Physicians’ legal responsibilities to their patients begin with the creation of the physician-patient relationship and continue as long as that relationship exists. A physician is potentially liable for medical professional liability only where there is a physician-patient relationship.¹

Q: What is the basis of the physician-patient relationship?

A: It is not necessary for a physician to deal directly or have physical contact with a patient to create a physician-patient relationship.²

A physician-patient relationship is established as a result of a contract, express or implied, that the doctor will treat the patient with proper professional skill.³ But it does not require the formalities of a contract—a contract can be implied in fact, which means it “arises from the acts and conduct of the parties, it being implied from the facts and circumstances that there was a mutual intention to contract.”⁴ For example, a Texas court has held that there is no consensual physician-patient relationship when a doctor merely offers advice to a colleague rather than to the patient, and does no more than answer the colleague’s professional inquiry.⁵

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² See St. John v. Pope, 901 S.W.2d at 423; See Dougherty v. Gifford, 826 S.W.2d 668, 674 (Tex.App.—Texarkana 1992, no writ) (physician-patient relationship existed between patient from whom biopsy was taken and doctors at laboratory that examined tissue from biopsy and negligently misdiagnosed malignant cancer).
⁵ See Lopez v. Aziz, 852 S.W.2d at 306.
The AMA’s Council on Ethical and Judicial Affairs (CEJA) publishes the Code of Medical Ethics, to which every TMA member is obligated to abide. It states the following regarding the physician patient relationship.

**E-9.12 Patient-Physician Relationship: Respect for Law and Human Rights**

The creation of the patient-physician relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination. Furthermore, physicians who are obligated under pre-existing contractual arrangements may not decline to accept patients as provided by those arrangements. (I, III, V, VI) Issued July 1986. Updated June 1994 and June 2008 based on the report "Modification of Ethics Policy to Ensure Inclusion for Transgender Physicians, Medical Students, and Patients," adopted November 2007.
Q: What ethical obligations does such a relationship impose upon the physician?

A: The American Medical Association’s Principles of Medical Ethics states that physicians shall provide competent medical service with compassion and respect for human dignity, deal honestly with patients, respect the rights of patients, safeguard patient confidences, and provide appropriate patient care in emergencies.

The practice of medicine is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above their own self-interest and above obligations to other groups, and to advocate for their patients’ welfare. Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

Furthermore, once it has been established that a physician-patient relationship exists, a physician must take great care in terminating that relationship, if the need to terminate arises. The following ethics opinion by the TMA Board of Councilors is applicable:

The patient-physician relationship is wholly voluntary in nature and therefore may be terminated by either party. However, physicians have an ethical obligation to support continuity of care for their patients. Thus, it is unethical for a physician to terminate the patient-physician relationship without first providing reasonable notice under existing circumstances of the physician’s intent to terminate the professional relationship. To terminate the patient-physician relationship without such notice may result in civil liability for abandonment.

Q: What legal obligations does such a relationship impose upon the physician?

A: The general rule is: If a physician-patient relationship exists, then a physician has the legal duty to do what an ordinary prudent physician would do under the same or similar circumstances, and to refrain from doing what an ordinary prudent physician would not do.

In such a case, the physician owes no duty to exercise professional judgment and care unless the court first determines that a physician-patient relationship exists.

Therefore, a physician is potentially liable for medical professional liability only where there is a physician-patient relationship.

Q: A person whom I have never treated comes to my office wanting medical attention. My nurse informs me of this, but I decide not to see the person and give instructions to go to a hospital. Is a physician-patient relationship created?


Id.

Id.


A: Probably not, but the determination of whether a physician-patient relationship exists is very fact specific. A physician is under no legal obligation to practice his profession or render services to whomever may request them. A physician is generally not to be held liable for arbitrarily refusing to respond to a call of a person even urgently in need of medical or surgical assistance provided that the relationship of physician and patient does not exist at the time the call is made or at the time the person presents himself for treatment. Please note, however, that the outcome would be different if the physician contractually agreed to treat the patient.

