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UNLIMITED MEDICAL LIABILITY?

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ABSTRACT

Pursuant to the standard account of the law, physicians only owe special legal duties within the confines of an established treatment relationship. However, this well-accepted adage of black letter medical malpractice law does not, in fact, reflect reality. Indeed, the physician-patient relationship is rarely well-defined, and—perhaps more troublingly—courts have been willing to find liability outside of its boundaries. This Essay scrutinizes the notion that doctors have heightened legal obligations solely to their current patients. It concludes that physicians may be liable for far more conduct than the conventional account implies. It ends by suggesting ways to cabin this potentially unlimited liability.

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INTRODUCTION

According to many health law casebooks,[1] the special relationship[2] between a doctor and her patient is the cornerstone of black-letter medical malpractice law. In theory, it forms the foundation of the physician's legal duties to the people that she treats. And beyond the boundaries of that relationship and other constraints on liability, such as statutes of limitations and repose, those obligations cease. Or so we are told.

However, the reality is far more complex. In many cases, the physician-patient relationship does not have well-defined boundaries, making it unclear when the heightened obligations begin or end. Complicating matters even further, some courts have been willing to find that a treatment relationship is not a prerequisite to liability in the first place. The result is that doctors can be held legally liable for far more conduct than the textbook account lets on.

This Essay interrogates the true role of the physician-patient relationship in medical malpractice liability. It begins by describing the standard account of the treatment relationship as a voluntary, contract-like arrangement between the doctor and patient that forms the foundation for medical malpractice liability. It then turns to the reality of the law, demonstrating how, in some cases, the patient-physician relationship has no obvious beginning or end. And, even more troubling, some jurisdictions have held doctors liable for medical malpractice when no treatment relationship ever existed. The Essay concludes with suggestions for clarifying the boundaries of physicians' special legal duties.

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[1] *See, e.g.*, MARK A. HALL, DAVID ORENTLICHER, MARY ANNE BOBINSKI, NICHOLAS BAGLEY & I. GLENN COHEN, HEALTH CARE LAW AND ETHICS 59 (9th ed. 2018) ("A physician is under no obligation to engage in practice or to accept professional employment, but when the professional services of a physician are accepted by another person for the purposes of medical or surgical treatment, the relation of physician and patient is created. The relation is a consensual one wherein the patient knowingly seeks the assistance of a physician and the physician knowingly accepts him as patient. The relationship between a physician and patient may result from an express or implied contract, either general or special, and the rights and liabilities of the parties thereto are governed by the general law of contract." (quoting Oliver v. Brock, 342 So. 2d 1, 3 (Ala. 1976))); LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW 231 (3d ed. 2016) ("A party does have an affirmative duty to protect another from external threats and can thus be liable for nonfeasance if—by custom, sentiment, and public policy—they share a 'special relationship,' particularly where the plaintiff is in some way dependent on the defendant. Among other examples, . . . doctors owe special duties to their patients").

[2] We refer to this relationship as the treatment relationship or the physician-patient relationship interchangeably throughout.

I. THE FICTION OF THE PHYSICIAN-PATIENT RELATIONSHIP

The common account of the physician-patient relationship holds that it is a prerequisite to medical malpractice liability. It envisions that relationship as either contractual or quasi-contractual, with the parties voluntarily creating their relationship by mutual agreement.[3] The treatment relationship begins when the doctor accepts the patient and ends when the period of care is over or one or both of the parties terminate the relationship.

Generally, there is no right to health care in the United States. Courts have long held that the state does not require a physician to practice at all or to offer services on terms that she deems unacceptable.[4] Thus, doctors typically have no duty to treat a potential new patient who comes to them seeking care. They can turn someone away for almost any reason or even no reason at all.[5] And—by the conventional account that is the subject of this Essay—absent a treatment relationship, the doctor has no obligation to the prospective patient other than the very limited duty of care that strangers owe to one another in tort law.[6]

The duration of the treatment relationship depends on the nature of the medical services provided.[7] Some types of care are episodic—like a trip to the emergency room—and stop when the medical issue resolves. For example, a patient might go to the ER with an acute case of food poisoning that passes within a day. Once the ER doctor has performed her services, the episode of care is (at least in theory) over, and the doctor has no further obligations to the patient.

