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COMMENTS

EASING THE MEDICAL MALPRACTICE CRISIS: RESTRICTING THE CREATION OF DUTY THROUGH AN IMPLIED DOCTOR-PATIENT RELATIONSHIP

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I. INTRODUCTION

As doctors in regions throughout the country are forced to abandon their practices,[1] medical malpractice liability issues have reached the forefront of national debate. Noting this trend, many commentators claim that physicians and the health care sector are in a crisis.[2] At the heart of this controversy are rising malpractice insurance premiums. The soaring price of insurance has raised the cost of medical practice to prohibitive levels.[3] Unable to pay for coverage, many

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1. *See, e.g., Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care: Testimony Before the Senate Subcomm. On Labor, Health and Human Servs., Comm. on Appropriations,* 108th Cong. (2003) (Statement of Claude A. Allen, Deputy Secretary, U.S. Dept. of Health and Human Servs.) (noting physicians are relocating to states with lower premiums), *available at* http://www.hhs.gov/asl/testify/t030313.html (last revised Mar. 14, 2003) [hereinafter *Addressing the New Health Care Crisis*]; MIMI MARCHEV, NAT'L ACAD. FOR STATE HEALTH POLICY, THE MEDICAL MALPRACTICE INSURANCE CRISIS: *OPPORTUNITY FOR STATE ACTION* 1 (2002), *available at* http://www.nashp.org/Files/gnl48_medical_malpractice.pdf (last visited June 19, 2004) (noting reports of doctors retiring or moving to other states); Edward Hudgins, *Doctors Shrug*, WASH. TIMES, Jan. 12, 2003, at B3 (stating that many physicians are quitting their practices), *available at* 2003 WL 7703906; Francis X. Clines, *Insurance-Squeezed Doctors Fold Their Tents*, N.Y. TIMES, June 13, 2002, at A24 (quoting Dr. Ahmed D. Faheen, "Practically every day, doctors are leaving.").

2. *E.g., Addressing the New Health Care Crisis*, *supra* note 1 (asserting that the medical liability crisis is about patients, rather than about doctors, hospitals, or insurance companies); Karen A. Miller, *Confluence Of Technology, Safety Costs, Insurance and Economy has Produced a Health Care "Perfect Storm,"* ALLENTOWN MORNING CALL, Mar. 28, 2004, at D1 (claiming Pennsylvania's health care system is facing a crisis), *available at* 2004 WL 74199196; Joanne Huist Smith & Kevin Lamb, *Women's Health-Care Crisis Looms*, DAYTON DAILY NEWS, June 23, 2002 (noting doctors who fear health care for women in the Miami Valley will reach a crisis within one year), *available at* http://www.consumerwatchdog.org/healthcare/nw/nw002523.php3 (last visited June 19, 2004).

3. *See, e.g.*, Hudgins, *supra* note 1 (noting physicians who have seen the costs of medical malpractice skyrocket); Miller, *supra* note 2 (exploring the issues behind the "skyrocketing cost of medical liability insurance"); Smith & Lamb, *supra* note 2 (citing increases of insurance rates by 20 to 30 percent in 2000, 37 to 200 percent in 2002, and 60 percent for 2003).

doctors must leave the profession.[4] While the hemorrhage continues, groups bitterly dispute the cause of the spiking premiums.[5]

Recent case law may impact the malpractice debate. In a case of first impression, the Maryland Court of Special Appeals held in *Sterling v. Johns Hopkins Hospital* that an implied physician-patient relationship is not created in a transfer situation when the treating doctor remains free to exercise his own judgment and diagnosis is complete at the time of the consultation.[6] The *Sterling* decision respects the historical bases of medical malpractice jurisprudence while limiting the creation of a doctor-patient relationship in a transfer situation. Restricting duty through an implied physician-patient relationship will limit the malpractice liability of physicians in Maryland, consistent with public policy objectives to maintain affordable malpractice insurance premiums. Thus, situations exposing doctors to liability diminish, causing the number of successful malpractice claims to decrease, and malpractice premiums to decline.

II. LEGAL BACKGROUND

Hybrid Tort/Contract Theory and the Elements of a Medical Malpractice Claim

Originally, "medical malpractice was recognized as a legal wrong before the rise of negligence as a separate tort and the development of modern contract principles,"[7] but today it is somewhat of a hybrid of contract and tort theories.[8] The bedrock assumption of each theory of liability, however, is that a relationship exists between the physician and the patient at the time of the injury.[9] This relationship may arise from either an express or implied contract.[10] In a contract for medical services, similar to other contexts, a physician has the right to enter into a consensual relationship with another party of his choosing for mutual

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4. *See, e.g., Addressing the New Health Care Crisis*, *supra* note 1 (noting doctors leaving states like Nevada, Mississippi, Pennsylvania, West Virginia, and Florida); Hudgins, *supra* note 1 (asserting that physicians are leaving the profession); Clines, *supra* note 1 (citing instances of doctors leaving problem states like West Virginia, New Jersey, Florida, Nevada and Pennsylvania).

5. *See* MARCHEV, *supra* note 1, at 5-6 (noting conflicting reports by insurance advocates, consumer advocates and governmental entities regarding the amounts and causes of rising premiums); Miller, *supra* note 2 (listing six factors contributing to the rise in premiums); Smith & Lamb, *supra* note 2 (citing conflicting reports from consumer groups and insurance groups).

6. 802 A.2d 440, 459 (Md. Ct. Spec. App. 2002).

7. Corbet v. McKinney, 980 S.W.2d 166, 169 (Mo. Ct. App. 1998) (quoting 1 LOUISELL & WILLIAMS, MEDICAL MALPRACTICE, § 8.01 at 8-3 (1998)).

8. *See* Dingle v. Belin, 749 A.2d 157, 164 (Md. 2000) (cautioning, however, that care must be taken to keep tort and contract claims separate).

9. James L. Rigelhaupt, Annotation, *What Constitutes Physician-Patient Relationships for Malpractice Purposes*, 17 A.L.R. 4th 132, 135-36 (1982).

10. *Id.* The contractual element between the parties is based on the doctor's promise to "treat the patient with proper professional skill and the patient will pay for such treatment." *Id.*

benefit.[11] A doctor (or patient) may define the terms of employment, and is *not required* to accept any individual into his care.[12] Most simply, a contractual obligation is created when the doctor voluntarily accepts the patient, and subsequently breaches the contract which gives rise to a cause of action.[13] Proceeding under a purely contractual theory, however, does not involve investigation of the doctor's negligence.[14] Here, the only question is whether the doctor's performance produced the results promised.[15] As a result, the contractual approach is not appropriate in all situations.[16]

Although triggered when a contractual relationship has been created, duty emanates from "[t]he duty of a physician or surgeon to bring skill and care to the amelioration of the condition" and "has its foundation in public considerations that are inseparable from the nature and exercise of his calling."[17] As embodied in the Hippocratic Oath,[18] the medical profession mandates that a physician care for his patients. Courts have found that this obligation creates a fiduciary relationship.[19] It is a fiduciary relationship because "[t]he very basis of this affinity is the notion that the physician is learned, skillful, and experienced in an area of which the patient knows little, but which is of the most vital importance to him."[20] Therefore, the nature of the relationship involves something more than mere contractual rights. Thus, modern medical malpractice theory has developed as a hybrid, incorporating elements of both tort and contract theory.

Writing for the Maryland Court of Appeals in *Dingle v. Belin*, Judge Wilner best canvassed the background of the contract/tort hybrid theory.[21] In his

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11. *See* DAVID M. HARNEY, MEDICAL MALPRACTICE 8 (1973) (noting that patients also have a general liberty to contract).

12. Sharon M. Glenn, *Liability in the Absence of a Traditional Physician-Patient Relationship: What Every "On-Call" Doctor Should Know: Mozingo v. Pitt County Memorial Hospital*, 28 WAKE FOREST L. REV. 747, 753 (1993).

13. HARNEY, *supra* note 11, at 8.

14. HARNEY, *supra* note 11, at 8. For this reason, proceeding under a contract claim is preferred over negligence theory. The doctor may have performed the work to standard, but may not have completed the procedure in the manner in which the contracting parties had agreed. Further, "the contract approach, where available, is sometimes chosen over a tort action because of the longer statutory period during which the action may be commenced." HARNEY, *supra* note 11, at 8.

15. HARNEY, *supra* note 11, at 8. (noting that a patient was allowed to recover under a contractual theory when a dentist installed artificial plates in the plaintiff's mouth that did not meet his satisfaction).

16. *See* HARNEY, *supra* note 11, at 8.

17. Rigelhaupt, *supra* note 9, at 136.

18. MILLER-KEANE ENCYCLOPEDIA & DICTIONARY OF MEDICINE, NURSING, & ALLIED HEALTH 694 (5th ed. 1992) (Hippocratic Oath stating "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone....In every house where I come I will enter only for the good of my patients....").

19. Lockett v. Goodill, 430 P.2d 589, 591 (Wash. 1967).

20. HARNEY, *supra* note 11, at 6-7.

21. 749 A.2d 157, 164 (Md. 2000).

opinion, he illustrated how Maryland has approached medical malpractice claims, stating:

> We have long recognized, as have most courts, that, except in those unusual circumstances when a doctor acts gratuitously or in an emergency situation, recovery for malpractice 'is allowed only where there is a relationship of doctor and patient as a result of a contract, express or implied, that the doctor will treat the patient with proper professional skill and the patient will pay for such treatment, and there has been a breach of professional duty to the patient.'[22]

Furthermore, Judge Wilner highlighted the nexus between tort and contract liability theory in Maryland, noting "the relationship that spawns the malpractice claim is thus ordinarily a contractual one."[23] However, tort theory is often used instead of contract theory because greater damages, usually for pain and suffering, are ordinarily available.[24] Nevertheless, Judge Wilner pointed out that "malpractice actions have traditionally been tort-based, the tort arising from the underlying contractual relationship."[25] In other words, "a duty of care for the treatment of an injured party does not arise unless the doctor has expressly or impliedly accepted that person as his patient."[26]

Notwithstanding the contractual theory of recovery, most medical malpractice claims are founded in tort law.[27] As a result, the elements of the general negligence case apply in the context of Maryland medical malpractice litigation.[28] The prima facie case for negligence requires: "(1) that the defendant was under a duty[29] to protect the plaintiff from injury, (2) that the defendant breached that duty, (3) that the plaintiff suffered actual injury or loss, and (4) that the loss or injury proximately resulted from the defendant's breach of the duty."[30] In all negligence suits as well as those involving medical malpractice claims, duty

22. *Id.* (quoting Hoover v. Williamson, 203 A.2d 861, 862 (Md. 1964)).