In a case with similar facts, the court of appeals held that no physician-patient relationship existed where the physician’s affidavit stated that: (a) the physician at no time had a physician-patient relationship existed; (b) the physician had never met or agreed to treat the patient; (c) the physician had never billed the patient for medical services; (d) the physician denied that his office was an emergency room; and (e) the physician stated he did not advertise that the general public would be treated in his office for emergencies. The affidavit of the patient failed to controvert that a physician-patient relationship did not exist. As stated previously, the physician-patient relationship is voluntary and requires the agreement of both parties. Generally, this means a patient may not unilaterally designate a physician and create the professional relationship. Instead, the physician must agree through some affirmative act (which can be a prior contractual agreement with a hospital or health plan).

Q: If a patient receives cosmetic treatment at my office by my staff, and I never see the patient, is a physician-patient relationship established?

A: It is very possible that a physician-patient relationship is established in that case. In fact, a Texas court found a physician-patient relationship existed where the physician never saw the patient, but reviewed the patient’s records and signed off on them after the treatment. In that case, Stanford v. Cannon, the court found a physician-patient relationship existed based on the acts and conduct of the parties, despite the fact the physician never saw the patient nor directly influenced the patient’s care. In that case, an individual went to the office seeking laser hair removal treatment. The patient filled out a medical history form and a consent form explaining the mode of action of the treatment, the proposed benefits of treatment, the probability of success and the possible complications of treatment. The consent form provided, “I consent to allow the medical personnel at Cosmetic Skin Laser & Hair Removal of Greenville under the supervision and control of Jack Thomas M.D. to perform Laser Hair Removal with the CoolGlide Nd–Yag Laser.” The physician signed and dated the notes after the treatment, having never seen the patient nor participated in the procedure. The notes were written

12 Id.
15 Id., emphasis added.
by the “technician” who performed the laser hair removal.\textsuperscript{16} The court held that a physician-patient relationship existed, because Dr. Thomas reviewed and approved of the treatments and the patient agreed to Dr. Thomas’ supervision and control of the procedures.

Q: If I examine a person for a pre-employment medical examination at the employer’s expense but do not treat any conditions I discover, is a physician-patient relationship created?

A: A doctor's examination of a person solely for the benefit of a third party, such as to determine the person’s fitness for employment or extent of disability for a worker's compensation claim, does not create a physician-patient relationship.\textsuperscript{17} Courts have held that no physician-patient relationship exists in those situations, because the examination is not performed for the benefit of the examinee or for the purpose of providing treatment for the examinee.\textsuperscript{18} For example, courts have held when a doctor examines a person for the sole purpose of a worker's compensation assessment, no physician-patient relationship exists and the doctor's only duty is to conduct the examination in a manner not to cause harm to the person being examined.\textsuperscript{19}

Even though a doctor is not liable for professional negligence when examining a nonpatient, however, he remains liable for any injury he may cause during the procedure. This has been referred to as the “duty not to injure.”\textsuperscript{20} Indeed, one court has held that the physician’s duty not to injure the examinee did not include a duty to inform the examinee of a finding of a mass on her lung during an examination.\textsuperscript{21} In that case, a physician examined an applicant for social security disability benefits at the request of the Texas Rehabilitation Commission. The court held there was no physician-patient relationship owing the examinee a duty because the examinee had not selected the physician, had not submitted herself to the examination for the purpose of medical treatment, and had not requested the physician to inform her of his findings. The purpose of the examination, at the request of the commission, was to determine her rehabilitative potential.

Q: If I am on call for a hospital emergency room and consult with the emergency department physician about a patient but decline to examine the patient or

\textsuperscript{16} The operation of a laser hair removal device was not subject to regulation by the State at the time this cause of action arose a laser hair removal device could be used without a physician or health care provider present.
\textsuperscript{17} See Johnston v. Sibley, 558 S.W.2d 135, 137-38 (Tex.App.—Tyler 1977, writ ref'd n.r.e.); Ramirez v. Carreras, 10 S.W.3d 757 (Tex.App.—Corpus Christi 2000, pet. denied); Lotspeich v. Chance Vought Aircraft, 369 S.W.2d 705, 709 (Tex.Civ.App.—Dallas 1963, writ ref'd n.r.e.).
\textsuperscript{19} Johnston v. Sibley, 558 S.W.2d at 135-36; Ramirez v. Carreras, 10 S.W.3d at 762.
\textsuperscript{20} Ramirez v. Carreras, 10 S.W.3d at 762; Johnston v. Sibley, 558 S.W.2d at 135-36;
otherwise become involved in the patient’s care, is a physician-patient relationship created?