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[3] Findlay v. Bd. of Supervisors of Mohave Cnty., 230 P.2d 526, 531 (Ariz. 1951); Agnew v. Parks, 343 P.2d 118, 123 (Cal. Ct. App. 1959); Hankerson v. Thomas, 148 A.2d 583, 584 (D.C. 1959); Newmyer v. Sidwell Friends Sch., 128 A.3d 1023, 1034 (D.C. 2015).

[4] *See, e.g.*, Hurley v. Eddingfield, 59 N.E. 1058, 1058 (Ind. 1901).

[5] The major exceptions to this general rule are the Emergency Medical Treatment and Active Labor Act, which requires certain facilities to screen and stabilize people seeking emergency care, and various antidiscrimination protections that prevent providers from rejecting patients based on attributes like race, sex, age, or disability. *See* 42 U.S.C. § 18116.

[6] Collective Asset Partners LLC v. Schaumburg, 432 S.W.3d 435, 440–41 (Tex. App. 2014) (noting that the threshold question in a negligence case is whether a duty is owed and that the claimant has the burden to demonstrate both the requirement of and breach of a duty owed to the claimant); *see also* Jackson v. City of Joliet, 715 F.2d 1200, 1202 (7th Cir. 1983); Susan Hoffman, Note, *Statutes Establishing a Duty to Report Crimes or Render Assistance to Strangers: Making Apathy Criminal*, 72 KY. L.J. 827, 829 (1984).

[7] Burnett v. Layman, 181 S.W. 157, 158 (Tenn. 1915) ("It is well settled that a physician who undertakes the treatment of a case may not abandon his patient until in his judgment the facts justify the cessation of attention, unless he give [sic] to the patient due notice that he intends to quit the case and affords the patient opportunity to procure other medical attendance.").

While some care is acute or episodic, a significant amount of medical practice is ongoing, like primary care or treatment for a chronic condition. In cases when the period of care has no clear end, one or both parties could terminate the relationship. Patients can end the treatment relationship on a whim. For example, a patient may decide that she no longer wishes to see a particular doctor and never return.[8] However, given the power imbalance between physicians and their patients, laws and professional guidance hold physicians to a higher standard. To unilaterally terminate the treatment relationship, physicians must provide "reasonable notice" in writing, to enable patients to seek substitute care.[9] And even that might not be enough.[10] Some states, like Iowa, require a physician to "ensure that emergency medical care is available to the patient during the 30-day period following notice of the termination of the physician-patient relationship."[11] However, if the patient is not in immediate need of medical attention, supplying the patient with a list of replacement physicians may be an acceptable way to sever the relationship.[12]

Once a physician accepts a patient—by examining, diagnosing, or treating her—a treatment relationship forms. In at least some jurisdictions, the formation of this relationship transforms the doctor from a legal stranger who owes the prospective patient no special legal obligation to the newly accepted patient's fiduciary.[13] This newly formed relationship gives rise to duties, including the duty to continue treatment[14] and the duty to meet the accepted standard of care[15] (including to make the appropriate disclosures).[16] These duties can give rise to tort liability for abandonment or malpractice, respectively.

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8 Laura Hale Brockway, *Terminating Patient Relationships: How to Dismiss Without Abandoning*, TEX. MED. LIAB. TR. (Mar. 17, 2021), https://hub.tmlt.org/tmlt-blog/terminating-patient-relationships-how-to-dismiss-without-abandoning.

9 *See, e.g.*, Grant v. Douglas Women's Clinic, P.C., 580 S.E.2d 532, 534 (Ga. App. 2003).

10 *See, e.g.*, Payton v. Weave, 182 Cal. Rptr. 225 (Ct. App. 1982).

11 IOWA ADMIN. CODE r. 653-13.7 (147, 148, 272C) (2021).

12 Hill v. Medlantic Health Care Grp., 933 A.2d 314, 329 (D.C. 2007).

13 *See* D.A.B. v. Brown, 570 N.W.2d 168, 171–72 (Minn. Ct. App. 1997); (noting states that have broadly rejected fiduciary duties for physicians, including Minnesota and Delaware).