23. *Id.*

24. *Id.*

25. *Id.* (citing Schaefer v. Miller, 587 A.2d 491 (Md. 1991)).

26. Glenn, *supra* note 12, at 753.

27. Glenn, *supra* note 12, at 757.

28. Shilkret v. Annapolis Emergency Hosp. Ass'n, 349 A.2d 245, 247 (Md. 1975).

29. As to the duty element, "United States law, with a few exceptions, does not require one person to act affirmatively to assist another. Once a person acts, however, he is under a legal duty to act in a reasonably prudent manner. Thus, even though physicians have no legal duty to counsel their patients...the physician who undertakes to counsel a patient owes a duty to do so non-negligently." Frederick A. Paola, *Physicians, Firearm Counseling, and Legal Liability*, 94 S. MED. J. 88, 88 (2001).

30. Grimes v. Kennedy Krieger Inst., Inc., 782 A.2d 807, 841 (Md. 2001) (original emphasis omitted) (quoting Rosenblatt v. Exxon, 642 A.2d 180, 188 (Md. 1994).

is the threshold requirement, and must be established before proceeding to analyze the other elements.[31] Maryland courts regard duty as a question of law.[32]

Duty only arises from either an express or implied physician-patient relationship.[33] In most situations, it is clear that a physician-patient relationship has been established.[34] An example is an express doctor-patient relationship, where the patient has sought out the physician's services and the doctor provides them to the individual directly. The creation of a duty, however, becomes difficult to parse when the plaintiff claims that the duty was created impliedly by the doctor's actions.

Implied duty is inferred by the courts from the actions of the parties or the terms of employment.[35] A court traditionally regards the doctor's affirmative action to treat the patient or prescribe a course of treatment as adequate to form a physician-patient relationship.[36] The question then becomes, what is an affirmative action on the part of the doctor indicating s/he accepted the individual as a patient? It is not usually enough to create an implied relationship where "[t]here may have been some interaction between the patient and the physician, for example, a telephone call . . . ."[37] But, where a physician is consulted by the treating doctor the situation must be scrutinized to determine "whether the second physician's participation creates a professional relationship between that physician and the patient."[38] It is not surprising then, that the investigation of whether duty was created can be a highly fact specific inquiry.[39] Often, a court will closely examine the terms of the physician's employment (usually the doctor's on-call status is in dispute), or what the parties said in the course of the patient's treatment.[40]

Duty Not Created Through an Implied Physician-Patient Relationship

Throughout the course of a patient's treatment, the treating doctor may contact other doctors for advice, an opinion, or a prescriptive plan without creating

31. Sterling v. Johns Hopkins Hosp., 802 A.2d 440, 444 (Md. Ct. Spec. App. 2002).

32. *Id.* at 445.

33. *Id.* at 445-46.

34. WILLIAM J. CURRAN ET AL., HEALTH CARE LAW AND ETHICS 162 (5th ed. 1998).

35. *See Sterling*, 802 A.2d at 455 (noting that a physician-patient relationship may be implied "where the doctor takes affirmative action to participate in the care and treatment of a patient.").

36. *Id.*

37. CURRAN ET AL., *supra* note 34, at 162.

38. CURRAN ET AL., *supra* note 34, at 162.

39. *But see Sterling*, 802 A.2d at 445 (noting that whether a duty existed is a question of law).

40. *Id.* at 455-58 (scrutinizing Dr. Gray's deposition testimony to determine the relationship between Dr. Gray, Dr. Khouzami, and Ms. Sterling).

a duty. Even in this context, creation of a duty for a medical malpractice cause of action based on negligence theory still requires the existence of a physician-patient relationship.[41] The creation of a physician-patient relationship through either a telephone call made to a physician for the purposes of consultation[42] or the doctor's on-call status at the time of the injury is relevant to the *Sterling* transfer situation.[43]

Affirmative acceptance of a patient does not occur through informal consultation between doctors. In *Reynolds v. Decatur Memorial Hospital*, the Appellate Court for Illinois held that a physician-patient relationship was not established when the treating physician merely telephoned another doctor to ask his opinion about the proper diagnosis and that doctor suggested a course of treatment without committing himself further to the patient.[44] The treating physician in *Reynolds* believed her patient, a young boy who had fallen from a sofa, had an infectious disease but telephoned a colleague because she was unsure.[45] The second physician, Dr. Fulbright, a staff member of the hospital, suggested that a spinal tap be performed to determine the source of the infection.[46] During the course of the conversation, Fulbright made no other comments regarding the treatment of the patient, nor did he agree to see the patient at a later time.[47]

The Illinois court held that the telephone conversation did not create a physician-patient relationship between Fulbright and the boy because Fulbright "did nothing more than answer an inquiry from a colleague."[48] A duty arises only when the doctor consents to accepting the individual as a patient,[49] and no aspect of the conversation indicated that Fulbright had agreed to take the boy under his

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41. Reynolds v. Decatur Mem'l Hosp., 660 N.E.2d 235, 238-39 (Ill. App. Ct. 1996).

42. *Id.* at 239; Corbet v. McKinney, 980 S.W.2d 166, 168 (Mo. Ct. App. 1998); Irvin v. Smith, 31 P.3d 934, 951-52 (Kan. 2001).

43. Oja v. Kin, 581 N.W.2d 739, 743 (Mich. Ct. App. 1998); Prosise v. Foster, 544 S.E.2d 331, 333 (Va. 2001).

44. 660 N.E.2d at 236.

45. *Id.* at 237.

46. *Id.*

47. *Id.* The court described the conversation, stating "Fulbright inquired if the child had a stiff neck. Bonds said she did not know, went to check Kevin's neck, and returned to inform Fulbright that his neck was stiff. At the end of the conversation Fulbright suggested a spinal tap to determine whether meningitis, encephalitis, or something similar was involved. Bonds did not ask Fulbright to treat Kevin, nor did Fulbright commit himself to further involvement with Kevin..." *Id.*

48. *Id.* at 239 (noting that Fulbright did not "direct the actions of hospital employees in a telephone conversation with an emergency room nurse," as in Wheeler v. Yettie Kersting Mem'l Hosp., 866 S.W.2d 32, 39-40 (Tex. App. 1993), a case where a relationship was found to have existed.).

49. *Id.* (noting there "is a consensual relationship in which the patient knowingly seeks the physician's assistance and the physician knowingly accepts the person as a patient. . . . A doctor who gives an informal opinion at the request of a treating physician does not owe a duty of care to the patient whose case was discussed.").

care.[50] Hospital rules concerning the protocol for telephone consultation between two physicians were also of no avail to the plaintiff.[51] Consequently, the telephone consultation between the treating physician and Dr. Fulbright did not create a physician-patient relationship because Fulbright only provided an informal opinion.[52]

Telephone conversations between doctors with different areas of expertise also do not necessarily create a doctor-patient relationship.[53] A telephone conversation between an attending general practice emergency room physician and a specialist who gives a specific opinion does not create a physician-patient relationship, even though the attending doctor would not have overridden the specialist's advice.[54]

In *Corbet v. McKinney*, the attending doctor telephoned a specialist colleague to discuss a patient's symptoms. Mrs. Corbett arrived at Missouri Baptist Medical Center and was seen by emergency room physician Dr. Ockner.[55] Acting on the advice of the patient's regular physician, Dr. Ockner contacted the defendant, an ear, nose, and throat specialist.[56] Regarding the content of the conversation, "Dr. Ockner testified that he called defendant as a consultant, presented the information from [the] patient's medical chart to him, that defendant mentioned that he had a case or two like it in the previous week and that 'this is usually a viral illness.'"[57] Corbett became deaf as a result of the improper diagnosis.[58] Ockner also testified that he made the diagnosis, but would not have overridden the advice of the specialist.[59]

The *Corbet* court referred to the reasoning of *Lopez v. Aziz*, where no physician-patient relationship was established because "[n]othing in the record suggests that either doctor contemplated that [defendant's] comments were binding

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50. *Reynolds*, 660 N.E.2d at 239.

51. *Id.* (holding "the rules of the Decatur Memorial Hospital are not dispositive in this case. Such rules are more appropriately considered in determining whether the standard of care was met."). The hospital rules governing consultations between physicians required that,

> Appropriate consultation shall be obtained by practitioners in cases in which the patient is not a good medical or surgical risk and in cases in which the diagnosis is obscure, where there is doubt as to the best therapeutic measure to be utilized, or where the treatment is difficult and especially in cases with probable disorders or complications lying within a field other than the one in which the attending physician is primarily qualified.

Id. at 238.

52. *Id.* at 239.

53. Corbet v. McKinney, 980 S.W.2d 166, 168-69 (Mo. Ct. App. 1998).

54. *Id.* at 170 (citing Hill by Burston v. Kokosky, 463 N.W.2d 265, 267 (Mich. Ct. App. 1990), and Lopez v. Aziz, 852 S.W.2d 303, 306-07 (Tex. App. 1993).

55. *Id.* at 168.