A: The mere fact that a physician is on call does not, in and of itself, create a physician-patient relationship.22 The relationship is a consensual one and when no prior relationship exists, the doctor must take some action to treat the patient before the relationship can be established.23

If the physician is not under a contractual obligation to be on-call and is not required by the hospital to be on-call to maintain staff privileges, no cause of action for medical malpractice exists because a physician-patient relationship is not created.24

A physician may agree to a physician-patient relationship pursuant to a formal contract. Often this occurs before the physician knows the patient’s name or is contacted about the patient. Furthermore, the patient need not be a party to the formal contract.

[A] consensual relationship between a physician and a patient may exist where others have contracted with the physician on the patient’s behalf... The important fact in determining whether the relationship is a consensual one ... is not who contracted for the service but whether it was contracted for with the express or implied consent of the patient or for his benefit.... Where ... healthcare services are rendered on behalf of the patient and are done for the patient's benefit, a consensual physician-patient relationship exists for the purposes of medical malpractice.25

A physician may agree in advance with a hospital to the creation of a physician-patient relationship that leaves the physician no discretion to decline treatment of the hospital’s clients.26 Likewise, a patient’s health care plan can create a physician-patient relationship if the physician is the designated doctor for the health care plan.27

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22 See St. John v. Pope, 901 S.W.2d at 424; see also Day v. Harkins & Munoz, 961 S.W.2d at 281; Ortiz v. Shah, 905 S.W.2d at 611; Wheeler v. Yettie Kersting Memorial Hosp., 866 S.W.2d 32, 38 (Tex.App.—Houston [1st Dist.] 1993, no writ).


25 Dougherty v. Gifford, 826 S.W.2d at 675.


27 Hand v. Tavera, 864 S.W.2d at 680.
For example, in *Lection v. Dyll*, a physician was required to serve as an on-call physician to the ER, pursuant to the hospital by-laws. According to the hospital bylaws, an on-call physician is obligated to provide emergency medical care to a patient in the emergency room. Apparently the court considered the bylaws to be a contract and opined: “In this case, section 4.2.4 of the Hospital By-Laws requires Dyll to assist emergency room physicians with their neurology patients and to treat all emergency room patients.”

In that case, the ER physician examined a patient who had presented with neurological symptoms; the ER physician performed an EKG, a CT scan, and paged the neurologist on-call. The ER physician provided the on-call neurologist the results of the testing and asked what should be done. The neurologist opined that no further treatment needed to be done for this patient at the time, and that it sounded like the patient had a hemiplegic migraine. In the lawsuit, the neurologist claimed he had no physician-patient relationship with the patient, because he never met or talked to the patient, examined the patient, performed or reviewed any tests on the patient, or sent her a bill for his services. The court, however, found that the physician made a medical decision concerning the need for treatment and admission to the hospital, therefore “affirmative acts” towards the patient’s treatment. The court ultimately held that the neurologist failed to prove that no physician-patient relationship existed. Central to the court’s holding were two factors: (1) a contractual obligation on the physician to advise concerning treatment of emergency room patients when consulted, and (2) actual consultation of and advising by the physician. The court held that the neurologist was under a contractual obligation with the hospital to assist the ER physician in treating the patient, and there was an actual consultation and advising by the neurologist concerning the patient. Thus, both factors were met.