14 C.T. Drechsler, Annotation, *Liability of Physician Who Abandons a Case*, 57 A.L.R.2d 432 § 4 (1958).

15 *See* Peter Moffett & Gregory Moore, *The Standard of Care: Legal History and Definition: The Bad and Good News*, 12 W.J. EMERGENCY MED. 109, 109 (Feb. 2011); Texas & Pac. Ry. v. Behymer, 189 U.S. 468, 470 (1903).

16 JESSICA W. BERG, PAUL S. APPELBAUM, CHARLES W. LIDZ & LISA S. PARKER, INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 140 (2d ed. 2001).

II. THE REALITIES OF THE PHYSICIAN-PATIENT RELATIONSHIP

While the standard account holds that a treatment relationship is what triggers a doctor's heightened legal duties,[17] the reality of when a physician has special obligations is much hazier.

To start, it may be unclear what kind of conduct establishes the patient-physician relationship in the first place. For example, one court held that an on-call urologist, who consulted with an ER doctor about a patient who had a urinary tract infection and a kidney stone, had established a treatment relationship, despite never seeing the patient.[18] Courts are currently split as to whether providing a consultation to a treating physician gives rise to a duty.[19] And, in some jurisdictions, simply providing advice to someone the patient knows might be sufficient to start a treatment relationship. One case went to trial after a woman called her personal physician, seeking advice about her husband's health.[20] While the doctor had no direct contact with the patient's husband, the trial court nevertheless found that whether a treatment relationship existed was a question of fact that hinged on the content of the telephone call.[21]

The ending of a treatment relationship may be as hazy as its beginning. At least one court has been willing to establish time restrictions—five years of no contact—after which the parties must reestablish their relationship, as opposed to simply continuing it.[22] But a court in a different jurisdiction has noted that a physician "cannot discharge a case and relieve himself of responsibility for it, by simply staying away without notice to the patient."[23] Courts have observed that physicians who become aware of risks years after the treatment could still be required to notify the patient when the risks become known.[24] And many genetics labs are reinterpreting test results to reflect the most current knowledge of genetic science. These reinterpreted results can change a patient's risk profile.

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17 *See supra* note 1 and accompanying text.

18 Mackey v. Sarroca, 35 N.E.3d 631, 640 (Ill. App. Ct. 2015).

19 *See* Diggs v. Ariz. Cardiologists, Ltd., 8 P.3d 386, 388–89 (Ariz. Ct. App. 2000) (discussing split in authority); Kelley v. Middle Tenn. Emergency Physicians, P.C., 133 S.W.3d 587, 593–94 (Tenn. 2004) (surveying the split among courts).

20 Bienz v. Cent. Suffolk Hosp., 557 N.Y.S.2d 139, 139 (App. Div.1990).

21 *Id.*

22 O'Donnell v. Siegel, 854 N.Y.S.2d 45, 47–48 (App. Div. 2008).

23 Bolles v. Kinton, 263 P. 26, 27 (Colo. 1928).

24 *See, e.g.*, Mink v. Univ. of Chi., 460 F. Supp 713, 720 (N.D. Ill. 1978). *But see* Alasdair G. W. Hunter, Neil Sharpe, Michelle Mullen & Wendy S. Meschino, *Ethical, Legal, and Practical Concerns about Recontacting Patients to Inform Them of New Information: The Case in Medical Genetics*, 103 AM. J. MED. GENET. 265, 271 (2001).

Doctors who receive these updated results could potentially have a legal obligation to make a reasonable effort to recontact patients.[25]

While courts may find a treatment relationship existed even when the physician had not intended to establish one, many jurisdictions follow the conventional approach and require a patient-physician relationship for establishing medical malpractice liability.[26] What may be more surprising is that, in other jurisdictions, liability requires no such relationship—past or present—at all.[27] In 2019, the Minnesota Supreme Court held that a doctor could be held liable for medical malpractice even if she had never accepted the patient. In that case, a hospitalist denied a patient admission over the phone after the patient presented at a clinic with abdominal pain, fever, chills, and unusually high levels of white blood cells.[28] The patient was found dead in her home three days later from sepsis caused by an untreated staph infection.[29] The court did not find a physician-patient relationship between the hospitalist and the patient, but nevertheless the court held the hospitalist liable for medical malpractice, stating that they had "never held that such a relationship is necessary to maintain a malpractice action under Minnesota law."[30] They focused instead on "foreseeability of harm to a particular third party, without regard to the existence of a physician-patient relationship."[31] The court noted that while the position is a minority view, it is hardly unique among the states.[32]

While this Essay takes the decision at face value—that a treatment relationship is not necessarily a prerequisite to medical malpractice liability—

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[25] *See* Jessica L. Roberts & Alexandra L. Foulkes, *Genetic Duties*, 62 WM. & MARY L. REV. 143, 148–49 (2020).