56. *Id.*

57. *Id.*

58. *Id.*

59. Corbett v. McKinney, 980 S.W.2d 166, 168 (Mo. Ct. App. 1998).

on [the treating physician] or that [defendant] had any authority or responsibility to control the course of [patient's] treatment."[60] Therefore, even though the emergency room physician may have relied on the specialist's knowledge in making the diagnosis, a physician-patient relationship had not been established through the telephone conversation because the attending physician "retained responsibility for [patient's] care . . . weighed [defendant's] advice, and he made a decision to accept it."[61]

Courts have also reviewed analogous factual situations when considering a defendant physician's motion for summary judgment.[62] Granting summary judgment in favor of the defendant physician is appropriate when the creation of a physician-patient relationship is alleged based solely on a telephone conversation producing an informal opinion.[63]

In *Irvin v. Smith*, a neurologist discussed a patient's treatment over the phone with the attending doctor and agreed to see the patient in the morning.[64] Irvin, a young girl, was taken to a hospital for treatment of seizures and a high fever, possibly related to a blockage in her shunt.[65] The treating physician telephoned the defendant neurologist to determine if a shuntogram[66] was necessary, and the two doctors agreed that they would perform it the next morning.[67] Before the procedure was attempted, however, the patient's condition quickly deteriorated and she suffered severe permanent brain damage.[68]

The Supreme Court of Kansas held an implied relationship had not been established by the telephone conversation because the defendant, Dr. Gilmartin, "had not examined Irvin, had not reviewed her hospital chart, and had never spoken with either her or her parents."[69] The only contact between the doctors was the telephone call, and it was of no consequence that they agreed to treat the

60. *Id.* at 170 (quoting Lopez v. Aziz, 852 S.W.2d 303, 306-07 (Tex. App. 1993)). The court did not find the relationship of the doctors conclusive. Although it did not expressly say so, the fact that the emergency room physician relied upon the specialist's advice in his diagnosis did not create a physician-patient relationship. Furthermore, the specialist never had any contact with the patient or received any payment from her. *Id.*

61. *Id.*

62. *See* Sterling v. Johns Hopkins Hosp., 802 A.2d 440 (Md. Ct. Spec. App. 2002); Corbet v. McKinney, 980 S.W.2d 162 (Mo. Co. App. 1998); Grimes v. Kennedy Krieger Inst., Inc., 782 A.2d 807 (Md. 2001).

63. *See* Irvin v. Smith, 31 P.3d 934 (Kan. 2001).

64. 31 P.3d 934, 939 (Kan. 2001).

65. *Id.* at 938 (explaining that a shunt "is a pump with a tube. The tube extends from the brain to the abdomen. The purpose of the shunt is to drain excess cerebrospinal fluid from the skull.").

66. *Id.* at 939 ("a shuntogram is a procedure which involves injection of a radioactive isotope into the shunt to check for shunt blockage").

67. *Id.*

68. *Id.*

69. *Id.* at 943.

patient in the morning.[70] Further considering these facts the court said, "[t]here is no claim that [the defendant] entered any orders in the case or took any other action other than discussing the case in general terms with Smith and agreeing to consult the next day. This, by itself, does not create a physician-patient relationship."[71] No facts giving rise to a physician-patient relationship had been set forth beyond the telephone call. Therefore, summary judgment for the defendant was appropriate because duty had not been established.[72]

In addition to cases rejecting the creation of an implied physician-patient relationship through a telephone call to a doctor, some courts have also held that a physician-patient relationship is not created through a doctor's "on-call" status.[73] In *Oja v. Kin,* a hospital admitted a patient who had a severe gunshot wound to the jaw.[74] The treating emergency room physician contacted the on-call ear, nose, and throat physician, Dr. Kin.[75] Defendant Kin refused to come to the hospital because he was not feeling well. During the conversation, Dr. Kin did not offer any advice on the course of treatment.[76] The patient died after being transferred to another hospital.

In the opinion, the Court of Appeals of Michigan held that the on-call status of the defendant by itself did not automatically create a physician-patient relationship with the decedent.[77] It stressed that "Dr. Kin averred that he told the emergency room resident that he was ill and that she should contact another physician. He denied ever accepting the decedent as a patient."[78] As a result, when contacted and the on-call doctor refuses to see the patient, a plaintiff may not rely solely upon the on-call status of the doctor to demonstrate that an implied physician-patient relationship existed.[79]

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70. Irvin v. Smith, 31 P.3d 934, 943 (Kan. 2001).

71. *Id.*

72. *Id.* at 942-44.

73. Oja v. Kin, 581 N.W.2d 739, 743 (Mich. Ct. App. 1998); Prosise v. Foster, 544 S.E.2d 331, 333 (Va. 2001).

74. *Oja,* 581 N.W.2d at 741.

75. *Id.*

76. *Id.*

77. *Id.* at 743. There was some discussion in the opinion about Kin's on-call contract with the hospital. The court noted that Kin did have an obligation to the hospital to be available during his on-call tenure. But, the plaintiff could not allege that this obligation created a physician-patient relationship unless he was intended as a third-party beneficiary. *Sua sponte,* the court determined that the patient was not intended as a third party beneficiary, and therefore, on-call status alone was not enough to confer duty on the defendant. *Id.* at 743-44.

78. Oja v. Kin, 581 N.W.2d 739, 743 (Mich. Ct. App. 1998).

79. *Id.* The court comprehensively described the landscape of when a relationship may be created by implication. It explained, "merely listening to another physician's description of a patient's problem and offering a professional opinion regarding the proper course of treatment is not enough. Under those circumstances, a doctor is not agreeing to enter into a contract with the patient. Instead, she is simply offering informal assistance to a colleague. At the other end of the spectrum, a doctor who is on call

Finally, the creation of a doctor-patient relationship through on-call status has also been considered in the context of teaching hospitals.[80] On-call status at a teaching hospital does not create a physician-patient relationship, even when the on-call doctor is supervising residents, when the treating resident does not communicate with the on-call doctor about the patient, and the on-call doctor does not provide direct medical services.[81]

In *Prosise v. Foster*, no discussion took place between the on-call physician and the resident on duty.[82] Dr. Foster was on-call at the Medical College of Virginia Hospital Pediatric Emergency Room when four-year-old Crystal Prosise was examined.[83] First-year resident Dr. Narang treated Prosise and sent her home.[84] The next day, Prosise returned to the hospital under the direction of her pediatrician and was examined by Foster.[85] Concluding Narang's initial diagnosis and treatment for dehydration was incorrect, Foster determined Crystal had a type of chicken pox that affected the entire body, and altered the course of treatment.[86] Foster's change in treatment was too late; Prosise died from the symptoms a few weeks later.[87]

Following the Maryland Court of Special Appeals in *Rivera v. Prince George's County Health Department*,[88] the Virginia Supreme Court held that a physician-patient relationship was not established merely as a result of on-call status.[89] Even though the defendant was on-call at a teaching hospital and responsible for supervising residents, she was never contacted regarding the initial course of treatment.[90] Articulating the basis of its holding, the court said "Dr. Foster's direct actions do not indicate that she accepted Crystal as a patient . . . . She did not treat Crystal, she did not participate in any treatment decisions . . . and she was not consulted [by the attending physicians or other hospital staff.]"[91] Therefore, on-call status alone is not sufficient to create a physician-patient relationship even in a teaching hospital where a doctor is responsible for residents.[92]

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and who, on the phone or in person, receives a description of a patient's condition and then essentially directs the course of that patient's treatment, has consented to a physician-patient relationship." *Id.*

80. Prosise v. Foster, 544 S.E.2d 331 (Va. 2001).
81. *Id.* at 334.
82. *Id.* at 332.
83. *Id.* at 331-32.
84. *Id.* at 332.
85. *Id.*
86. Prosise v. Foster, 544 S.E.2d 331, 332 (Va. 2001).
87. *Id.*
88. 649 A.2d 1212 (Md. Ct. Spec. App. 1994).
89. *Prosise*, 544 S.E.2d at 334.
90. *Id.*
91. *Id.*
92. *Id.*

The Creation of Duty Through an Implied Physician-Patient Relationship

Some courts have charted a competing fleet of cases, finding a physician-patient relationship is created under similar factual circumstances.[93] The North Carolina Supreme Court, in *Mozingo v. Pitt County Memorial Hospital*, held that the doctor responsible for supervising residents owes a duty to patients treated by those residents while he is on-call.[94]

In *Mozingo*, the on-call physician was supervising residents from his house, ready to take calls from residents if they had questions.[95] A resident contacted the doctor when Mrs. Mozingo's baby's shoulder became lodged in her pelvic cavity during birth.[96] The on-call physician immediately came to the hospital, but the baby had already been born suffering severe and permanent injuries.[97]

The Supreme Court of North Carolina held that because the defendant "knew the residents at the Hospital were actually treating patients when he undertook the duty to supervise the residents as an on-call supervising physician," the defendant owed a duty to the patients under his residents' care.[98] In the opinion, the court concentrated on the defendant's stipulation[99] that he had "responsibility for supervision of the OB/GYN residents and interns at the time of the birth" and therefore, had a duty to ensure that the residents were practicing medicine in a non-negligent fashion.[100] Consequently, a competing line of cases was born holding an on-call physician owes a duty to patients under the care of his supervised residents.

Subsequent cases have been decided based on the theory of on-call liability set forth in *Mozingo*.[101] Attempting to set up clear guidelines in a case of first

93. Mozingo v. Pitt County Mem'l Hosp., Inc., 415 S.E.2d 341 (N.C. 1992); Wheeler v. Yettie Kersting Mem'l Hosp., 866 S.W.2d 32 (Tex. App. 1993).

94. *Mozingo*, 415 S.E.2d at 346-47.

95. *Id.* at 342.

96. *Id.*

97. *Id.* at 342-43.

98. *Id.* at 344-45, 47.

99. *Id.* at 344. The Supreme Court of North Carolina used the defendant's stipulation and weighed it heavily against him. It noted "[s]tipulations are viewed favorably by the courts because their usage tends to simplify, shorten, or settle litigation, as well as save costs to litigants." *Id.* (quoting Pelham Realty Corp. v. Bd. of Transp., 279 S.E.2d 826, 830 (N.C. 1981)).

100. Mozingo v. Pitt County Mem'l Hosp., Inc., 415 S.E.2d 341, 344-45 (N.C. 1992) (stating that "a physician who undertakes to provide on-call supervision of residents actually treating a patient may be held accountable to that patient, if the physician negligently supervises those residents and such negligent supervision proximately causes the patient's injuries.").

