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Could Somebody Call a Doctor?

On-Call Physicians and the Duty to Treat

*Millard v. Corrado*¹

I. INTRODUCTION

The law of negligence imposes few affirmative duties on actors in society. In the medical profession specifically, negligence law traditionally contains no requirement that a physician provide medical treatment to those in need absent an existing relationship between the doctor and patient.² Yet there has long been the sense that doctors owe a higher duty to the public, and courts are finding ways to redefine the doctor-patient relationship to allow plaintiffs greater access to claims for a physician's failure to render care. In *Millard v. Corrado*, the Missouri Court of Appeals for the Eastern District of Missouri provides plaintiffs with two new potential avenues of recovery when an on-call physician fails or refuses to treat: (1) a traditional medical malpractice claim, even though the physician had no contact with the plaintiff, and (2) a claim for general negligence based on public policy and the foreseeability of harm.

II. FACTS AND HOLDING

Marjorie Millard sustained life-threatening injuries in an automobile accident during the mid-morning hours of November 5, 1994.³ The accident occurred in Callaway County, Missouri, near the intersection of Highway 54 and Interstate 70.⁴ The closest hospital was the Audrain Medical Center, located approximately fourteen miles away in Mexico, Missouri.⁵ The University of Missouri Medical Center ("University Hospital") in Columbia was approximately twenty-five miles away.⁶

Emergency Medical Technicians ("EMTs") arrived on the scene at 10:28 a.m. and were unable to detect Mrs. Millard's blood pressure or pulse.⁷ Because the Audrain Medical Center was closer and purported to maintain twenty-four hour emergency surgical services, the EMTs radioed the hospital and advised

1. 14 S.W.3d 42 (Mo. Ct. App. 1999).

2. See RESTATEMENT (SECOND) OF TORTS § 314 (1965).

3. *Millard*, 14 S.W.3d at 44. Mrs. Millard suffered broken ribs, a ruptured diaphragm, and damage to her adrenal and renal arteries and her renal vein. *Id.*

4. *Id.*

5. *Id.*

6. *Id.* at 45.

7. *Id.*

that they were en route with a "Class 1" or critical patient.⁸ The hospital did not respond.⁹

Mrs. Millard's ambulance arrived at the Audrain Medical Center at 11:07 a.m., where the staff began stabilization and diagnostic procedures.¹⁰ At 11:45 a.m., an EMT paged Dr. Joseph Corrado, the general surgeon designated on call for the day.¹¹ At 11:54 a.m., the emergency room physician diagnosed an intra-abdominal bleed.¹² Dr. Corrado was paged again at 11:55 a.m., but still failed to respond.¹³ Efforts were made to transfer Mrs. Millard to the University Hospital's trauma center by helicopter, but hospital staff discovered that it was grounded due to adverse weather.¹⁴

Mrs. Millard was also examined by Drs. Thomas Welsh and Ben Jolly, who arrived in the emergency department shortly after noon.¹⁵ They concurred with the emergency room physician's diagnosis, but while both were members of the hospital staff, neither had privileges to perform general surgery.¹⁶

Dr. Corrado responded to his pages at 12:23 p.m. and spoke with Dr. Welsh. Dr. Welsh then prepared a patient history indicating that he and Dr. Corrado discussed the situation and determined that Mrs. Millard should be transferred to the University Hospital.¹⁷ Mrs. Millard arrived at the University Hospital via ambulance at 1:45 p.m. and underwent emergency surgery at 2:15 p.m.¹⁸ She survived, but lost her left kidney, gallbladder, colon, and a portion of her small intestine.¹⁹

Several days prior to November 5, 1994, Dr. Corrado placed his name on the hospital's on-call roster, as he was the only on-staff general surgeon not

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*

17. *Id.* The patient history report provides:

We did contact Dr. Corrado by phone. The situation was discussed and the options addressed. It was felt that in view of the extent and nature of the patient's injury, [Mrs. Millard] would be best served by transfer to the University of Missouri Medical Center, where a trauma team was available. It was not felt to be prudent to attempt to care for her at Audrain Medical Center.

Id. Dr. Corrado provided testimony contrary to the report. He stated that he was merely advised that the hospital had received a patient with intra-abdominal injuries who was to be transferred to the University Hospital. *Id.*

18. *Id.*

19. *Id.*

scheduled for vacation that day.²⁰ On the morning of November 5, Dr. Corrado advised Dr. Jolly that he planned to attend an out-of-town meeting and asked Dr. Jolly to cover his on-call duties while he was gone.²¹ Dr. Jolly agreed, although he was not privileged to perform general surgery at the hospital.²² Dr. Corrado left the hospital without advising any other hospital staff member that he would be out of town and unable to respond to emergency room calls.²³ At the time of Mrs. Millard's accident, Audrain Medical Center's by-laws required on-call physicians to respond to calls within thirty minutes.²⁴

Mrs. Millard filed an action for negligence, alleging that her injuries were compounded as a direct and proximate result of the delay in treatment caused by Dr. Corrado's unavailability.²⁵ Her husband claimed a loss of consortium and medical expenses.²⁶ Dr. Corrado filed for summary judgment, claiming the Millards had failed to prove that a doctor-patient relationship existed, thus entitling him to judgment as a matter of law.²⁷ The trial court agreed, finding no doctor-patient relationship between the parties to support a claim for medical malpractice.²⁸ The trial court further ruled that the Millards' allegations of Dr. Corrado's failure to treat were necessarily based on special medical skills possessed only by doctors, barring any claim for general negligence.²⁹

The Millards appealed to the Missouri Court of Appeals for the Eastern District of Missouri, claiming that Dr. Corrado owed a duty to treat Mrs. Millard within a reasonable time, even absent a doctor-patient relationship.³⁰ The court recognized that public policy or a reasonable foreseeability of harm may provide grounds for imposing such a duty of care.³¹ Applying those principles to the

20. *Id.* at 44.

21. *Id.*

22. *Id.*

23. *Id.*

24. *Id.* at 47, 50.

25. *Id.* at 45-46.

26. *Id.* at 46.