[26] *See, e.g.*, *Siwa v. Koch,* 902 N.E.2d 1173 (Ill. App. Ct. 2009), *appeal denied*, 910 N.E.2d 1133 (Ill. 2009).

[27] Warren v. Dinter, 926 N.W.2d 370, 375 (Minn. 2019).

[28] *Id.* at 372.

[29] *Id.* at 373.

[30] *Id.* at 375.

[31] *Id*. at 376.

[32] *Id.* at 377 (first citing Ritchie v. Krasner, 211 P.3d 1272, 1279 (Ariz. Ct. App. 2009) ("A duty may arise even in the absence of a formal relationship."); then citing Plowman v. Fort Madison Cmty. Hosp., 896 N.W.2d 393, 401 (Iowa 2017) ("Although this contractual physician-patient relationship is sufficient to establish a duty, it is not required.") (citation omitted); then citing Horton v. Or. Health & Sci. Univ., 373 P.3d 1158, 1162 (Or. Ct. App. 2016) ("We begin with, and quickly dispose of, defendants' contention that a medical-malpractice claim must always be premised on the existence of a special status—that is, a physician-patient relationship—between the plaintiff and the defendant. We have repeatedly rejected that argument . . ."); and then citing Oblachinski v. Reynolds, 706 S.E.2d 844, 846 (S.C. 2011) ("However, a doctor-patient relationship is not required in every legal action against a medical provider. Limited circumstances exist where a reasonably foreseeable third party can maintain a suit against a physician for malpractice.")).

the court could have decided this case differently. Specifically, it could have held that a patient-physician relationship existed for the limited purpose of deciding whether emergency treatment was necessary.

Regardless, in the above case, the hospitalist was at least involved in decisions bearing on the patient's ultimate medical outcome. However, courts have recognized duties to warn non-patient third parties in certain contexts. For example, in the infamous case *Tarasoff v. Regents of the University of California*, the court held that mental health professionals have a duty to warn third parties of potential violence.[33] Courts have likewise found duties to warn third parties of disease risk,[34] including when the condition was not contagious.[35]

While threats of violence and disease are time-sensitive, courts have recognized duties to warn of decades-old risks. In a 1999 federal district court case, almost twenty years after a physician had allegedly failed to warn the plaintiff, the court found a duty to warn. Notably, that doctor had never seen the plaintiff as a patient.[36] A man received radiation treatment as a child in the 1940s and later developed a neural tumor.[37] In 1996, as an adult man living in a different state, he sued the physician who initiated a research program investigating the treatment in 1977.[38] Even though the doctor had attempted to recruit the patient into the study in the 1980s, that recruitment effort did not satisfy the duty to warn.[39] The court held that the physician in charge of a research program that uncovered the dangers associated with the treatments—who never actually saw the patient—had a duty to warn him of the risks.[40]

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[33] Tarasoff v. Regents of the Univ. of Cal., 551 P.2d. 334, 353 (Cal. 1976).

[34] Jones v. Stanko, 160 N.E. 456, 458 (Ohio 1928). *But see* Hunter, Sharpe, Mullen & Meschino, *supra* note 24, at 269.

[35] One state supreme court held a physician liable for failing to warn a patient's wife of her risk of Rocky Mountain Fever. Although the disease is transmitted by the bite of an infected tick and not passed person-to-person, the court reasoned that the doctor should have known that the patient's spouse was exposed to the same conditions and thus in danger of contracting the disease. *See* Bradshaw v. Daniel, 854 S.W.2d 864, 872–73 (Tenn. 1993).

[36] Blaz v. Michael Reese Hosp. Found., 74 F. Supp. 2d 803, 804 (N.D. Ill. 1999).