101. *See e.g* McKinney v. Schlatter, 692 N.E.2d 1045 (Ohio Ct. App. 1997); Lownsbury v. Van Buren, 762 N.E.2d 354 (Ohio 2002); Millard v. Corrado, 14 S.W.3d 42 (Mo. Ct. App. 1999).

impression, in *McKinney v. Schlatter*, the Court of Appeals of Ohio established a three prong test where,

> a physician-patient relationship can exist by implication between an emergency room patient and an on-call physician who is consulted by the patient's physician but who has never met, spoken with, or consulted the patient when the on-call physician (1) participates in the diagnosis of the patient's condition, (2) participates in or prescribes a course of treatment for the patient, and (3) owes a duty to the hospital, staff or patient for whose benefit he is on call.[102]

In other words, if an on-call doctor has a pre-existing duty to the hospital, duty is created when a health care professional contacts him regarding treatment and the doctor offers an opinion.[103]

In *McKinney,* the treating physician contacted the on-call cardiologist about a patient who arrived complaining of chest pains. [104] The cardiologist determined that the ailment was probably not cardiac in nature.[105] Consequently, the treating physician released the patient, and the patient died a few hours later.[106]

Using the three prong test, the appellate court reversed the trial court's directed verdict for the defendant physician. The court noted a jury could find a duty where, despite not meeting or speaking with the patient, the on-call cardiologist diagnosed the ailment as non-cardiac and participated in the course of treatment by prescribing specific tests to be performed.[107] In its analysis, the Court of Appeals of Ohio acknowledged that it was expanding medical malpractice liability, but considered it necessary for public policy reasons.[108]

Perhaps realizing that the bright-line rules established in *McKinney* expanded medical malpractice liability too far, the Supreme Court of Ohio overruled the three prong test in *Lownsbury v. VanBuren.*[109] In *Lownsbury*, the court found that a reasonable jury could conclude the requisite relationship had arisen between a supervisory doctor at a teaching hospital and a patient.[110]

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102. *McKinney*, 692 N.E.2d at 1050.

103. *Id.*

104. *Id.* at 1046.

105. *Id.*

106. *Id.* at 1047.

107. *Id.* at 1050-51.

108. McKinney v. Schlatter, 692 N.E.2d 1045, 1050 (Ohio Ct. App. 1997) (explaining that "[t]o find otherwise would allow on-call cardiologists and kindred specialists who, with a duty to do so, provide what one could term 'indirect medical care' to escape all liability even after rendering a diagnosis and prescribing a course of treatment"). *Id.*

109. 762 N.E.2d 354, 362 (Ohio 2002).

110. *Id.* at 362-63.

Therefore, granting summary judgment in favor of the defendant was improper.[111] Through his contractual agreement to supervise residents, the doctor assumed a duty to patients treated by the resident physicians.[112] The residents performed a test on the patient rather than immediately sending her to the labor induction unit per the supervisor's request, and a child was born with serious birth defects as a result.[113]

Even though it abandoned the three prong test, the court in *Lownsbury* affirmed the principle that duty may be implied through the actions of the doctor. Striking at the heart of the definition of when duty is created, the court noted "[t]he basic underlying concept in these cases is that a physician-patient relationship, and thus a duty of care, may arise from whatever circumstances evince the physician's consent to act for the patient's medical benefit."[114] Furthermore, the court instructed that "physicians who practice in the institutional environment may be found to have voluntarily assumed a duty of supervisory care pursuant to their contractual and employment arrangements with the hospital."[115] The three prong test, however, was flawed because it "subsume[d]" the ultimate question of duty.[116] A physician-patient relationship was present here because the doctor was "actively involved"[117] in caring for the patient through his supervisory role at an institutional hospital. Therefore, although the court abandoned the three-prong test, it left in place the principle from *McKinney* that a physician patient relationship may exist without any direct contact between the patient and the doctor.

Just as courts have found that a duty may be created while a doctor is on-call, affirmative acceptance of a patient occurs when the doctor directs the action of the treating nurse.[118] In *Wheeler v. Yettie Kersting Memorial Hospital*, a duty arose when a nurse telephoned the on-call doctor who evaluated the status of a pregnant woman requesting transfer to another facility. A nurse telephoned a staff doctor to describe the patient's symptoms, and the physician approved the transfer.[119] While the patient was en route to John Sealy hospital, labor began with

111. *Id.* at 364.

112. *See id.* at 363.

113. *Id.* at 355-56.

114. *Id.* at 360.

115. Lownsbury v. VanBuren, 762 N.E.2d 354, 360 (Ohio 2002) (holding that "a physician-patient relationship can be established between a physician who contracts, agrees, undertakes, or otherwise assumes the obligation to provide resident supervision at a teaching hospital and a hospital patient with whom the physician had no direct or indirect contact.") *Id.* at 362.

116. *Id.* at 362.

117. Sterling v. Johns Hopkins Hosp., 802 A.2d 440, 449 (Md. Ct. Spec. App. 2002) (quoting Lownsbury v. VanBuren). The *Sterling* court spends much time placing the *Lownsbury* decision within the context of *McKinney* and other medical malpractice cases. *Id.* at 448-49.

118. Wheeler v. Yettie Kersting Mem'l Hosp., 866 S.W.2d 32, 40 (Tex. App. 1993).

119. *See id.* at 35 (Although the doctor had approved the transfer, the EMTs who were transporting the patient expressed concern about whether Wheeler was stable enough to transport. The nurse at

numerous complications.[120] The baby suffocated and was delivered still-born.[121] Focusing on the telephone call from the nurse, the court held that the defendant doctor had a duty to Mrs. Wheeler and her child because he analyzed her symptoms, made a medical determination, and prescribed transfer as part of the course of treatment.[122] In this situation, the court believed that the doctor's telephone instructions to transfer the patient indicated an affirmative act, whereby the doctor was accepting the individual as a patient.[123]

Leading Maryland Cases

Few Maryland cases have considered when an implied physician-patient relationship gives rise to duty. There are, however, two cases upon which the court in *Sterling* rested its analysis.[124]

A more dated approach to medical malpractice law, *Thomas v. Corso*, found a physician patient relationship existed between an on-call doctor and a patient when the doctor prescribed a course of treatment and the doctor had responsibility for newly admitted patients while on-call.[125] In *Thomas*, the patient was brought to the hospital after being struck by a car.[126] The attending nurse telephoned the on-call doctor, who prescribed a course of treatment from home because he believed the symptoms did not demonstrate any sense of urgency.[127] Over the next several hours, the patient's blood pressure lowered and he eventually died.[128] The Court of Appeals found that the doctor had a duty to the patient because a physician-patient relationship had been created when the doctor took the individual under his care and outlined a specific manner of treatment for the patient's symptoms.[129]

The Court of Special Appeals of Maryland has since departed from the reasoning in *Thomas*, restricting a doctor's liability to the terms of his on-call

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Yettie Kersting "instructed [the EMTs] to 'put the patient in the ambulance, turn on the lights and sirens and go.'") *Id.*

120. *Id.* at 36 (noting that "the fetus was not coming out of the birth canal . . . . Several minutes later, the baby, a boy, presented in a frank breech position (buttocks first). He was delivered up to the neck with good color and extremities moving, at which point Mrs. Wheeler's cervix clamped down around the baby's neck... and the birth process stopped.").

121. *Id.*

122. *Id.* at 40.

123. *See id.* Although the court did not expressly use the phrase "affirmatively act," a duty arises when the doctor accepts the individual as a patient. Acceptance of a patient is implied when the doctor takes definite steps toward caring for the individual. *Id.* at 37-40.

124. Sterling v. Johns Hopkins Hosp., 802 A.2d 440 (Md. Ct. Spec. App. 2002).

125. Thomas v. Corso, 288 A.2d 379 (Md. 1972).

126. *Id.* at 382.

127. *Id.* at 383, 385.

128. *Id.* at 384.

129. *Id.* at 383, 388.

agreement. Diverging from the *Mozingo* line of cases,[130] the Court of Special Appeals' holding in *Rivera v. Prince George's County Health Department* is instructive:

> Unless the 'on call' agreement between a hospital and a physician provides otherwise, an 'on call' physician who has not accepted a patient or has not, pursuant to his 'on call' status, consulted with a treating or attending physician in regards to the patient, or has not been summonsed pursuant to his 'on call' agreement to consult with an attending physician or attend or treat a patient, is not liable for the negligence of others during the 'on call' but unsummonsed period.[131]

In *Rivera*, Dr. Oh was on call at a Prince George's County medical facility.[132] The plaintiff had come to the facility on prior consecutive days for treatment of pregnancy complications.[133] On September 8, 1978, the plaintiff's baby was delivered by residents at the facility.[134] Apparently, during the pregnancy (but before delivery) the mother had developed an infection in her uterus, which led to the child being born mentally retarded.[135] Because Dr. Oh was on-call the day the baby was delivered, the mother claimed that he was negligent in fulfilling his on-call duties to the facility and liable for damages.[136]

The Court of Special Appeals held that no physician-patient relationship existed between the parties because, prior to the injury, Dr. Oh did not examine or prescribe a course of treatment for the patient and was not contacted by any of the residents.[137] Distinguishing *Thomas*, the Court pointed out that Dr. Oh fulfilled his

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130. *See* Rivera v. Prince George's County Health Dep't, 649 A.2d 1212, 1225 (Md. Ct. Spec. App. 1994). ("[t]he duties of 'on call' physicians have not heretofore received significant appellate attention. There is only one case of which we are aware in Maryland where an 'on call' doctor was found to have been negligent 'in his response to a call.'....One state, North Carolina, has addressed the issue in at least one case in both the intermediate appellate court and the Supreme Court of that State. Both courts adopted a broad definition of the duties and liabilities of physicians 'on call'....We find, however, the logic of the dissents in those cases to be more persuasive.").

131. *Id.* at 1232.

132. *Id.* at 1215.

133. *Id.*

134. Rivera v. Prince George's County Health Dep't, 649 A.2d 1212, 1215 (Md. Ct. Spec. App. 1994).

135. *Id.* ("The minor appellant was subsequently diagnosed as suffering from severe mental retardation caused by 'hypoxia,' a condition where an infection invades the uterus and deprives the fetus of oxygen.").

136. *Id.* at 1214-15, 1225.