27. *Id.* Dr. Corrado asserted four facts in support of his claim: (1) that he was attending an out-of-town meeting when Mrs. Millard received her treatment at the Audrain Medical Center, (2) that Dr. Jolly was the on-call physician at the time, (3) that he did not render any treatment to the plaintiff, and (4) that he provided no consultation regarding her care. *Id.* at 50-51.

28. *Id.* at 49.

29. *Id.* at 46. The trial court essentially adopted Dr. Corrado's claims in its order granting his motion, further adding that the doctor was unaware that Mrs. Millard was in need of treatment at the Audrain Medical Center until she had already been sent to the University Hospital. *Id.* at 49. *But see supra* note 17 (providing conflicting testimony in the patient history report regarding the level of Dr. Corrado's involvement in Mrs. Millard's care).

30. *Millard v. Corrado*, 14 S.W.3d 42, 44 (Mo. Ct. App. 1999).

31. *Id.* at 47. The court used the factors set forth in *Hoover's Dairy, Inc. v. Mid-America Dairymen, Inc.*, 700 S.W.2d 426, 432 (Mo. 1985), as a guide in evaluating the

facts before it, the court found that Mrs. Millard was a foreseeable patient and that Dr. Corrado's attempt to delegate his on-call duty to Dr. Jolly failed as Dr. Jolly was unauthorized to perform general surgery on any patients received by the emergency department.³² The opinion further stated that Dr. Corrado's failure to notify the hospital of his absence "created a false security that a general surgeon would be available to treat emergency patients,"³³ on which Mrs. Millard relied. If the Audrain Medical Center had known of his absence, the ambulance could have been routed directly to the University Hospital, saving Mrs. Millard several hours of delay in receiving care.³⁴ The court determined that under such circumstances, on-call physicians have a general duty to reasonably foreseeable patients to notify the hospital when they will be unable to respond to calls, a duty independent of the doctor-patient relationship.³⁵

The Millards also alleged that the trial court overlooked several evidentiary facts in finding that there was no dispute as to the existence of a doctor-patient relationship between the parties.³⁶ While conceding that Dr. Corrado provided no hands-on treatment to Mrs. Millard, the plaintiffs pointed to Dr. Corrado's on-call status, evidence of hospital by-laws requiring a thirty-minute response time for all on-call physicians, and the telephone conversation with Dr. Welsh³⁷ as sufficient to establish a doctor-patient relationship.³⁸ Acknowledging that such a relationship could arise absent personal contact between the parties,³⁹ the court concluded summary judgment was inappropriate.⁴⁰ Given the uncontroverted evidence of the hospital by-law requirements, the court held that the Millards had established that Mrs. Millard had a reasonable expectation of a contract between

public policy reasons for imposing a legal duty on Dr. Corrado. Those factors include:

- (1) the social consensus that the interest is worth protecting, (2) the foreseeability of harm and the degree of certainty that the protected person suffered the injury, (3) the moral blame society attaches to the conduct, (4) the prevention of future harm, (5) the consideration of cost and ability to spread the risk of loss, and (6) the economic burden on the actor and the community.

Millard, 14 S.W.3d at 47.

32. *Millard*, 14 S.W.3d at 48.

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.* at 49; see also *supra* note 17.

37. See *supra* note 17.

38. *Millard v. Corrado*, 14 S.W.3d 42, 49 (Mo. Ct. App. 1999).

39. See *Corbet v. McKinney*, 980 S.W.2d 166 (Mo. Ct. App. 1998). On similar facts, the court held that no doctor-patient relationship existed where a specialist was consulted by an emergency physician over the telephone, presenting the case as set forth in the patient's medical chart. *Id.* at 168-69. The court found that even though a physician may not physically examine a patient, "a physician-patient relationship can still arise where the physician is *contractually obligated* to provide assistance in the patient's diagnosis or treatment and does so." *Id.* at 169 (emphasis added).

40. *Millard*, 14 S.W.3d at 52.

the hospital and Dr. Corrado requiring him to provide emergency room treatment when on call.⁴¹

III. LEGAL BACKGROUND

A. General Negligence

The elements of a negligence claim are familiar to any first-year law student: duty, breach, proximate cause, and damages.⁴² The Missouri Supreme Court thoroughly reviewed the state's negligence doctrine in *Hoover's Dairy, Inc. v. Mid-America Dairymen, Inc.*,⁴³ and noted that the duty to exercise care is often established on a case-by-case basis.⁴⁴ A duty generally arises when a foreseeable harm exists, such that a reasonable person would have anticipated the danger and acted to prevent it.⁴⁵ The existence of a duty further depends on the following: (1) the value society places upon protecting the plaintiff's interest, (2) the foreseeability of harm, (3) the moral blameworthiness of the defendant's conduct, (4) the prevention of future harm, (5) the ability to disperse the risk of loss, and (6) the burden on the defendant and others in acting to avoid the harm.⁴⁶

Misfeasance forms the basis of most negligence actions; liability seldom attaches for the failure to act under common law.⁴⁷ Liability for the failure to act requires "some definite relation between the parties, of such a character that social policy justifies the imposition of a duty to act."⁴⁸ This definition aptly describes the doctor-patient relationship, as is recognized under the law.⁴⁹ Thus, it is only after a doctor-patient relationship is established that the physician becomes obligated to render any necessary care.⁵⁰

The requirement that one exercise due care can also arise through affirmative conduct; one who takes action on behalf of another must use

41. *Id.* at 50.

42. See WILLIAM L. PROSSER, *THE LAW OF TORTS* § 30, at 146 (3d ed. 1964).

43. 700 S.W.2d 426 (Mo. 1985).

44. *Id.* at 431.

45. *Id.*

46. *Id.* at 432.

47. See RESTATEMENT (SECOND) OF TORTS § 314 cmt. c (1965). Section 314, entitled "Duty to Act for Protection of Others," states: "The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action." RESTATEMENT (SECOND) OF TORTS § 314 cmt. c (1965).