On the other hand, in *St. John v. Pope*, the Texas Supreme Court considered whether an on-call physician, consulted by an emergency room physician over the telephone, formed a physician-patient relationship by expressing his opinion that the patient be transferred to another facility. In that case, the patient came to the emergency room of a hospital with fever and back pain following recent back surgery, and the emergency room physician phoned the hospital internist on call. The on-call physician listened to the description of the patient’s symptoms and recommended that the patient either be referred to a hospital that had a neurosurgeon or to the physician who had performed the surgery. The court noted that implicit in that determination was a conclusion that the patient’s condition

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29 Section 4.2.4 of the Hospital By–Laws provides:
  Each physician member of the active staff shall serve as an on-call physician to the emergency room by participating in the emergency room call rotation. An on-call physician is obligated to provide emergency medical care to a patient in the emergency room. The on-call physician, shall, when so requested by the emergency room physician, assume primary responsibility for the medical care of a patient requiring admission for treatment, provided that the medical needs of the patient fall within the usual scope of the physician's practice, training and abilities. The on-call physician shall not be required to provide further treatment to the patient if the patient is not admitted to the hospital.
30 *Id.* at 713.
31 *St. John v. Pope*, 901 S.W.2d at 424.
was related to neurology or neurosurgery, and that the hospital was not able to handle cases involving these specialties. For reasons unclear in the record, the patient was not transferred but went home. Ultimately, the patient had meningitis and suffered permanent disabilities.\footnote{St. John v. Pope, 901 S.W.2d at 422.}

The court concluded that a physician may decline treatment and thereby decline to create a physician-patient relationship, even on the basis of an erroneous conclusion that the patient’s condition is beyond his or her ability to treat.\footnote{Id. at 423.} The court held that the on-call physician had no physician-patient relationship with the patient, and had not at any time agreed to examine or treat the patient. The court reasoned that, although the on-call physician listened to the ER physician’s description of the patient’s symptoms and made a conclusion regarding the basis of the patient’s condition, “he did so for the purpose of evaluating whether he should take the case, not as a diagnosis for a course of treatment.”\footnote{Id. at 424.} Furthermore, the court noted that there was no evidence of an agreement requiring the on-call physician to treat the patient.\footnote{Id.}

\textbf{EMTALA}

The Texas Supreme Court has expressly stated that “… a physician may agree in advance to the creation of the physician-patient relationship. For example, a physician’s agreement with a hospital may leave no discretion to decline treatment of the hospital’s clients.”\footnote{Id.}

This statement may indicate that physicians who must come to the hospital under a duty imposed by EMTALA, who have an agreement with the hospital to provide services to patients in trauma settings (or to take call generally) without discretion to decline treatment, or who are obligated to take call and appear in the ER as a consequence of medical staff bylaws may have a physician-patient relationship that has been agreed to in advance.

Q: Suppose I am on call for a hospital emergency room and consult with the emergency department physician about a patient but decline to examine the patient or otherwise become involved in the patient’s care; I also am responsible while on call for authorizing admissions of certain managed care patients. If a patient presents an identification card for that managed care plan, is a physician-patient relationship created?

A: Probably. That situation arose in a San Antonio case, \textit{Hand v. Tavera}. The patient came to the emergency room complaining of a 3-day headache. He presented a Humana Health Care Plan card. The ER physician was able to periodically reduce the blood pressure with medication, and after several hours, decided that the patient should be admitted to the hospital. This required approval from another physician.

\textit{Hand v. Tavera}
The ER physician discussed the case with the responsible physician at that time for authorizing admissions of Humana Health Care Plan patients. That physician, an internist, concluded that the patient’s problems “should be controlled by outpatient medication and follow-up in the office.” The patient was sent home but suffered a stroke a few hours later. The Texas Court of Appeals (San Antonio) found that two clauses in the contract between Humana Health Care Plan and the defendant physician obligated him to treat the patient:

Physician agrees to provide or arrange for covered health care services for enrollees in accordance with Attachment B. [Attachment B specifies various physician responsibilities, including “emergency care of a covered enrollee who has been assigned to a physician.”] And Physician agrees to provide enrollees with medical services which are within the normal scope of physician’s medical practice. These services shall be made available to enrollees without discrimination and in the same manner as provided to physician’s other patients. Physician agrees to provide medical service to enrollees in accordance with the prevailing practices and standards of the profession and community.