137. *Id.* at 1225. The Court of Special Appeals examined the on call agreement and found that Dr. Oh abided by its terms. The Court noted the weakness in the plaintiff's case and stated that "all Dr. Oh was required to do under his agreement and arrangement with the Hospital, at all times relevant to the case at bar, was to be 'on call.' When called upon, he then assumed his duties, *i.e.*, to consult with,

on-call duties and responded promptly when the call was eventually made, while Dr. Thomas took three hours to arrive at the hospital.[138] Therefore, by explicitly diverging from *Mozingo*, the Court of Special Appeals in *Rivera* required the doctor's on-call agreement with the hospital expressly impose liability on the doctor, the doctor participate in diagnosing or prescribing a course of treatment with the treating physician, or the doctor expressly accept the individual as a patient before a physician-patient relationship is created.

III. STERLING V. JOHNS HOPKINS HOSPITAL

The Facts Supporting Sterling's Malpractice Claim

Nearly 33 weeks into her pregnancy,[139] Ms. Sterling was suffering from several symptoms including nausea, vomiting, borderline blood pressure, proteinuria,[140] edema,[141] hypertension, and abdominal pain.[142] On recommendation from her personal physician, Laverne Sterling was admitted to the Peninsula Regional Medical Center[143] on August 2, 1993.[144] The following day, her condition worsened considerably.[145] In addition to her existing conditions, Sterling developed hematuria and bleeding in her mouth.[146] The treating physician, Dr. Floyd Gray, administered several tests,[147] and around 12:30 pm, he

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advise, and attend the residents. The evidence is clear that he did just that when called. The damage, however, had already occurred to appellant by the time the residents contacted him." *Id.*

138. *Id.* at 1231.

139. Sterling v. Johns Hopkins Hosp., 802 A.2d 440, 442 (Md. Ct. Spec. App. 2002) (stating that, when admitted, Ms. Sterling was exactly 32.6 weeks pregnant).

140. *Id.* (defining proteinuria as the presence of protein in the urine).

141. *Id.* (defining edema as swelling due to fluid retention).

142. *Id.*

143. The PRMC is an urgent care center located on the Eastern Shore of Maryland, a rural area. According to the American Association of Homes and Services for the Aging, health care services in rural areas are faced with many challenges; they tend to be small, lack significant funding and resources, and have difficulty in attracting qualified medical professionals when compared to large urban hospitals. *Statement of the American Association of Homes and Services for the Aging: Hearing Before the House Comm. on Ways and Means*, Jun. 12, 2001, *available at* http://waysandmeans.house.gov/legacy/health/107cong/6-12-01/records/aahs.htm (last visited June 19, 2004).

144. *Sterling*, 802 A.2d at 442.

145. *Id.*

146. *Id.*

147. *Id.*

conclusively diagnosed Sterling with severe pre-eclampsia[148] and HELLP syndrome.[149]

Because Sterling's symptoms qualified her condition as a "high risk" pregnancy, Dr. Gray decided that it would be best to transfer Ms. Sterling to a hospital that would be better able to treat her condition.[150] Following protocol, Dr. Gray contacted the Emergency Medical Resource Center, which provides referral services in emergency medical transfer situations.[151] The referral service instructed Dr. Gray to contact Johns Hopkins Hospital,[152] a designated "High-Risk Maternal Consultation/Referral Service" that was equipped with the resources and facilities to treat Ms. Sterling's severe, potentially life-threatening condition.[153]

To facilitate a possible transfer, the referral service put Dr. Gray in contact with Johns Hopkins Hospital.[154] Speaking with resident Dr. Erica Leventhal, Dr. Gray explained Sterling's symptoms and that he had placed Sterling on a magnesium sulfate drip.[155] This information was given to the on-call physician, Dr. Khouzami, who called Dr. Gray to discuss the transfer further.[156] In accordance with MIEMSS[157] transfer protocol, Dr. Gray described his diagnosis of severe pre-eclampsia and HELLP syndrome, and that Sterling was receiving a magnesium sulfate drip.[158] He further explained the earlier tests he conducted which led to his diagnosis.[159] After their discussion, Dr. Khouzami recorded the information in the Hopkins Maternal Transport Log and determined that it was

148. *Id.* (citing STEADMAN'S MEDICAL DICTIONARY at 1419 (26th ed. 1995), the court characterized severe pre-eclampsia as "a serious complication of pregnancy." The disorder is described as including "hypertension with proteinuria or edema, or both...." *Id.* n.2.

149. *Id.* (citing Maureen O'Hara Padden, *HELLP Syndrome,* AM. FAM. PHYSICIAN, Sept. 1, 1999, at 829, the court defined HELLP syndrome as "a syndrome characterized by hemolysis, elevated liver enzyme levels, and low platelet count." *Id.* n.2.

150. *Sterling*, 802 A.2d at 442.

151. *Id.* at 442 n.3. Emergency Medical Resource Center "is a referral service established in 1978 by the Maryland Institute for Emergency Medical Services Systems (MIEMSS) through the Departments of Obstetrics and Gynecology at the Johns Hopkins Hospital and University of Maryland Hospital. The service was created to provide a coordinated maternal transport system to reduce morbidity and mortality." *Id.* at 442 n.3.

152. *Id.* at 442.

153. *Id.* at 442 n.4 (noting that the designation was created in order to improve medical care for pregnant women).

154. *Id.*

155. *Id.* (stating that Dr. Gray told Dr. Leventhal that Sterling was experiencing hypertension, hematuria, proteinuria, elevated liver enzymes, severe abdominal pain, nausea, and vomiting). *Id.*

156. Sterling v. Johns Hopkins Hosp., 802 A.2d 440, 442-43 (Md. Ct. Spec. App. 2002). Dr. Khouzami telephoned Dr. Gray and they determined that a transfer was necessary. MIEMSS protocol was followed throughout the procedure. *Id.*

157. *See supra* note 151 defining MIEMMS.

158. *Sterling*, 802 A.2d at 443.

159. *Id.*

appropriate to transfer Ms. Sterling to Hopkins for treatment.[160] Although Dr. Gray initially wanted Ms. Sterling taken to Baltimore by helicopter, MEIMSS procedure called for transport by ambulance and the two doctors agreed that this course should be taken.[161]

During transfer to Hopkins via ambulance, Ms. Sterling became unresponsive.[162] The ambulance then changed course for Memorial Hospital in Easton.[163] While at the hospital, doctors found Ms. Sterling had experienced an intraventricular hemorrhage and an emergency cesarean section was necessary to save the child.[164] After the cesarean section, Ms. Sterling was airlifted to University of Maryland where she died from the hemorrhage.[165] A medical malpractice suit followed Ms. Sterling's death, naming Dr. Gray, PRMC, and Johns Hopkins as defendants.[166] Johns Hopkins argued in a motion for summary judgment that the plaintiff failed to establish a physician-patient relationship between the decedent and the Hopkins physician, and therefore, Hopkins was entitled to summary judgment as a matter of law.[167] The circuit court accepted this argument, and denied the plaintiff's motion for reconsideration.[168] Plaintiff then appealed to the Court of Special Appeals.[169]

Sterling at the Court of Special Appeals

In a case of first impression,[170] the Court of Special Appeals found that Johns Hopkins did not owe a duty to Sterling because a physician-patient relationship had not been created through a telephone conversation regarding transfer of a patient.[171] In the opinion, the court investigated case law outside of the state,[172] moved to a discussion of relevant Maryland cases,[173] and finally analyzed the

160. *Id.*

161. *Id.* "Dr. Gray requested that Sterling be transferred via helicopter. At the hearing below, plaintiffs' counsel represented that the 'decision to transport, the medical decision made by Dr. Khouzami, was a deviation in the standard of care.' Counsel for Johns Hopkins argued that under MEIMSS protocol at this time pregnant women who were receiving I.V. magnesium sulfate could not be transferred by helicopter." *Id.* n.5.

162. *Sterling*, 802 A.2d at 443. Ms. Sterling was transferred by a local ambulance company. *Id.*

163. *Id.*

164. *Id.*

165. *Id.*

166. *Id.* at 441.

167. *Id.* at 443.

168. *Sterling*, 802 A.2d at 441.

169. *Id.*

170. *Id.* at 455-56 ("We are unaware of any case that addresses the liability of a hospital that has accepted the transfer of a patient without having any direct contact with that patient.").

171. *Id.* at 443, 446.

172. *Id.* at 449-53.

173. *Id.* at 454-55.

creation of duty in the situation at bar.[174] The panel held that because there was no physician-patient relationship, and thus no duty, the circuit court was correct in granting summary judgment in favor of Johns Hopkins.[175]

The Court Follows the Majority of Jurisdictions

Two competing lines of case law have developed in the context of determining when a duty arises based on an implied physician-patient relationship.[176] Consequently, the Maryland Court of Special Appeals was compelled to select which legal theory to follow.[177] Maryland courts have only considered a situation involving a patient's indirect contact with an *on-call* physician, and have not imposed a duty in any situation involving liability of a hospital in a transfer situation based on a implied physician-patient relationship.[178] In *Sterling*, Judge Theime rejected the cases that more easily recognize the creation of a physician-patient relationship and followed the majority of jurisdictions which maintain that an on-call doctor does not have a duty to the patient if he only gives advice to the treating physician.[179] Although the court heavily cited cases from outside the jurisdiction,[180] *Sterling* rests upon *Rivera v. Prince George's County Health Department*[181] and *Thomas v. Corso* to support its analysis.[182] Judge Theime noted in *Sterling* that the Court of Special Appeals has recoiled from the

174. *Sterling*, 802 A.2d at 455-59.

175. *Id.* at 459.

176. *Compare* Prosise v. Foster, 544 S.E.2d 331, 334 (Va. 2001), *with* Mozingo v. Pitt County Mem'l Hosp., Inc., 415 S.E.2d 341 (N.C. 1992). The Virginia court in *Prosise* chose not to follow the North Carolina court in *Mozingo*. *Prosise*, 544 S.E.2d at 333-34. *Mozingo* is generally regarded as the flagship case in a line of cases which more freely recognize the creation of a physician-patient relationship.