48. PROSSER, *supra* note 42, § 54, at 335; see also RESTATEMENT (SECOND) OF TORTS § 314 cmt. c (1965).

49. See 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 202 (1981).

50. See James L. Rigelhaupt, Jr., Annotation, *What Constitutes Physician-Patient Relationship for Malpractice Purposes*, 17 A.L.R.4th 132 (1982).

reasonable care.⁵¹ When the failure to do so increases the risk of or causes harm because of another's reliance on the undertaking, the actor is subject to liability.⁵² This liability is extended to third persons foreseeably harmed by a negligent undertaking, as set forth in Section 324A of the *Restatement (Second) of Torts*:

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 from 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
- (b) he has undertaken to perform a duty owed by the other to the third person, or
- (c) the harm is suffered because of reliance of the other or the third person upon the undertaking.⁵³

Courts interpreting Section 324A have been hesitant to impose liability unless it can be shown that the third party was intended to benefit from the relationship between the third party and the alleged tortfeasor.⁵⁴

Section 324A was acknowledged as the law in Missouri in *Brown v. Michigan Mutual Insurance Co.*⁵⁵ The action was brought by employees of an independent contractor hired to clean up a chemical spill at a grain elevator.⁵⁶ The employees were injured in an explosion and brought suit against the grain mill's insurer, who had solicited to inspect the premises for hazards.⁵⁷ The court found that when the insurance company promoted its inspection services to its

51. See RESTATEMENT (SECOND) OF TORTS § 323 (1965); 57A AM. JUR. 2D *Negligence* § 96 (1989).

52. See RESTATEMENT (SECOND) OF TORTS § 323 (1965).

53. RESTATEMENT (SECOND) OF TORTS § 324A (1965).

54. See *Smith v. Allendale Mut. Ins. Co.*, 303 N.W.2d 702, 712 (Mich. 1981). In *Smith* and several companion cases decided with it, Section 324A provided the focus for the court's examination of whether a casualty insurer may be liable to its insured's employees for a failure to detect fire hazards during periodic inspections. The court found three instances in which an undertaking gives rise to a duty: "a contractual undertaking by a defendant to render particular services, an undertaking by an agent or employee to render services to his employer . . . , or an undertaking whose unambiguous object is to benefit another" *Id.* at 710-11. Ultimately, the court determined that intent was key, as "[e]vidence demonstrating merely that a benefit was conferred upon another is not sufficient to establish an undertaking which betokens duty." *Id.* at 712. The court found no specific intent by the insurer, either express or implied, for the inspections to benefit the employees. *Id.* at 714.

55. 665 S.W.2d 630, 634 (Mo. Ct. App. 1983).

56. *Id.* at 632.

57. *Id.*

insured, it clearly implied a benefit not only to the insured, but to third parties such as the plaintiffs “by making the insured mills safe places to work through accident prevention measures.”⁵⁸ Once the defendant undertook to inspect for hazards, its liability extended to the employees of the independent contractor when an accident resulted from a failure to correct a known condition.⁵⁹

Section 324A has been invoked by several state courts to resolve questions of the duty owed to third parties in the medical context. Successful plaintiffs generally have some special relationship to the person on whose behalf the medical care was undertaken.⁶⁰ For example, in *Miller v. Rivard*⁶¹ and *DiMarco v. Lynch Homes-Chester County, Inc.*,⁶² physicians were held liable when negligent treatment of patients resulted in harm to their spouses. The *DiMarco* court noted that a doctor-patient relationship did in fact exist, albeit between the defendant and the plaintiff’s wife.⁶³ The *Miller* court reasoned that spouses occupy “a manageable, predictable class.”⁶⁴ Prior to *Millard*, whether a contract between a hospital and an on-call physician represented an undertaking sufficient to impose general negligence liability for a failure to treat potential patients had yet to be considered by Missouri courts.

58. *Id.* at 635-36. The text of the solicitations stated, in part, “that if ‘someone gets hurt . . . you will lose,’” and that “‘your Mill Mutual engineer is specially trained . . . to lower the probability [of accidents] substantially.’” *Id.* at 634.

59. *Id.* at 635-36.

60. *But see* *Troxel v. A.I. Dupont Inst.*, 675 A.2d 314 (Pa. Super. Ct. 1996) (physicians had a duty to unknown pregnant women that required them to warn patient that her child could expose them to dangerous contagious disease).

61. 585 N.Y.S.2d 523 (App. Div. 1992). In *Miller*, a wife’s wrongful conception claim against her husband’s doctors for a failed vasectomy survived summary judgment when the doctors had been advised the reason for the vasectomy was to avoid a potentially dangerous pregnancy. *Id.* at 527. The court’s decision was further based on the special nature of the claim—allowing Mrs. Miller’s wrongful conception claim “accords with the overwhelming majority position in other jurisdictions” that each spouse may recover damages in such cases, regardless of which one received the negligent medical treatment or advice. *Id.* at 526.

62. 559 A.2d 530 (Pa. Super. Ct. 1989). The plaintiff in *DiMarco* contracted hepatitis from his wife, a phlebotomist, whose physicians failed to advise her that she could spread the disease by sexual relations for up to six months after exposure. *Id.* at 531. Acknowledging the absence of a doctor-patient relationship, the court recognized a claim under Section 324A by extending the duty of the doctor to the patient’s spouse, noting the important public policy concerns at stake in dealing with a communicable disease. *Id.* at 535.

63. *Id.* at 533.

64. *Miller*, 585 N.Y.S.2d at 527.

B. Medical Negligence

Medical malpractice was an established tort before the negligence cause of action.⁶⁵ Liability originally arose from a theory of public duty—the physician's special relationship to the public at large.⁶⁶ With the development of negligence doctrines, this duty became more focused on the doctor's relationship to the individual patient.⁶⁷ The first hurdle to sufficiently pleading a medical malpractice claim, therefore, is establishing a doctor-patient relationship, and thereby, a duty to treat.⁶⁸ The relationship can only arise by mutual knowledge and consent; a contract to treat and be treated.⁶⁹ Yet an increasing number of courts are entertaining negligence claims where the doctor had no personal contact with the patient.⁷⁰ Some plaintiffs have argued that a doctor-patient relationship may arise when an on-call physician is consulted by telephone regarding the patient's care, but to date courts have been willing to impose liability only when the doctor is under some contractual obligation to provide on-call services to the hospital.⁷¹

*Hiser v. Randolph*⁷² was one of the earliest cases imposing malpractice liability under this contract theory, despite a lack of personal contact between the parties. The defendant, Dr. Randolph, was contacted at home by a hospital nurse at approximately 11:50 p.m. regarding a patient who had arrived in a semi-comatose condition due to acute diabetes.⁷³ Randolph refused to treat the patient and told the nurse to call the patient's treating physician.⁷⁴ The treating physician also refused to come in, claiming that Randolph was on call and therefore responsible for the patient.⁷⁵ Randolph still refused to come to the hospital, so the chief-of-staff was called and eventually came in to treat the patient.⁷⁶ Unfortunately, the patient died the next morning.⁷⁷

65. See *Corbet v. McKinney*, 980 S.W.2d 166, 169 (Mo. Ct. App. 1998) (citing 1 DAVID W. LOUISELL & HAROLD WILLIAMS, *MEDICAL MALPRACTICE* § 8.01, at 8-3 (1998)).

