224} Lockett distinguished \textit{NBD} from \textit{Irvin} because Dr. Gilmartin knew his advice would directly affect Dr. Smith’s course of treatment of Irvin.\textsuperscript{225} Additionally, Lockett noted that Dr. Gilmartin agreed to personally perform the shutogram.\textsuperscript{226} Further, Dr. Gilmartin performed the shutogram the following day which had a significant impact on Irvin’s injury.\textsuperscript{227} 

Lockett found \textit{Diggs v. Arizona Cardiologists, Ltd.}, to be more persuasive.\textsuperscript{228} In \textit{Diggs}, the emergency room physician consulted the cardiologist regarding a patient with severe chest pain.\textsuperscript{229} The patient was then released and died of a heart attack three hours later.\textsuperscript{230} The Arizona court found that the cardiologist was in the best position to rule out a myocardial infarction based on the echocardiogram because of his knowledge and expertise, and therefore owed a duty of care to the patient.\textsuperscript{231} 

Lockett further noted that the Arizona court relied on the Restatement (Second) of Torts section 324A, which states: “One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of a third person or his things, is subject to liability to the third person for physical harm resulting form his failure to exercise reasonable care to protect his undertaking if (a) his failure to exercise reasonable care increases the risk of such harm, or . . . (c) the harm is suffered because of reliance of the other or third person upon the undertaking.”\textsuperscript{232} 

The Arizona court found that the consulting doctor undertook to provide his expertise to the treating physician, knowing that it was necessary for the protection of the patient and that the treating physician would rely on it.\textsuperscript{233} The treating physician did not exercise an independent judgment to the patient’s diagnosis because he subordinated his professional judgment to that of the specialist.\textsuperscript{234} Therefore, the court held the consultant became the provider of medical treatment which gave rise to a duty of reasonable care.\textsuperscript{235} 

\begin{footnotes}
\textsuperscript{224} Id.
\textsuperscript{225} Id.
\textsuperscript{226} Id.
\textsuperscript{227} Id. at 950-51.
\textsuperscript{228} Id. at 951.
\textsuperscript{229} Id.
\textsuperscript{230} Id.
\textsuperscript{231} Id.
\textsuperscript{232} Id.
\textsuperscript{233} Id.
\textsuperscript{234} Id.
\textsuperscript{235} Id.
\end{footnotes}
Finally, Lockett argued that the majority should not have characterized Dr. Gilmartin’s involvement as an informal consultation. Dr. Gilmartin and Dr. Smith both decided to perform the shuntogram the following day, which caused Irvin’s injuries. Further, Lockett stated that Dr. Gilmartin’s experience and expertise factored into the decision to delay the treatment. Therefore, Lockett stated that the district court’s grant of summary judgment should be reversed and the facts should be submitted to the jury to determine whether a physician-patient relationship existed.

V. COMMENT

In recent years, courts have been finding ways to redefine the doctor-patient relationship to allow plaintiffs greater access to claims against physicians. In Diggs v. Arizona Cardiologists, Ltd., the Arizona court used the Restatement (Second) of Torts section 324A to extend a duty of care to the consulting patient. In Millard v. Corrado, the Missouri Court of Appeals for the Eastern District of Missouri provided two avenues of recovery: (1) a traditional medical malpractice claim, even though the physician had no contact with the patient, and (2) a claim for general negligence based on public policy and the foreseeability of harm. In Tenuto v. Lederle Laboratories, the New York Court of Appeals held that a pediatrician owed parents a duty of care, based on common-law principles of ordinary negligence and malpractice, to warn them of their personal health risks from vaccination.

The recent holding by the Kansas Supreme Court in Irving v. Smith does not follow this trend in the case law across the country. In Irving, the court limited a physician’s potential liability by limiting physician-patient relationships to those cases where a consulting doctor performs a full bedside review of the case, including a physical examination of the patient. Although many courts have found physician-patient relationships only in cases where “formal” consultations occurred, these courts have not held such a narrow definition of “formal.” Some courts have held that formal consultations arise when a physician attempts to evaluate, diagnose, or treat a

236. Id.
237. Id. at 951-52.
238. Id. at 952.
239. Id.
241. Diggs, 198 Ariz. at 202-203.
242. Drummond, supra note 240, at 1055 (citing Millard v. Corrado, 14 S.W.3d 42 (Mo. Ct. App. 1999)).
244. Irvin, 31 P.3d at 942-43.
patient. Additionally, courts find formal consultations when a doctor offers treatment advice that is likely to be accepted by the attending physician because of the consultant’s superior expert knowledge in a particular field. Other courts have found physician-patient relationships if the consulting doctor provided a service to the patient.