177. Since *Sterling* was a case of first impression, the Court of Special Appeals adopted a theory of implied physician-patient relationships in the context of medical malpractice. *Sterling*, 802 A.2d at 446, 455-59.

178. *See* Rivera v. Prince George's County Health Dep't, 649 A.2d 1212 (Md. Ct. Spec. App. 1994).

179. *Sterling*, 802 A.2d at 459.

180. *See id.* at 449-53. Although the Court is guided by its previous decision in *Rivera*, it utilizes case law from outside the jurisdiction in its analysis. Two examples are Lection v. Dyll, 65 S.W.3d 696, 704 (Tex. App. 2001), where the Court of Special Appeals agreed with the Texas court which stated "[a] physician may agree in advance with a hospital to the creation of a physician-patient relationship that leaves him no discretion to decline treatment of the hospital's clients," *Sterling*, 802 A.2d at 455 n.10, and Lopez v. Aziz, 852 S.W.2d 303, 307 (Tex. App. 1993), which held that an implied relationship had not been established when the treating physician was free to accept or reject the advice of the consulting physician. *Sterling*, 802 A.2d at 458.

181. *Sterling*, 802 A.2d. at 454-55.

182. *Id.*

Thomas decision, as illustrated by *Rivera*.[183] Relying heavily upon *Rivera*, he noted "[i]n the absence of an express agreement, 'on-call' means nothing more than that."[184] A duty was not established in *Rivera* because "[h]e did not exercise control over [hospital residents'] actions on a regular basis" and "was merely to be consulted regarding any complications that the residents encountered in caring for obstetrical patients."[185] Therefore, the *Sterling* court rejected *Mozingo* and its progeny by extending the logic of *Rivera* to a physician-patient relationship created by implication in a transfer situation.

Communication Regarding Transfer Did Not Create an Implied Doctor-Patient Relationship

Even though the court did not find that a duty by implication had arisen on behalf of Johns Hopkins, the *Sterling* opinion nevertheless regarded it as well settled that a duty may be created by implication "where the doctor takes affirmative action to participate in the care and treatment of a patient."[186] Based on this principle, the Court of Special Appeals went one step further and held that a duty of the on-call or transferee doctor is not established "where . . . the treating physician exercises his or her own independent judgment in determining whether to accept or reject [a consultant's] advice . . . the consultative physician should not be regarded as a joint provider of medical services with respect to the patient."[187] In reaching this conclusion, the court examined the relationship between the treating physician (Dr.Gray) and PRMC, and Dr. Khouzami and Johns Hopkins Hospital.[188]

In his analysis, Judge Theime primarily relied upon the record of Dr. Gray's deposition to determine the extent to which Gray was acting independent of Khouzami and Johns Hopkins.[189] The deposition record of Dr. Gray utilized by the court is set forth below:

> Q: Did you make a diagnosis of severe pre-eclampsia at 10:50, Doctor?
>
> A: Yes.

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183. *Id.* In describing *Rivera*, Judge Theime leads into a discussion of *Thomas*, and indicates that the Court of Special Appeals distinguished *Rivera* from that decision. *Id.*

184. *Id.* at 454.

185. *Id.* (quoting Rivera v. Prince George's County Health Dep't, 649 A.2d 1212, 1225 (Md. Ct. Spec. App. 1994)).

186. *Id.* at 455.

187. *Sterling*, 802 A.2d at 455 (quoting Gilinsky v. Indelicato, 894 F. Supp. 86, 92 (E.D.N.Y. 1995)).

188. *Id.* at 456.

189. *Id.* at 456-57.

Q: Did you make a diagnosis of HELLP syndrome at 10:50?

. . .

A: 12:33 . . . .

. . .

Q: Was the telephone call [to Hopkins at 12:30], in your mind, Doctor, made as a referral, or as a consultation or a combination? What is it?

A: Somewhat a combination.

Q: . . . if a consultant recommends something to you, and you are the primary physician, you still make the decision with the hands on the patient whether to do it or not?

A: I'm the one looking at the patient.

Q: You are the one looking at the patient. You are the one calling the shots. If somebody told you this patient could go by ambulance, and they are going to stop off at Easton for lunch, you might say I'm not shipping this patient. The patient is unstable. . . .

A: That's right.

. . . .

Q: That is well within your discretion? You have the power to do that?

A: That's true.

Q: Do you, Doctor, testify today that you told the Hopkins personnel that this was, indeed, an emergency?

A: Yes.

Q: Did you tell the Hopkins people that you believed that this patient, not that you believed, that you had made a diagnosis of severe pre-eclampsia, and you believed the patient had HELLP syndrome?

A: Yes.

Q: Doctor [Khouzami] calls you at 1:20. Do you have any new information by 1:20 to tell him?

A: Yes. Do you want me to read my note?

. . . Doctor [Khouzami] returned call, had been presented patient. Urinary output 10 ccs last, so we are, obviously, with pre-eclampsia, we developed – that is off the note. Blood pressure stable. I have the flow sheet here just to clarify that. This was 1 o'clock. At 1 o'clock her blood pressure is 160 over 87, 138 over 87. So it was in that range. Patient remains lethargic secondary to Morphine. Dr. [Khouzami] feels ground transport, (ambulance), acceptable, will arrange ASAP. That is the note.[190]

190. *Id.*

Judge Theime relied on this testimony to find that duty had not been established because Dr. Gray made a full diagnosis of severe pre-enclampsia and HELLP syndrome before he contacted Johns Hopkins or had any discussion with Dr. Khouzami.[191] Underscoring its classification of Dr. Khouzami as a mere consultative physician under the *Rivera* analysis, the court stated "Dr. Gray had reached a firm conclusion regarding Ms. Sterling's condition and Dr. Khouzami did nothing to add to this diagnosis of the patient or prepare a course of treatment."[192] Therefore, because Gray had finalized his diagnosis of Sterling's symptoms before speaking with Khouzami, the court characterized the conversation as a consultation rather then a prescription for a course of treatment.[193]

Furthermore, the Court of Special Appeals also relied on other portions of Dr. Gray's deposition testimony in its analysis. Dr. Gray proclaimed that he had the final say on whether or not Sterling would be transferred.[194] In his words he was "the one looking at the patient" and could "override anything that somebody from Hopkins sa[id.]"[195] The court believed that Dr. Gray therefore exercised decision-making power independent from Dr. Khouzami and Johns Hopkins when he chose to transfer Sterling.[196] The court's characterization of this testimony contributed to its determination that no genuine issue of material fact was in dispute, allowing Johns Hopkins' motion for summary judgment to be granted.[197]

To counter Dr. Gray's deposition testimony and survive the motion for summary judgment, the plaintiff offered the deposition testimony of Dr. Khouzami.[198] Dr. Khouzami stated in deposition that he would make the decision as to whether Sterling would be transported to Johns Hopkins, and that he "gave permission for the transport . . . [and] approved the transport based on the information [he] had[.]"[199] Furthermore, Dr. Khouzami's deposition testimony also shows that he gave a diagnosis of severe pre-eclampsia as well and approved a transfer of the patient.[200] The plaintiff argued that this deposition testimony demonstrated a dispute as to a genuine issue of material fact because Dr.

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191. *Id.* at 457 ("Although Dr. Khouzami acknowledged that he, too, had rendered diagnoses of pre-enclampsia with the HELLP complication, Dr. Gray had already reached these conclusions before discussing the case with the Hopkins attending physician.").

192. *Id.*

193. *Sterling*, 802 A.2d, at 458.

194. *Id.* at 456. After questioning Dr. Gray at the deposition whether he could override anything somebody from Hopkins said, he responded, "That's correct." *Id.*

195. *Id.* at 458.

196. *Id.*

197. *Id.* at 457-59.

198. *Id.* at 457.

199. *Sterling*, 802 A.2d at 457.

200. *Id.* (noting "[h]is deposition testimony also indicates that he rendered a diagnosis of severe pre-eclampsia....").

Khouzami's testimony communicated his acceptance of Sterling as a patient and showed he participated in the prescription of a course of treatment.[201]

Rejecting this argument, Judge Theime held that the deposition testimony did not establish Dr. Khouzami had either accepted Sterling as a patient or prescribed a course of treatment.[202] Instead, he reasoned "[n]otwithstanding Dr. Khouzami's testimony, it was Dr. Gray, the physician with direct contact with Ms. Sterling, who rendered the initial diagnoses in this case and who initiated contact with Hopkins for transfer."[203] In a sense, because the court believed Dr. Gray could override any transport decision from Hopkins, it disregarded Dr. Khouzami's statements at deposition.[204] Therefore, Dr. Khouzami's deposition testimony was weakened, and did not demonstrate dispute of a genuine issue of material fact. In short, the court concluded "Dr. Gray's acknowledgement that he had the final say in making the decision to transfer Ms. Sterling constitutes a crucial factor in this case which militates against the imposition of a duty of care on Dr. Khouzami and . . . Johns Hopkins Hospital."[205] Even though Dr. Khouzami made the statements in his deposition, he did not have decision-making authority as to the transfer.[206]

In addition, the court did not consider the selection method of transport conclusive.[207] Even though Dr.Gray requested a helicopter, Sterling was taken from the Eastern Shore to Baltimore by ambulance because Dr. Khouzami believed it was appropriate and complied with the standard of care.[208] This did not contribute to finding that a duty by implication had arisen between Sterling and Johns Hopkins Hospital.

In conclusion, the court held that there was no dispute as to any material fact, and subsequently granted the motion for summary judgment in favor of Johns Hopkins.[209] A physician-patient relationship had not been established, and

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201. *Id.* The plaintiff essentially contended that the course of treatment in this case was the transfer itself, and because Khouzami had agreed to the transfer and insisted on transport by ambulance, he was prescribing a course of treatment. Therefore, the plaintiff argued this presented a dispute as to a material fact; whether Khouzami was acting merely as a consultant without a duty to Sterling, or conversely, as a doctor who had accepted her as a patient and was prescribing a course of treatment. *Id.*

202. *Id.* at 458.

203. *Id.* at 457-58.