66. See 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 202 (1981).

67. See *Corbet*, 980 S.W.2d at 169.

68. *Id.*

69. *Id.*

70. See *id.* at 166; see, e.g., *Hiser v. Randolph*, 617 P.2d 774 (Ariz. Ct. App. 1980); *Schendel v. Hennepin County Med. Ctr.*, 484 N.W.2d 803 (Minn. Ct. App. 1992); *McKinney v. Schlatter*, 692 N.E.2d 1045 (Ohio Ct. App. 1997); *Hand v. Tavera*, 864 S.W.2d 678 (Tex. App. 1993).

71. See *supra* note 70.

72. 617 P.2d 774 (Ariz. Ct. App. 1980).

73. *Id.* at 775.

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

Randolph asserted that he had no duty to treat the patient.⁷⁸ The patient's husband, as plaintiff, argued that Randolph's participation in a physician group cooperating with the hospital to establish emergency room on-call schedules imposed such a duty.⁷⁹ The plaintiff also produced evidence showing that on-call physicians were paid by the hospital for each shift.⁸⁰ The court reasoned that in accepting payment for his on-call services and consenting to hospital by-laws having an express purpose of ensuring that all emergency room patients receive the "best possible care," Randolph contracted away his right to refuse to treat the plaintiff's decedent.⁸¹

In *Fought v. Solce*,⁸² the Texas Court of Appeals held that merely volunteering for on-call duty imposes no legal obligation on a physician.⁸³ Dr. Solce volunteered as the orthopaedic specialist on call, but declined twice to come to the hospital and treat the plaintiff's multiple leg fractures.⁸⁴ The plaintiff was transferred to a trauma center and claimed that the delay in treatment caused the amputation of his leg.⁸⁵ Solce argued that he had never entered into a doctor-patient relationship with the plaintiff because he believed the trauma center was better equipped to treat the plaintiff's injuries.⁸⁶ The court acknowledged the lack of a doctor-patient relationship, but looked for some other duty that might have given rise to a malpractice claim.⁸⁷ The court was unable to find such a duty where the on-call services were purely voluntary.⁸⁸

Four years later, the same court rejected a claim that a doctor-patient relationship may be found when a physician has agreed to abide by hospital regulations calling for his active participation in emergency services and requiring twenty-minute availability when on call. In *Ortiz v. Shah*,⁸⁹ the defendant, Dr. Shah, was the second physician listed as on-call; he was contacted when the first physician proved unavailable.⁹⁰ Shah hesitated before agreeing

78. *Id.* at 776. Dr. Randolph contended that he refused to treat the patient because he did not think he was able to adequately care for her diabetes. *Id.* There was evidence, however, that the parties had an antagonistic relationship, or that Randolph's refusal was because the patient's husband was a lawyer. *Id.*

79. *Id.* at 775. By-laws were established to regulate the group "subject to the ultimate authority of the hospital governing board . . ." *Id.* at 777.

80. *Id.* at 775. Physicians were paid \$100 per shift. *Id.*

81. *Id.* at 776-77.

82. 821 S.W.2d 218 (Tex. App. 1991).

83. *Id.* at 220.

84. *Id.* at 219.

85. *Id.*

86. *Id.*

87. *Id.*

88. *Id.* at 220. The decision states that Solce had no contractual obligation to provide on-call services, nor were they required in order to maintain staff privileges. *Id.*

89. 905 S.W.2d 609 (Tex. App. 1995).

90. *Id.* at 610.

to come in, and the patient died in surgery before Shah ever arrived to provide treatment.⁹¹ The plaintiffs pointed to hospital by-laws and policies requiring that surgeons “be within 20 minutes of the hospital” when on call as a basis for liability.⁹² The court summarily dismissed these terms as “very general”⁹³ and noted that Texas common law requires that a doctor take “some affirmative act” toward treatment in order to create a doctor-patient relationship.⁹⁴ The court held that merely agreeing to be on call, even pursuant to by-laws or other hospital policies, fails to meet that standard.⁹⁵

The plaintiffs in *Shah* also asked the court to adopt the rule of *Hand v. Tavera*,⁹⁶ under which a doctor-patient relationship may arise through the doctor’s contractual relationship with third parties. However, the court was unwilling to extend *Hand* to the facts before it.⁹⁷

The Ohio Court of Appeals developed a three-prong test for imposing a duty to treat on on-call physicians having no patient contact in *McKinney v. Schlatter*.⁹⁸ Schlatter had come to the emergency room with acute chest and stomach pain.⁹⁹ The attending emergency room physician ran diagnostic tests, then called the hospital’s on-call cardiologist with the results.¹⁰⁰ The cardiologist

91. *Id.*

92. *Id.* at 611. A separate term in the by-laws required that the surgeon “be available within 20 minutes while on call.” *Id.* at 611 n.1.

93. *Id.* The court’s discussion is limited to a brief footnote, where it stated: “Ortiz apparently takes the position that Dr. Shah was not at the hospital within twenty minutes, and therefore he breached his specific agreement to treat Ortiz.” *Id.*

94. *Id.* at 612.

95. *Id.*

96. 864 S.W.2d 678 (Tex. App. 1993). In *Hand*, a doctor-patient relationship was found to exist by virtue of an HMO contract. Unlike the situation in *Shah*, however, the doctor had consulted in the patient’s emergency room care, which the *Shah* court used to distinguish the two cases. See *Ortiz v. Shah*, 905 S.W.2d 609, 611-12 (Tex. App. 1995).