The court noted that the patient paid premiums to Humana to purchase medical care in advance of need, that Humana met its obligation to the patient and other enrollees by employing the defendant’s medical group to treat them, and that the medical group had agreed to treat Humana enrollees in exchange for fees received from Humana. The court concluded:

We hold that when the health care plan’s insured shows up at a participating hospital emergency room, and the plan’s doctor on call is consulted about treatment or admission, there is a physician-patient relationship between the doctor and the insured.  

Q: If a person makes a “new patient” appointment with my office, has a physician-patient relationship been established prior to my having actually met, examined, and treated the person?

A: Generally, the answer is no, there is no physician-patient relationship. “[T]he mere act of ... agreeing to see the patient at a later time [does] not establish the physician-patient relationship.” The basis for the creation of the physician-patient relationship is consensual one, between both the physician and the patient. With that understanding, one can see how, without having met the patient, there is no physician-patient relationship.

Q: If I see a patient at a hospital, do I have a continuing duty to that patient?

A: Probably not. The Texas Court of Appeals, Fort Worth held the following in that regard:

[T]he examination of a patient at a hospital by a consulting or referred specialist physician does not create a continuing duty upon that physician to insure follow-up is maintained once the physician has supplied the primary or referring physician with the results unless the patient and the consulting or referred specialist physician take some further affirmative action to continue the relationship.  

In that case, Gross, MD v. Burt, a neonatologist was the admitting and attending physician for premature twins while they remained in the NICU. The neonatologist determined that the twins needed to be screened for retinopathy of prematurity (ROP). When a premature infant at the particular facility where the twins were admitted met certain criteria under protocols, that infant's name is placed on one of the consulting ophthalmologists' examining lists. The actual screening is performed by a pediatric ophthalmologist who is a consulting physician requested or ordered by the attending physician, and who then reports back directly to the attending physician. Dr. Gross performed the screening tests. Dr. Gross determined one of the twins had Stage I ROP in his right eye. He forwarded an ROP “Initial Evaluation” report of his findings and recommendations back to the admitting neonatologist and recommended that the child seek a follow-up visit within two weeks. The parents of the child did not follow-up as instructed and missed several appointments. When both twins were finally examined after discharge they were diagnosed as being legally blind. The parents filed a lawsuit against Dr. Gross, alleging negligence.

The court recognized that “If we were to expand the duty of continued care to all patients who are seen at hospitals by consulting physicians beyond the hospital setting based solely upon the fact that they were seen by the physician in the hospital, there would be no end to the physician-patient relationship.” The court decided that where the specialist is to provide a screening and then report findings back to the admitting and treating physician (who controls the patient’s care) it would not impose “a post-hospital never-ending duty.”

Although it is clear Texas law recognizes self-limiting relationships, physicians should be careful in attempting to rely entirely upon this concept as it is difficult to determine exactly when the professional relationship has terminated. In the dissenting opinion for the Gross, MD case, Justice Sue Walker stated that the majority opinion relies upon cases that “address only whether an initial physician-

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40 Id.
41 Id. at 228.
patient relationship was created, not whether an existing physician-patient relationship later continued or was terminated.”42

A physician is generally required to provide a patient with reasonable notice of the physician’s intent to terminate the professional relationship. A letter sent to the patient, return receipt requested, to ensure that the patient is aware of the physician's decision and offer some evidence of the communication is a common risk management technique. A copy of the letter and the return receipt should be retained. If the letter is refused (for lack of a signature) sending a letter through regular first class mail may suffice. The TMA Board of Councilors ethics opinion on termination of the physician patient relationship is as follows:

*The patient-physician relationship is wholly voluntary in nature and therefore may be terminated by either party. However, physicians have an ethical obligation to support continuity of care for their patients. Thus, it is unethical for a physician to terminate the patient-physician relationship without first providing reasonable notice under existing circumstances of the physician’s intent to terminate the professional relationship. To terminate the patient-physician relationship without such notice may result in civil liability for abandonment.

For further information on termination you may consider requesting TMA’s whitepaper on the termination of the physician-patient relationship.

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42 Id. at 247.