204. *Id.* No doubt, the practical effect of the court's decision was to disregard the consultative physician's statements. The court relied on Dr. Gray's decision making authority to override any of Khouzami's recommendations. *Id.*

205. *Sterling*, 802 A.2d. at 458.

206. *Id.*

207. *Id.* at 457-58. (noting Dr. Gray was reluctant to send the patient by ambulance, but still made the ultimate determination regarding how she would be transferred).

208. *Id.* The protocol for transfer in a situation where an individual is receiving a magnesium sulfate drip calls for transport by ambulance. *Id.* at 443 n.5. Dr.Khouzami told Dr.Gray that an ambulance would have been acceptable in this situation, even though Dr. Gray wanted Sterling to be taken to Baltimore by helicopter. *Id.* at 457-58.

209. *Id.* at 458-59.

therefore, Johns Hopkins did not owe Sterling a duty of care.[210] As a policy matter the court stated, "[w]e thus cannot assume that a hospital accepting a transfer owes the same duties as the transferring hospital, as the accepting hospital is not currently treating the patient and thus has not established a responsibility towards the patient."[211] The *Sterling* opinion, therefore, held that an implied duty was not created when Dr. Gray contacted Johns Hopkins hospital to facilitate transfer of Ms. Sterling.[212]

IV. *STERLING*, PRIOR CASE LAW, AND THE MEDICAL MALPRACTICE CRISIS

In *Sterling v. Johns Hopkins Hospital*, the Court of Special Appeals affirmed its position among the majority of jurisdictions, requiring that a doctor affirmatively accept a patient by participating in treatment or diagnosis before duty is created by an implied doctor-patient relationship.[213] Considering a case of first impression, however, the court properly set precedent by restricting a physician-patient relationship by implication in a transfer situation when the treating physician remains free to exercise his own judgment and diagnosis is completed at the time of consultation. Thus, the Court of Special Appeals respected the historical theory underlying medical malpractice and avoided the danger of expanding duty where a doctor has not fully accepted an individual into his care. *Sterling* is important for issues surrounding medical malpractice because restricting the factual situations that impose liability on doctors will decrease malpractice insurance premiums, thus easing the current health care crisis.

The Court of Special Appeals Properly Affirmed Its Position Requiring an Affirmative Act To Demonstrate Acceptance as a Patient

Nearly all jurisdictions recognize that medical malpractice involves principles of both contract and tort law.[214] Perhaps moving away from the historical basis in contract, however, the *Mozingo* case held that a duty may be imposed even when a doctor has never accepted a patient.[215] In *Sterling,* the Court of Special Appeals affirmed its position among the majority of jurisdictions,

210. *Id.*

211. *Sterling,* 802 A.2d. at 459.

212. *Id.*

213. *But see* Mozingo v. Pitt County Mem'l Hosp., Inc., 415 S.E.2d 341 (N.C. 1992).

214. *See* HARNEY, *supra* note 11, at 8.

215. *Mozingo,* 415 S.E.2d at 347.

stressing the *Mozingo* approach is incorrect.[216] Much criticized,[217] *Mozingo* relied upon the doctor's on-call status as well as his stipulation that he was responsible for supervising residents to find that a physician-patient relationship had been established.[218] Critics argue that the North Carolina Supreme Court betrayed the contractual history of medical malpractice in *Mozingo*, because the doctor performed all of the terms of his contract.[219] He was available when contacted and immediately came to the hospital when called.[220] Furthermore, opponents to the *Mozingo* decision note that the court's decision excessively expanded the scope of duty in North Carolina.[221] Consequently, a physician in North Carolina would have a duty to a patient whom he has never treated or examined.[222]

As a result, the court's decision in *Mozingo* has not been followed by many other jurisdictions, and in some cases, has been expressly rejected.[223] Serving as a strong example is the Virginia Supreme Court's decision in *Prosise v. Foster.* That case, as noted above, held that duty would not be imposed on the on-call physician for a resident's misdiagnosis "because the evidence failed to show a consensual relationship in which the patient's care was entrusted to the [on-call] physician and the physician accepted the case."[224] As a result of the decision, the Virginia high court followed Maryland, quoting heavily from *Rivera.*[225] A physician-patient relationship would not be created by implication "in the absence of proof that the doctor had accepted the patient, or had been summoned for consultation or treatment, 'unless the 'on-call' agreement between a hospital and a

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216. *Sterling*, 802 A.2d at 449-51. Here, The Court of Special Appeals showed that many courts have followed the analysis established in *Rivera. Id.*

217. *See e.g.*, Glenn, *supra* note 12, at 769; *see also* Rivera v. Prince George's County Health Dep't, 649 A.2d 1212 (Md. Ct. Spec. App. 1994); Prosise v. Foster, 544 S.E.2d 331 (Va. 2001).

218. *See Mozingo.* 415 S.E.2d at 344-45.

219. Glenn, *supra* note 12 at 769 ("In *Mozingo*, the terms of the contract between the doctor's employer and the medical school stated that 'on call' physicians would remain available by telephone and come to the hospital when needed. It is undisputed that Dr. Kazior was available for consultation with the residents and that he departed immediately for the hospital upon hearing of Sandra Mozingo's delivery complications. Therefore, the plaintiff should not have been able to maintain a cause of action against the doctor based on a contort liability theory.") Glenn, *supra* note 12, at 769.

220. Glenn, *supra* note 12, at 769.

221. Glenn, *supra* note 12, at 770.

222. Glenn, *supra* note 12, at 771. Commentators have also pointed out other implications of *Mozingo*, notably that "[b]ecause a party contracting with a hospital to care for patients will not be able to determine the scope of his liability after *Mozingo*, he will not be eligible for summary judgment in any case if a plaintiff asserts that the standard of care has not been met. *Id.* at 771.

223. *See* Sterling v. Johns Hopkins Hosp., 802 A.2d 440 (Md. Ct. Spec. App. 2002); Rivera v. Prince George's County Health Dep't, 649 A.2d 1212 (Md. Ct. Spec. App. 1994); Prosise v. Foster, 544 S.E.2d 331 (Va. 2001). Maryland and Virginia are two examples of states that expressly reject the *Mozingo* standard.

224. *Prosise*, 544 S.E.2d at 334.

225. *Id.*

physician provides otherwise.'"[226] Requiring that a doctor affirmatively accept the patient before a physician-patient relationship is created comports with the contractual theory underlying medical malpractice claims.[227]

The *Sterling* court noted the competing lines of cases in this area of the law,[228] and maintained that Maryland was hesitant to follow the North Carolina courts and expand duty through an implied physician-patient relationship merely on the basis of on-call status.[229] Thus, the Maryland precedent established in *Rivera* and affirmed in *Sterling* appears to be the best reasoned approach, in accord with many other jurisdictions.

The Court of Special Appeals Correctly Held an Implied Physician-Patient Relationship Had Not Been Created in the Sterling Transfer Situation

Established case law outside of Maryland examining the creation of a physician-patient relationship by implication influenced the Court of Special Appeals in *Sterling*. Considering a case of first impression, the court properly set precedent restricting the establishment of a physician-patient relationship by implication in a transfer situation when the treating physician remains free to exercise his own judgment and the diagnosis is completed. Such a holding was consistent with the contractual principles of medical malpractice which guided the court's decision.[230]

Sterling is consistent with cases highlighting the influence of contractual principles, such as *Lownsbury*,[231] where a physician-patient relationship only arises if the consulting doctor has already assumed the responsibility of supervision pursuant to a prior agreement.[232] In the supervisory fact scenario, when a doctor has assumed full responsibility of treatment he should be prepared to accept the full duty of that patient's care. Perhaps then, if a doctor does not have full responsibility or control over a patient, the requisite physician-patient relationship is *not* established because there is another doctor that may determine the course of treatment. Considering this, the *Sterling* court may have illustrated it was adopting such logic stating,

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226. *Sterling*, 802 A.2d at 450 (citing *Rivera*, 649 A.2d at 1232).

227. *See Sterling*, 802 A.2d at 458-59.

228. *Id.* at 448-55.

229. *Id.* at 454-55.

230. *See id.* at 444 n.6.

231. Lownsbury v. Venture, 762 N.E.2d 354 (Ohio Ct. App. 2002).

232. *See id.* at 363 (noting, "the determinative issue in this case is not whether Dr. Stover had any contact with Lownsbury or the residents treating her, but whether and to what extent Dr. Stover assumed the obligation to supervise the residents at Akron City Hospital.").

> We thus cannot assume that a hospital accepting a transfer owes the same duties as the transferring hospital, as the accepting hospital is not currently treating the patient and thus has not established a responsibility towards the patient. Furthermore, the accepting hospital is unable to examine the patient to make informed decisions. We will not extend to such hospitals a duty of medical care where the patient remains under the supervision and care of her treating or attending physician.[233]

From this excerpt, Dr. Khouzami's relationship with the patient was overpowered by Dr. Gray because Dr. Gray could have changed the course of treatment at any time. The court explicitly noted that it would not find that a physician-patient relationship was created by implication where "the patient remains under the supervision and care of her treating or attending physician."[234] In a sense, Dr. Khouzami could not accept Ms. Sterling as a patient until Dr. Gray had relinquished control over her treatment plan. Quite possibly, the court believed not having full authority over a patient weakens the assumption that the patient is under that doctor's care. Therefore, in harmony with the historic contractual and negligence principles of medical malpractice, the Court of Special Appeals properly restricted duty and found that an implied relationship had not been created.

In addition, the *Sterling* court also underscored the fact that an implied duty had not arisen because Dr. Khouzami did not participate in the diagnosis of the patient.[235] To the court, when Dr. Gray spoke with Khouzami about the transfer, a full diagnosis of pre-enclampsia and HELLP syndrome had been completed.[236] Dr. Khouzami did not make a diagnosis, but rather, only "*confirmed* . . . that the treatment given was appropriate and agreed to a transfer of that patient."[237] (emphasis added) The Court of Special Appeals believed that confirmation of a diagnosis did not qualify as a diagnosis itself. Such a holding is consistent with the rule that a physician-patient relationship arises when the doctor makes a diagnosis or prescribes a course of treatment.[238] Conversely, if a doctor does not diagnose a patient or set forth a treatment plan, he has not yet accepted her as a patient and a physician-patient relationship does not exist. Noting the specific facts of *Sterling*,

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233. *Sterling*, 802 A.2d at 459.