97. See *Shah*, 905 S.W.2d at 611-12. The Texas Supreme Court agreed in a separate case that “[t]he mere fact that a doctor is ‘on call’ does not in itself impose any duty.” *St. John v. Pope*, 901 S.W.2d 420, 424 (Tex. 1995) (citing *Fought v. Solce*, 821 S.W.2d 218 (Tex. App. 1991), among others). In *Pope*, the plaintiff alleged that a phone call to the on-call internist by the emergency room physician, relating his case history, was sufficient to create a doctor-patient relationship. *Id.* at 421. The doctor declined to take the case and ordered the patient transferred, maintaining the condition to be beyond the treatment capabilities of the hospital. *Id.* at 422. The court found that the doctor used the information to evaluate whether or not to create a doctor-patient relationship, which by itself imposed no duty of care. *Id.* at 424. The case does not address whether other contractual obligations could provide a basis for a doctor-patient relationship.

98. 692 N.E.2d 1045 (Ohio Ct. App. 1997).

99. *Id.* at 1046.

100. *Id.* The emergency room physician described the results of the patient’s chest X-rays, EKGs, and other tests to the on-call cardiologist over the telephone and asked for

did not think the symptoms indicated cardiac problems and did not recommend further testing.¹⁰¹ The patient was discharged with advice to follow up with his family physician.¹⁰² He died of an aortic aneurysm a few hours later.¹⁰³

The trial court directed a verdict for the cardiologist.¹⁰⁴ In reviewing that ruling, the appellate court held that a doctor-patient relationship may be established by an on-call physician's consultation if he (1) participates in diagnosing or (2) prescribes a course of treatment for the patient, and (3) owes a duty to either the hospital, its staff, or a patient for whose benefit he is on call.¹⁰⁵ "Once an on-call physician who has [such] a duty . . . is contacted . . . , and a discussion takes place . . . regarding the patient's symptoms, a possible diagnosis and course of treatment, a physician-patient relationship exists . . ."¹⁰⁶ While there was no evidence of a specific on-call policy at the subject hospital with which to satisfy the third prong of the test, the plaintiffs did offer evidence showing that ninety-five percent of hospitals require physicians to perform on-call services in exchange for staff privileges.¹⁰⁷ The Ohio court was even willing to look at the *absence* of evidence that the defendant had volunteered to be on call¹⁰⁸ in order to arrive at the result that a doctor-patient relationship existed.¹⁰⁹

The Missouri Court of Appeals looked to *Schlatter* in deciding *Corbet v. McKinney*.¹¹⁰ The plaintiff, Rebecca Corbet, arrived at the Missouri Baptist Medical Center emergency room with complaints about her ear.¹¹¹ Corbet was treated by the facility's attending emergency room physician, Dr. Ockner, who contacted the defendant and related her case as contained in her medical chart over the phone.¹¹² Ockner testified that the defendant thought Corbet was likely suffering from a viral illness.¹¹³ Relying on what he characterized as a consultation, Ockner discharged Corbet with instructions to follow up with the

his opinion on an "unstable angina." *Id.*

101. *Id.* at 1046-47.

102. *Id.* at 1047.

103. *Id.*

104. *Id.*

105. *Id.* The court acknowledged in so holding that "[w]e . . . are mindful that we are elaborating in the field of medical malpractice" *Id.* at 1050.

106. *Id.*

107. *Id.*

108. See *supra* notes 82-88 and accompanying text (discussing *Fought v. Solce*, 821 S.W.2d 218 (Tex. App. 1991), where the voluntary nature of the doctor's on-call duties precluded liability).

109. See *McKinney v. Schlatter*, 692 N.E.2d 1045, 1050 (Ohio Ct. App. 1997). The court also applied the first and second prongs in finding the existence of a doctor-patient relationship. *Id.* at 1050-51.

110. 980 S.W.2d 166, 169 (Mo. Ct. App. 1998).

111. *Id.* at 168.

112. *Id.*

113. *Id.*

defendant.¹¹⁴ Corbet did not receive follow-up care, and her condition resulted in partial deafness.¹¹⁵ She then sued the defendant for a failure to diagnose, even though he had never examined her and did not recall the phone call from Ockner.¹¹⁶ Applying the test set forth in *Schlatter*, the court found that Corbet's case failed to establish the third prong, i.e., there was no contractual obligation requiring the physician to provide on-call services.¹¹⁷ And while the treating physician testified that he called his on-call colleague for a consultation to "obtain a plan of treatment,"¹¹⁸ the court found that the on-call physician merely advised the patient's regular physician without taking actions demonstrating a "knowing consent to treat."¹¹⁹ Therefore, the on-call physician had no duty of care under the law.¹²⁰

Following *Corbet*, then, Missouri courts are to apply the three-facet test of *Schlatter* before imposing a duty to treat—an on-call physician must actively and knowingly consent to provide care, prescribe a course of care, and be contractually obligated to provide on-call services on behalf of the hospital.

IV. INSTANT DECISION

A. General Negligence

In *Millard*, the Missouri Court of Appeals for the Eastern District of Missouri asserted that where the alleged negligence "do[es] not involve a matter of medical science," a physician should not be exempt from general negligence liability.¹²¹ Thus, foreseeability of harm or public policy may dictate that doctors

114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.* at 170.

118. *Id.* at 168.

119. *Id.* at 170.

120. *Id.* Actions that indicate "knowing consent" include examining, diagnosing, treating, or prescribing treatment for the patient. *Id.* Under Texas law, such actions would constitute "affirmative action" toward the provision of care. See *supra* text accompanying note 94; see also *Oja v. Kin*, 581 N.W.2d 739, 743 (Mich. Ct. App. 1997) (doctor-patient relationship can only be implied where doctor has "done something" to indicate consent to treat); *Anderson v. Houser*, 523 S.E.2d 342, 347 (Ga. Ct. App. 1999) (following *Oja* in holding that mere offering of professional opinion is not enough to establish consent; doctor must consult in patient's condition and "essentially direct" the course of treatment). Both *Oja* and *Houser* noted the existence of hospital by-laws arguably creating obligations on the part of on-call physicians. In addition, both courts rejected arguments that the regulations imposed a duty of care on the basis that neither created any rights in third parties. See *Oja*, 581 N.W.2d at 744; *Houser*, 523 S.E.2d at 344.