[37] *Id.*

[38] *Id.*

[39] *Id.*

[40] *Id.* at 806–07 (reasoning that the physician's role of contacting patients to potentially participate in the research program "created the sort of 'special relationship' the Illinois Supreme Court requires for a finding of duty in the absence of a physician-patient relationship" (citing Kirk v. Michael Reese Hosp., 513 N.E.2d 387, 399 (Ill. 1987))).

In the following Part, we consider what this expansive and ambiguous scope of potential liability means for doctors and for their patients and propose ways to better define the boundaries of medical malpractice liability.

III. LIMITING THE PHYSICIAN-PATIENT RELATIONSHIP

Whether a treatment relationship exists may not always be apparent, and courts have extended malpractice liability beyond the borders of that relationship. Misunderstandings, inaccurate expectations, and poorly defined boundaries around the patient-physician relationship and its obligations could have negative implications for doctors and patients alike. Physicians may not be able to anticipate when they could be held liable and to whom. Uncertainty has notorious chilling effects.[41] Doctors may worry that any time they offer their expertise—even in passing—they could be subject to medical malpractice liability. Their hesitation could perhaps even lead them to accept fewer patients. This rational physician behavior could harm patients, who will lose the benefit of those additional medical opinions, as well as physicians, who will be deprived of the benefits of informal consultation. And, should a doctor be sued, the litigation will take time and attention away from the physician's medical practice, leading to diminished quality of care.[42]

Providing clarity around the patient-physician relationship and its related legal obligations will not render patients without legal recourse. In the case in which the hospitalist rejected the patient, the doctor was perhaps the most logical person to sue for the potentially negligent decision not to admit her. As noted, despite the court's reasoning, that physician arguably *did* have a treatment relationship with that patient, even if the physician ultimately decided against admission. Thus, the court could have found a limited relationship over that brief period of care. Furthermore, suing an individual doctor is but one way to allow patients to recover. They can also sue institutions, like hospitals.[43] And, in cases when there truly is no heightened duty of care, plaintiffs can still sue for ordinary negligence.

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[41] *See* Gerrit De Geest, *Who Should Be Immune from Tort Liability?*, 41 J. LEG. STUD. 291, 305 (2012).

[42] *See, e.g.*, Sara C. Charles, Charlene E. Pyskoty & Amy Nelson, *Physicians on Trial—Self-Reported Reactions to Malpractice Trials*, 148 W.J. MED. 358, 359–60 (1988); Sara C. Charles, Jeffrey R. Wilbert & Kevin J. Franke, *Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation*, 142 AM. J. PSYCHIATRY 437, 440 (1985).

[43] For cases of institutional liability, hospitals could have systems in place for when physicians leave. *See* FRANK A. SLOAN, PENNY B. GITHENS, ELLEN WRIGHT CLAYTON, GERALD B. HICKSON, DOUGLAS A. GENTILE & DAVID F. PARTLETT, SUING FOR MEDICAL MALPRACTICE 100–06 (1993).

As a practical matter, one might question why the treatment relationship and its obligations need redefining in the first place. After all, other limits exist on physician liability, like statutes of limitation[44] and repose.[45] Relying on these types of provisions to limit liability is not sufficient to address the ambiguity of the treatment relationship. As noted, medical malpractice is a form of professional negligence. While statutes of limitations and repose speak to when a patient may file a claim, they have no bearing on the standard by which a court will evaluate the alleged negligence. A physician who has not accepted a patient or believes that a treatment relationship has lapsed will not be on notice that these increased obligations apply.

This Part offers three potential ways to counteract the potentially unlimited liability of the current system.

A. *Defining the Treatment Relationship*

Better defining the contours of the treatment relationship could provide physicians with greater clarity about their potential legal liability, thus allowing them to focus on their current patients. We consider two ways of achieving this end: (1) physician-generated practices and (2) legislative interventions.