Courts have invariably held that informal consultations do not give rise to physician-patient relationships. In these cases, the physician often is just answering a colleague’s inquiry which can be accepted or rejected. The consulting physician does not agree to and does not actually diagnose or treat the patient. Often, the consultant is not paid and does not even know the patient’s name. Further, the consulting physician has not retained control over the patient’s course of treatment. Therefore, the physician’s low-level of involvement does not give rise to a duty of care.\(^{245}\)

In *Irvin v. Smith*, the majority ignored previous case law that had begun to draw the line between informal and formal consultations.\(^{246}\) Instead, the court offered a new definition: that a formal consultation must include a physical examination.\(^{247}\) Therefore, the majority diverged from prior case law which stated that direct physical contact is not always necessary in finding a physician-patient relationship.\(^{248}\) Judge Lockett, in his dissent, noted that the majority’s decision rested entirely on the public policy, that dissuading such consultations would be against the public’s interest.\(^{249}\)

Extending a physician-patient relationship to every telephone consultation between doctors would clearly be harmful to the public because it would limit doctors’ freedom to make informal inquiries to their colleagues. However, holding a physician to a duty of care only when he or she engages in a physical examination of a patient is also harmful to the public’s interest. When a physician engages in consultations that directly influence the treatment a patient will receive, the physician must be held to a certain standard of care. To avoid extending duties to physicians who answer mere inquiries, courts must clearly draw a distinction between formal and informal consultations.

Judge Lockett’s dissent analyzed the case with the prior definitions of informal and formal consultations in mind.\(^{250}\) Lockett recognized that Dr. Gilmartin did more than just answer a mere inquiry from Dr. Smith.\(^{251}\)

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245. However, in *Diggs v. Arizona*, the court noted that informal consultations do not often give rise to physician-patient relationships, but held that the consultant had a duty of care since he had expert knowledge in the area of consultation. *Diggs*, 198 Ariz. at 203.

246. *Irvin*, 31 P.3d at 941-43.

247. *Id.* at 942.

248. *Id.* at 941-43.

249. *Id.* at 948.

250. *Id.* at 949-50.

251. *Id.* at 950.
Instead, Dr. Gilmartin engaged in a lengthy conversation with Dr. Smith about the treatment Irving would receive. Dr. Gilmartin further agreed to perform the shuntogram the following day. Additionally, Dr. Gilmartin was a specialist who was contacted by Dr. Smith for his superior knowledge in this field. Finally, Dr. Gilmartin actually performed the shuntogram and surgery the following day.

Unlike previous cases in which courts have found informal consults, Dr. Gilmartin committed to further involvement in Irvin’s case, retained control over Irvin’s course of treatment, offered his medical opinion and services, and had superior knowledge as a child neurologist. Additionally, Dr. Smith was not free to accept or reject Dr. Gilmartin’s recommendations because the two agreed to jointly formulate a plan to evaluate Irvin, and Dr. Gilmartin agreed to take full responsibility for performing the shuntogram. Additionally, Dr. Smith was not making a mere inquiry to a colleague, but asking Dr. Gilmartin if he would join him in diagnosing and treating Irvin. Therefore, Dr. Gilmartin’s involvement in this case was more than informal. Even if there was a question of whether this involvement rose to the level of “formal,” this question should have been left for the jury to decide.

The Kansas Supreme court has limited the extension of a physician-patient relationship to consulting doctors. If other jurisdictions follow the holding in Irving, plaintiffs will be cut off from many claims that were once avenues for relief. Hopefully, Kansas and other jurisdictions will limit Irving to its facts, but the case has still been a setback for plaintiffs in the medical malpractice field.

VI. CONCLUSION

In conclusion, the Kansas Supreme Court, in Irvin v. Smith, held that generally a physician-patient relationship is created only where the physician personally examines the patient. Unlike several state courts in recent years that have expanded the theories under which a doctor may be held liable, the Irvin court limited a consulting doctor’s liability. The Irving holding relieves consulting doctors of liability even though they may have had a large impact on the treatment, or lack of treatment, the patient received. It remains to be seen whether other states will adopt the Irvin court’s reasoning and limit liability only to those doctors who directly examine the patient. But for now, in Kansas, a plaintiff’s access to medical malpractice claims has been somewhat restricted.

252. Id. at 950-51.
253. Id. at 950.
254. Id. Id. at 951-52.
255. Id. Id. at 949.
WHO IS ACTUALLY CALLING THE SHOTS?

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