121. *Millard v. Corrado*, 14 S.W.3d 42, 47 (Mo. Ct. App. 1999).

exercise a certain degree of care, even in matters outside the medical relationship.¹²²

Addressing the public policy issue first, the court applied the six factors identified by the Missouri Supreme Court in *Hoover's Dairy* that impose a duty of care which include: (1) the social consensus that the interest is worth protecting, (2) the foreseeability of harm and the degree of certainty that the protected person suffered the injury, (3) the moral blame society attaches to the conduct, (4) the prevention of future harm, (5) the consideration of cost and ability to spread the risk of loss, and (6) the economic burden on the actor and the community.¹²³ A state regulation not in effect at the time of Mrs. Millard's accident, which required on-call physicians to arrive at the hospital within thirty minutes of a summons, evidenced a social consensus that doctors respond to emergency patients within a reasonable time.¹²⁴ The burdens of requiring on-call physicians to notify the hospital of an inability to fulfill on-call duties were deemed insignificant compared to the otherwise substantial risks to potential patients.¹²⁵ The inconvenience of a phone call was similarly outweighed by the benefit in preventing future harm.¹²⁶

Noting that foreseeability is the "touchstone" for imposing a duty, the court found the risk of harm to which Mrs. Millard was exposed reasonably foreseeable.¹²⁷ It was foreseeable that a patient with such injuries would be brought to the hospital during the time Dr. Corrado was away.¹²⁸ Dr. Corrado was aware that Dr. Jolly could not provide the necessary care to emergency patients requiring general surgery in Dr. Corrado's absence.¹²⁹ Dr. Corrado also knew, or should have known, that the hospital would falsely surmise that it had the ability to treat emergency patients who required a general surgeon. Furthermore, he was also aware that any patients taken to Audrain Medical Center requiring general surgery would have to be transferred to the University Hospital in Columbia.¹³⁰ Given these factors, the court concluded that a

122. *Id.*

123. *Id.*; see also *Hoover's Dairy, Inc. v. Mid-America Dairymen, Inc.*, 700 S.W.2d 426, 432 (Mo. 1985).

124. *Millard*, 14 S.W.3d at 47; see MO. CODE REGS. ANN. tit. 19, § 30-20.021(3)(C)(5) (1999) (stating, in pertinent part, that on-call surgeons "shall arrive at the hospital within thirty (30) minutes of being summoned"). While this regulation had not been adopted at the time of Mrs. Millard's accident, the court noted that the legislature often acts in response to public sentiment, meaning the social consensus behind the rule could well have existed at the time she was injured. *Millard*, 14 S.W.3d at 47.

125. *Millard*, 14 S.W.3d at 47.

126. *Id.*

127. *Id.*

128. *Id.*

129. *Id.* at 48.

130. *Id.*

reasonably prudent physician would have notified the hospital of his absence.¹³¹ Because of the state regulation governing response time of on-call physicians, the slight burden of preventing harm, and the reasonable foreseeability of risk, the court held that on-call physicians have a duty to notify the hospital of their inability to fulfill on-call duties.¹³²

B. Medical Negligence

In defending Mrs. Millard's medical negligence claim, Dr. Corrado relied on a lack of personal contact with her and asserted that the treatment decisions had been made, including the decision to transfer, before he responded to his pages.¹³³ Acknowledging the lack of hands-on treatment, the court applied *Corbet* to find that existing hospital by-laws imposed a contractual obligation on Dr. Corrado to respond to pages within thirty minutes while on call.¹³⁴ This evidence created a reasonable inference in favor of the Millards that Dr. Corrado was contractually obligated to treat all emergency patients who presented to the emergency room with general surgery requirements while he was on call.¹³⁵

The evidence also showed that a sufficient factual dispute existed between Dr. Corrado's version of his telephone conversation with Dr. Welsh and the contents of the patient history report to preclude summary judgment.¹³⁶ The trial court's finding that Dr. Corrado was unaware of Mrs. Millard's presence at the hospital until she had already been transferred was contradicted by testimony, which included his own.¹³⁷ Because the plaintiffs' uncontroverted evidence of the defendant's duty to treat, via his contractual obligation to the hospital, and the evidence of a genuine dispute regarding the level of Dr. Corrado's participation in her care were both overlooked by the trial court, the court held that summary judgment was inappropriate.¹³⁸

131. *Id.*

132. *Id.*

133. *Id.* at 51-52.

134. *Id.* at 50. In addition to the hospital by-laws, the plaintiffs introduced deposition testimony of hospital employees regarding the policy. *Id.* Dr. Corrado did not present any evidence to rebut the existence of a contractual obligation. *Id.* Examining the case on review of summary judgment, the court accepted all of the plaintiff's evidence as true. *Id.*

135. *Id.*

136. *Id.* at 51.

137. *Id.* at 52.

138. *Id.*

C. Concurring Opinion

Judge Crahan concurred in the court's decision, contending that the plaintiffs established a negligence claim whether or not a doctor-patient relationship existed.¹³⁹ Basing his analysis on Section 324A of the *Restatement (Second) of Torts*, Judge Crahan found that the Millards had satisfied all three elements necessary for recovery.¹⁴⁰ Dr. Corrado agreed to perform on-call services for Audrain Medical Center, in order to benefit prospective emergency room patients.¹⁴¹ He thereafter created a foreseeable risk of harm by allowing the hospital to detrimentally rely on the belief that it had a general surgeon available for emergency calls.¹⁴² Finally, his absence caused a delay in Mrs. Millard's care, thereby increasing the risk of harm.¹⁴³ Under this test, the concurrence held that Dr. Corrado owed a duty of care to Mrs. Millard, which should have prevented him from obtaining summary judgment.¹⁴⁴

V. COMMENT

While common law imposes no duty on doctors to treat patients,¹⁴⁵ hospitals are required to render treatment in emergency situations when the plaintiff can prove he came to the hospital out of reasonable reliance that the hospital afforded emergency care.¹⁴⁶ A competitive hospital, therefore, may hold itself out as providing emergency room care, but it is exposed to negligence liability when

139. *Id.* at 53.