1. *Setting Expectations*

Even in the absence of well-defined legal boundaries, doctors can explicitly define the scope of the treatment relationship and their accompanying obligations. Recall that the patient-physician relationship begins when the doctor accepts the patient. When a patient first schedules an appointment, the provider could use that as an opportunity to clearly define the boundaries of the relationship that will result as part of the intake process. For example, a doctor might inform the patient that she is accepting the patient to provide a particular kind of care, like family medicine, or to treat a particular condition. The physician could further specify that she will act as the patient's fiduciary during the period of care and include limits, such as telling the patient that if she does not see her for a specified amount of time, the doctor will assume that their relationship has ended. Some institutions already have policies that require

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[44] *See, e.g.*, TEX. CIV. PRAC. & REM. CODE ANN. § 74.251(a) (West 2003); Molinet v. Kimbrell, 356 S.W.3d 407, 409 (Tex. 2011).

[45] *See, e.g.*, CIV. PRAC. & REM. § 74.251(b); *Molinet*, 356 S.W.3d at 411 (quoting CIV. PRAC. & REM. § 74.251(b)); Methodist Healthcare Sys. of San Antonio, Ltd. v. Rankin, 307 S.W.3d 283, 285 (Tex. 2010) (quoting CIV. PRAC. & REM. § 74.251(b)).

patients to file new patient paperwork and wait in a queue for an available physician if they return after being away for a certain amount of time. This is consistent with Medicare's policy of allowing physicians to bill for new patient evaluations after not having seen a patient for at least three years.[46] Informing patients before treatment begins of the limits on the relationship reflects the "quasi-contractual" nature of the patient-physician relationship. The patient will have a clear notion of the "terms" of the relationship and will be able to make an educated decision about whether to see that doctor. Of course, we realize that this kind of expectation-setting will not always be possible, such as in the context of emergencies, and that patients will not always be able to seek alternate providers.

However, in jurisdictions that do not require a physician-patient relationship as a condition precedent to medical malpractice claims, such precautions will likely do little to curtail liability.

2. Statutory Solutions

State statutes and regulations could also cabin medical malpractice liability. Existing laws already limit the scope of the treatment relationship. For example, many states identify activities that do not give rise to a physician-patient relationship, such as independent medical evaluations (e.g., for evaluation of work disability).[47] Legislatures could also adopt a clearer endpoint to the treatment relationship for liability purposes, such as assuming the relationship has ended if the doctor has not seen the patient for a statutorily determined amount of time. And, finally, in jurisdictions that do not already, states could explicitly make a treatment relationship a prerequisite to heightened duties of care.

Immunity could also offer a potential solution. A Virginia statute provides immunity from civil liability for physicians who fail "to review, or take action in response to the receipt of, a report containing the results of a laboratory test or examination conducted 'not at the request or with the written authorization of

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[46] *See* CTRS. FOR MEDICARE & MEDICAID SERVS., EVALUATION AND MANAGEMENT SERVICES GUIDE 6 (2022), https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdfs; *see also* Lori Cox, *New vs. Established Patients: Who's New to You?*, AAPC (Mar. 1, 2018), https://www.aapc.com/blog/41276-new-vs-established-patients-whos-new-to-you/.

[47] *See, e.g.*, Kirk v. Anderson, 496 P.3d 66, 72 (Utah 2021); Smith v. Radecki, 238 P.3d 111, 114–15 (Alaska 2010); Joseph v. McCann, 147 P.3d 547, 551 (Utah Ct. App. 2006).

a physician.'"[48] A successful immunity defense under this provision has four elements. The physician must establish that: (1) no treatment relationship existed at the time the results were received or accessed; (2) there was no request for consultation or responsibility for managing the patient's health related to the results; (3) the physician consulted on a specific condition, the results did not bear on the physician's management of the patient, and the physician had no reason to inform the patient of the results or to refer the patient to another doctor; and, (4) interpreting the results would have exceeded the physician's scope of practice and the physician had no reason to inform or refer the patient.[49]

This kind of protection could provide some insulation against liability for medical malpractice liability, but it would be a highly fact-intensive inquiry. For instance, imagine that after a routine physical, a patient's family doctor refers her to a cardiologist for an irregular heartbeat. The cardiologist suspects a possible genetic cause and sends the patient to a geneticist, who sees the patient and orders genetic testing using a panel of genes related to heart disease. At the time of the testing, all three physicians would have a treatment relationship with the patient and would bear some responsibility for her health. Now imagine that the patient changes family doctors and goes to her new physician with an upper respiratory infection. While the genetic test results might be in the patient's health record, her current family doctor could be immune from liability related to the genetic testing. That physician was not treating the patient when the patient received the results; the patient did not request a consultation, and given the involvement of a treating cardiologist, the family doctor was not obligated to manage the heart condition.