140. *Id.* at 54. The three elements are: (1) failure to exercise reasonable care, thereby increasing the risk of harm, (2) undertaking to perform a duty owed by one to a third person, and (3) reliance by another on the undertaking. See RESTATEMENT (SECOND) OF TORTS § 324A (1965).

141. *Millard v. Corrado*, 14 S.W.3d 42, 54 (Mo. Ct. App. 1999).

142. *Id.*

143. *Id.*

144. *Id.*

145. See *Hurley v. Eddingfield*, 59 N.E. 1058 (Ind. 1901).

146. See *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135 (Del. 1961). "[W]e are of the opinion that liability on the part of a hospital may be predicated on the refusal of service to a patient in case of an unmistakable emergency, if the patient has relied upon a well-established custom of the hospital to render aid in such a case." *Id.* at 140. This ruling is a statement of the undertaking and reliance theory embodied in RESTATEMENT (SECOND) OF TORTS § 323 (1965). See also *Standurf v. Sipes*, 447 S.W.2d 558 (Mo. 1969) (evidence of plaintiff's undertaking and reliance per the rule set forth in *Manlove* is sufficient to bar summary judgment for the hospital).

Common law has been somewhat eclipsed in this area by the enactment of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which imposes certain care requirements on Medicare participating hospitals in emergency situations. See 42 U.S.C. § 1395dd (1994) (enacted to combat "patient dumping" of uninsured patients presenting for emergency care).

a staff physician exercises his or her right to refuse to engage in treatment. The Missouri Code of State Regulations now imposes an affirmative duty on Missouri hospitals to provide emergency room care.¹⁴⁷ Under the regulations, plaintiffs suing a hospital for a failure to provide adequate emergency care can establish an undertaking by the hospital and their reliance thereon as a matter of law; the only elements in dispute are causation and damages. Ensuing sections require hospitals with emergency rooms to maintain a roster of the physicians and surgeons on call.¹⁴⁸ Perhaps recognizing that the regulations exact a more stringent obligation on the hospital than existed under common law, the Missouri State Board of Health responded by imposing additional duties on physicians. Furthermore, the regulations compel on-call surgeons to arrive within thirty minutes of being summoned for an emergency.¹⁴⁹

Dr. Corrado and amici argued that imposing a duty on on-call physicians to notify the hospital when they cannot comply with their on-call duties will have the unwanted social effect of deterring physicians from accepting on-call assignments.¹⁵⁰ In reality, however, hospitals already impose requirements that staff physicians perform on-call services as a matter of course.¹⁵¹ Hospitals now have an affirmative duty to provide emergency care, and most will require, as a condition of granting privileges, that doctors periodically serve on call. Once the physician accepts an on-call assignment, the state imposes a duty to treat under Title 19, Section 30-20.021 of the Missouri Code of State Regulations. While *Millard* opens up new avenues of potential malpractice liability, the current scheme leaves little room for physicians to refuse on-call assignments from their hospital employers.

While hospitals will certainly require that physicians provide emergency on-call services to meet their own legal obligations, it is important to note that the only duty actually imposed on physicians by *Millard* is notice.¹⁵² Specifically, physicians are to warn the hospital of conflicts with on-call schedules. Once the hospital has taken reasonable steps to establish an on-call system, it has arguably fulfilled its duty. If an on-call physician then exercises care to notify the hospital of his unavailability for on-call duty, the burden shifts back to the hospital to provide emergency room coverage. Where the hospital has exercised reasonable care in administering its emergency room procedures,

147. See MO. CODE REGS. ANN. tit. 19, § 30-20.021(3)(C)(1) (1999). This section, relating to emergency services, provides: "Each hospital providing general services to the community shall provide an easily accessible emergency area which shall be equipped and staffed to ensure that ill or injured persons can be promptly assessed and treated or transferred to a facility capable of providing needed specialized services." MO. CODE REGS. ANN. tit. 19, § 30-20.021(3)(C)(1) (1999).

148. See MO. CODE REGS. ANN. tit. 19, § 30-20.021(3)(C)(4)-(5) (1999).

149. See MO. CODE REGS. ANN. tit. 19, § 30-20.021(3)(C)(5) (1999).

150. *Millard v. Corrado*, 14 S.W.3d 42, 48 (Mo. Ct. App. 1999).

151. See *supra* text accompanying note 107.

152. *Millard*, 14 S.W.3d at 48.

but the on-call physician has failed to exercise reasonable care in undertaking his attendant duties, the liability falls on the physician as the party in the best position to prevent the loss.

The elements of Section 324A of the *Restatement (Second) of Torts* are stated in the alternative; a plaintiff need only satisfy one element to state a claim.¹⁵³ Because of the Missouri State Board of Health regulations, both hospitals with an on-call system in place and potential patients can rely on the belief that an on-call surgeon will be available within thirty minutes of being summoned.¹⁵⁴ Therefore, under Section 324A, on-call surgeons in Missouri are de facto liable for any harm caused by more than a thirty-minute delay in care.

It is difficult to predict whether courts will be willing to extend the rules contained in *Millard* beyond its facts. While the court found cases arising in various medical contexts to support its use of Section 324A, the facts of the comparison cases are generally distinguishable from *Millard*. A doctor-patient relationship unquestionably existed in both *DiMarco* and *Miller*,¹⁵⁵ through which a reasonably foreseeable plaintiff, the patient's spouse, had been harmed. Similarly, it is foreseeable that a patient will come to an emergency room expecting a physician to be available to provide care. While the rule of Section 324A could be applied to other factual situations, *Hoover* requires the implication of public policy in addition to the foreseeability of harm, providing a measure of judicial restraint.¹⁵⁶

In order to claim medical negligence against an on-call physician for a failure to treat, plaintiffs must first establish a doctor-patient relationship via the factors from *Schlatter*.¹⁵⁷ Unlike Section 324A, the plaintiff must also prove that the doctor actively consulted in the care.¹⁵⁸ The *Schlatter* test is written in the conjunctive; a plaintiff must satisfy all three elements in order to establish a duty of care by an on-call physician.¹⁵⁹ Once the doctor-patient relationship gives rise to a duty, the plaintiff must prove that the doctor violated the standard of care practiced by the same type of physician in his community.¹⁶⁰ In the case of on-call physicians and the failure to treat, however, the negligent act is removed

153. See *supra* text accompanying note 53.

154. See *supra* note 149.

155. See *supra* notes 61-62.

156. See *Hoover's Dairy, Inc. v. Mid-America Dairymen, Inc.*, 700 S.W.2d 426 (Mo. 1985); see also *supra* text accompanying note 124.

157. See *McKinney v. Schlatter*, 692 N.E.2d 1045 (Ohio Ct. App. 1997); see also *supra* text accompanying note 105.

158. See *supra* text accompanying note 105.

159. See *Schlatter*, 692 N.E.2d at 1050.

160. The elements of a prima facie case for medical malpractice in Missouri include: "(1) an act or omission by the defendant that failed to meet the requisite medical standard of care; (2) the act or omission was performed negligently, and (3) a causal connection between the act or omission and the plaintiff's injury." *Ritter v. BJC Barnes Jewish Christian Health Sys.*, 987 S.W.2d 377, 384 (Mo. Ct. App. 1999).

from the context of medical care entirely. Failure to arrive within thirty minutes of an emergency room call is the breach of the standard of care.

That a regulation may establish a standard of care to be applied in civil claims finds support in the *Restatement (Second) of Torts*.¹⁶¹ Under Section 286, the court may adopt the standards set forth in an administrative regulation as the standard of care, if the purpose of the regulation is at least partly to protect a class of persons to which the plaintiff belongs or to protect the interest that has been harmed against the type of hazard and particular harm that resulted.¹⁶² The purpose of Title 19, Section 30-20.021 of the Missouri Code of State Regulations is to establish “standards for the administration, medical staff, nursing staff and supporting departments to *provide a high level of care*.”¹⁶³ The court in *Shah* might find these terms too “general”¹⁶⁴ to communicate a purpose satisfying the elements of Section 286, but the *Hiser* court would likely interpret them more broadly.¹⁶⁵ Missouri seems to be on the path represented by *Hiser*. Assuming arguendo that the regulation may be accepted as providing a standard of care for on-call physicians, a plaintiff’s result is now the same whether claiming general or medical negligence.

Most of the cases cited by the court that permit a medical negligence action in the absence of personal contact between the doctor and patient rely on the particular language of the hospital by-laws or other regulations in imposing or declining to impose liability.¹⁶⁶ Several courts require language that conveys an express or implied intent for the on-call system to benefit the patient.¹⁶⁷ The *Millard* court is creating a contractual obligation on the part of certain physicians to treat, but plaintiffs with no knowledge of a particular hospital’s by-laws have no means to discern whether they bind an on-call physician to treat. Title 19,

161. See RESTATEMENT (SECOND) OF TORTS § 286 (1965).

162. See RESTATEMENT (SECOND) OF TORTS § 286 (1965).

163. MO. CODE REGS. ANN. tit. 19, § 30-20.021 (1999).

164. See *Ortiz v. Shah*, 905 S.W.2d 609, 611 n.1 (Tex. App. 1995) (finding that by-law provisions stating that surgeons are to actively participate in providing emergency services and requiring twenty-minute response when on call too “general” to establish any duty to patients).

165. See *Hiser v. Randolph*, 617 P.2d 774, 777-78 (Ariz. Ct. App. 1980) (holding that by-laws with the purpose of ensuring that patients “receive the best possible care” are sufficient to impose a duty to treat).

166. *Id.* at 777 (staff by-laws stating purpose of doctors’ organization was to “insure that all patients . . . treated in the Emergency Room receive the best possible care” obligated physician to treat emergency room patient); *Shah*, 905 S.W.2d at 611 (by-law terms requiring on-call physicians to be available within twenty minutes too “general” to establish duty to treat); *Fought v. Solce*, 821 S.W.2d 218, 200 (Tex. App. 1991) (no duty where on-call services are merely voluntary and not governed by by-laws or hospital regulations).

167. See, e.g., *Oja v. Kin*, 581 N.W.2d 739, 744 (Mich. Ct. App. 1998) (“Where the [patient] was not a party to the contract, the [patient] has no right to enforce it unless she can show that [she] was an intended third-party beneficiary.”).

Section 30-20.021 of the Missouri Code of State Regulations fills this gap. On-call surgeons are now bound to arrive at the hospital within thirty minutes of being paged. If a failure to do so results in harm to the patient, a claim for negligence arises under Section 324A of the *Restatement (Second) of Torts*, independent of any facts that establish a doctor-patient relationship. Plaintiffs asserting a medical malpractice claim based on an on-call surgeon's failure to treat have the added burden of proving some level of participation in the patient's care, which would often be sufficient to establish a doctor-patient relationship, even without the added contractual obligation to provide it. Under Section 324A of the *Restatement (Second) of Torts*, a violation of the terms of Title 19, Section 30-20.021 of the Missouri Code of State Regulations that results in harm to the plaintiff is all that is needed to support a claim against an on-call physician, essentially providing a new cause of action for plaintiffs in Missouri. The expanded potential for suits against health care providers will cause malpractice insurers to closely examine policy language to determine if they must provide coverage where a physician is held liable for damages arising in general negligence. In addition to the impact on medical malpractice cases, *Millard* may also cause an increase in litigation between medical malpractice insurance carriers and their physician-insureds.

VI. CONCLUSION

Millard represents a trend to expand the medical professions's duty to render services to the public at large, a trend also seen in recent legislative attempts to overhaul the country's health care finance and access system. Missouri's State Board of Health regulations are just such an attempt and strengthens the application of the principles developed in *Millard*. Like several state courts before it, the *Millard* court has generously extended both general and medical negligence to achieve an equitable result. Giving plaintiffs access to these alternative theories of liability will likely result in more cases being brought against on-call physicians. If an underlying purpose of tort law is to provide a social benefit, it remains to be seen whether *Millard* and similar cases will have the desired effect of providing incentives to doctors and hospitals to provide more efficient and reliable emergency services.

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