B. Eliminating Obligations to Non-Patients

The duty to warn third parties expands liability beyond the treatment relationship. Thus, one option would be to limit or even do away with this doctrine, either through the courts[50] or legislation.[51] Importantly, not all

48 *See* Oraee v. Breeding, 621 S.E.2d 48, 49 (Va. 2005) (interpreting VA. CODE ANN. § 8.01-581.18(A) (1993)).

49 VA. CODE ANN. § 8.01-581.18:1(A) (2006).

50 *See, e.g.*, Thapar v. Zezulka, 994 S.W.2d 635, 638 (Tex. 1999) (finding that a psychiatrist had no common-law duty to warn a victim, even though the patient admitted that he felt like killing the victim).

51 In *Safer v. Estate of Pack,* a New Jersey court found that a physician has a duty to warn those known to be at risk of a genetic disorder and that such a duty may not be satisfied by warning the patient. 677 A.2d 1188, 1192 (N.J. Super. Ct. App. Div. 1996). However, New Jersey effectively overturned this holding through subsequent legislation limiting the disclosure of identifiable genetic information. *See* N.J. STAT. 10:5-47 (1996).

jurisdictions recognize a duty to warn third parties in the first place.[52] Some jurisdictions already limit the scope of this doctrine,[53] and scholars have been critical of it since its inception.[54]

However, we should not eliminate a physician's obligation to disclose risks entirely. The duty to warn serves an important function. Patients lack knowledge and expertise and rely on their doctors to convey crucial, health-related information. Thus, courts and legislatures could only recognize obligations to disclose risk to patients—or perhaps even *former* patients.

The duty to warn makes the most sense in the context of actionable risk information, like disclosures about infectious diseases or genetics. Specifying that doctors have no duty to warn individuals who were never patients ensures that patients are informed without subjecting physicians to unanticipated liability. It is worth noting that, even if the law no longer recognizes a duty to warn, doctors could still have ethical obligations to disclose certain kinds of risks, depending on the circumstances.

CONCLUSION

By the textbook account, the treatment relationship is the foundation of a doctor's heightened duties. But this well-accepted adage fails to reflect the reality of medical malpractice liability. It is unclear when the physician-patient relationship begins, when it ends, or even whether it is a precursor to liability in the first place. This Essay has exposed the disconnect between the law in theory and the law in practice.

The ambiguity surrounding the boundaries of the patient-physician relationship can have a negative impact on both doctors and patients. While it may seem appealing to rely on other kinds of limits on medical malpractice liability, like statutes of limitations and repose, those protections ultimately fall short. The treatment relationship and its associated obligations require rethinking.

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[52] *See Thapar*, 994 S.W.2d at 638.

[53] *See, e.g.*, CAL. CIV. CODE § 43.92 (West 2013); COLO. REV. STAT. § 13-21-117 (2019); LA. STAT. ANN. § 9:2800.2 (2010); MINN. STAT. §§ 148.975–.976 (2015); WASH. REV. CODE. § 71.05.120(2) (2020).

[54] Toni Pryor Wise, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of* Tarasoff, 31 STAN. L. REV. 165, 165–67 (1978); Ahmad Adi & Mohammad Mathbout, *The Duty to Protect: Four Decades After* Tarasoff, AM. J. PSYCHIATRY RESIDENTS' J. 6, 6–7 (2018); Griffin Edwards, *Doing Their Duty: An Empirical Analysis of the Unintended Effect of* Tarasoff v. Regents *on Homicidal Activity*, 57 J.L. & ECON. 321, 322 (2014).

Better clarity and limits on liability are a good start. Physicians may wish to take it into their own hands to clarify the scope and duration of the treatment relationship at the outset. However, they may be hesitant to do so because of their loyalty to their patients. Instead, lawmakers could intervene. For instance, legislatures could adopt immunity in certain contexts. Courts and legislatures could rethink the duty to warn and only require physicians to make reasonable efforts to convey known risks to their current—and, perhaps in certain contexts, former—patients. These changes could insulate doctors from potentially unlimited liability, allowing them to focus their attention on practicing medicine.