234. *Id.*

235. *Sterling*, 802 A.2d at 458.

236. *Id.* at 457.

237. *Id.* at 458.

238. *See* Wheeler v. Yettie Kersting Mem'l Hosp., 866 S.W.2d 32 (Tex. App. 1993); Adams v. Via Christi, 19 P.3d 132 (Kan. 2001). Although these cases are somewhat different factually (in *Wheeler* the doctor was speaking with the nurse who relied on his treatment plan, *Wheeler*, 866 S.W.2d at 35, in *Adams* a doctor-patient relationship was renewed, *Adams*, 19 P.3d at 141), the diagnosis in each situation is what ultimately supported the finding that a duty had been created.

the Court of Special Appeals rightly found that Dr. Khouzami did not have a duty to Ms. Sterling because he acted more as a consultant rather than a doctor making a diagnosis.

Assuming, *arguendo,* that Dr. Khouzami prescribed a course of treatment, a physician-patient relationship would still not have been created.[239] During the telephone call, Dr. Gray and Dr. Khouzami discussed how the patient would be transferred to Johns Hopkins. Although Dr. Gray initially requested an air lift, Dr. Khouzami urged that transport by ambulance was sufficient and complied with the standard of care. Potentially, Ms. Sterling's transfer by ambulance could be regarded as prescribing a course of treatment. A plaintiff in Sterling's position could argue that even though Dr. Gray could override Dr. Khouzami's plan for transfer by ambulance, Dr. Gray relied on the plan because Dr. Khouzami was a specialist practicing at a designated "High-Risk Maternal Consultation/Referral Service."[240] Courts have held, however, that a duty is not created when the treating physician relies on the advice of a specialist in formulating a treatment plan.[241] Possibly anticipating this argument, the Court of Special Appeals properly restricted the creation of an implied physician-patient relationship in *Sterling*, even if Dr. Khouzami prescribed a course of treatment.

Furthermore, *Sterling* properly restricted duty through an implied physician-patient relationship even though Dr. Khouzami had consented to accept Sterling as a patient when she arrived. Initially, it could be argued that the Appellate Court of Illinois in *Reynolds v. Decatur Memorial Hospital* suggested that duty may arise if the doctor agrees to examine the patient at a later time.[242] Other courts, however have expressly considered and rejected that approach to creating a physician-patient relationship. In *Irvin v. Smith*, the Supreme Court of Kansas acknowledged that the consulting physician had agreed to examine the patient in the morning, but held that doing so did not amount to accepting the individual as a patient.[243] Therefore, no physician-patient relationship was created.[244] Similarly, Dr. Khouzami agreed to accept Sterling once she arrived at Hopkins.[245] Although the Court of Special Appeals did not specifically consider that argument, it was correct in restricting duty under the facts of *Sterling* bearing the *Irvin* decision in mind.

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239. *See* McKinney v. Schlatter, 692 N.E.2d 1045, 1050 (Ohio Ct. App. 1997). Although the *McKinney* three-prong test has been abandoned, courts still recognize that a duty may be created either when the doctor makes a diagnosis or when he prescribes a course of treatment. *See, e.g.*, Sterling, 802 A.2d at 448.

240. *See Sterling*, 802 A.2d at 441-42.

241. *See* Corbet v. McKinney, 980 S.W.2d 166, 170 (Mo. Ct. App. 1998) (suggesting it was inconsequential that the treating physical contacted the defendant, a specialist, and the treating physician "would not have overridden" the specialist). *Id.* at 168.

242. *See* Reynolds v. Decatur Mem'l Hosp., 660 N.E.2d 235, 240 (Ill. App. 1996).

243. Irvin v. Smith, 31 P.3d 934, 942, 944 (Kan. 2001).

244. *Id.* at 943

245. *See* Sterling v. Johns Hopkins Hosp., 802 A.2d 440, 442-43 (Md. Ct. Spec. App. 2002).

The Impact of Sterling on Public Policy and the Medical Malpractice Crisis

The Court of Special Appeals avoided the danger of expanding duty in medical malpractice litigation by restricting the creation of duty through an implied physician-patient relationship. Across the nation, medical malpractice litigation is among the most vigorously contested issues. Observers are concerned that increasing jury awards raise both the cost of malpractice insurance as well as health care costs overall.[246] Consequently, many protest that various measures of tort reform are necessary, such as damage caps or enterprise liability for hospitals rather than individualized liability for doctors.[247] The insurance industry claims that the rise in rates is due to an increase in malpractice litigation and jury awards in the millions of dollars.[248] Others, especially the plaintiffs' bar, place blame on large insurance companies, contending,

> Much of the extraordinary increase has come after a multiple year bear market that played havoc with the forecasts of so many financial products companies. . . . Medical malpractice insurers used their pools of reserve cash to invest aggressively during the 1990's. This allowed the insurance carriers to lower premiums, based on the erroneous belief that the market would stay high. According to this theory, when the market dropped, this poor planning resulted in sharply increasing premiums[249]

Exactly who is to blame for the current state of affairs is unclear. Most likely, it is a combination of these factors that influence the malpractice premiums doctors pay annually.[250] Regardless of which is the strongest factor, the issue threatens to harm doctors, patients, and lawyers.

Largely, one's opinion on which actor is the cause of the so-called medical malpractice crisis may depend on how one balances public policy concerns against the individual plaintiff, as well as partisan loyalties. Generally stated, the "public

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246. Robert Ward Shaw, *Punitive Damages in Medical Malpractice: An Economic Evaluation*, 81 N.C. L. REV. 2371, 2377 (2003).

247. *Id.* at 2378; Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 382-83 (1994) "One malpractice reform proposal that has gained prominence in the 1990s is enterprise medical liability. Under this approach the focus of medical malpractice litigation would be shifted from individual physicians to the health care organizations under whose auspices patients are treated." Abraham & Weiler, *supra* at 381.

248. Shaw, *supra* note 246, at 2378 (quoting Joseph B. Treaster, *Malpractice Rates Are Rising Sharply: Health Costs Follow*, N.Y. TIMES, Sept. 10, 2001, at A1).

249. Shaw, *supra* note 246, at 2379.

250. Shaw, *supra* note 246, at 2379.

policy rationale considers the greater good of the medical liability system over the fact-specific situation of each individual plaintiff," which a jury considers.[251] Each group has different goals in assessing pain and suffering, as jurors will grant damages based on the harm to that specific plaintiff, while legislators are concerned with the effect on the community as a whole.[252] Public policy issues such as ensuring that standards of medical care remain high and that doctors are available and able to practice medicine in the communities of individual states are issues of great importance in state capitals.

Recognizing the impact of increased medical malpractice liability on the public, many courts have stressed that policy concerns are of great importance when deciding exactly when duty may be established.[253] The *Sterling* decision will impact medical malpractice litigation because it may reduce the number of plaintiffs who are able to establish the duty element in their prima facie case. In *Sterling*, the court set a high standard for establishing a physician-patient relationship by implication in a transfer situation. As long as the treating doctor has the final say, a duty will not be imposed on the doctor at the transferee hospital even if he prescribes a course of treatment or refers to the individual as "his patient." Such a holding is especially significant in a transfer situation because discussion between doctors often takes place over the telephone.[254] If the court held that a plaintiff could always establish duty through a telephone conversation like the one in *Sterling*, "the consequence of such a role would be significant. It would have a chilling effect on [the] practice of medicine. It would stifle communication, education, and professional association, all to the detriment of the patient."[255]

Heeding further concerns, if duty had been created in *Sterling*, transferee hospitals such as Johns Hopkins may be less willing to discuss a patient's symptoms or even accept a transfer patient for treatment. Although one court has countered that restricting implied duty allows physicians to escape liability,[256] the weight of policy concerns seems to bear against defining duty in a broad sense, rather than taking a more narrow approach. Taking a global (rather than individualized) view of the impact of medical malpractice case law, it seems that stifling communication and transfers between hospitals would be a greater evil to

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251. Elizabeth Stewart Poisson, *Addressing the Impropriety of Statutory Caps on Pain and Suffering Awards in the Medical Liability System*, 82 N.C. L. REV. 759, 780 (2004).

252. *Id.*

253. *Id.*; *see e.g.*, Corbet v. McKinney, 980 S.W.2d 166, 169 (Mo. Ct. App. 1998).

254. *E.g.* Irvin v. Smith, 31 P.3d 934, 943 (Kan. 2001).

255. *Id.* at 943 (quoting Reynolds v. Decatur Mem'l Hosp., 660 N.E. 2d 235, 240 (Ill. App. 1996)).

256. McKinney v. Schlatter, 692 N.E.2d 1045, 1050 (Ohio Ct. App. 1997) (noting "[w]e find that the lack of direct contact between the patient and the on-call physician does not, in itself, preclude a physician-patient relationship. To find otherwise would allow on-call cardiologists and kindred specialists who, with a duty to do so, provide what one could term 'indirect medical care' to escape all liability even after rendering a diagnosis and prescribing a course of treatment.").

avoid rather than allowing a few doctors to escape liability in limited situations.[257] Thus, in *Sterling* the Court of Special Appeals correctly restricted duty by implication particularly in light of the important public policy concerns at issue.

In addition, *Sterling* will positively impact public policy issues not expressly considered in the decision. Currently, physicians face high malpractice insurance premiums, forcing many doctors to relocate or stop practicing altogether.[258] Statistics from Maryland also illustrate this trend.[259] The organization that insures most doctors in Maryland, the Medical Mutual Liability Insurance Society, has increased its rates by 28 percent over the past year, and is considering premium increases this summer of as much as 40 to 50 percent.[260] Possibly noting these difficulties, the Court of Special Appeals may have restricted duty arising from an implied physician-patient relationship to increase the difficulty of making a medical malpractice claim. If no physician-patient relationship has been formed, then no duty can be imposed on the doctor.[261] As a result, a plaintiff would not be able to meet the first element of the prima facie case in a medical malpractice suit.[262]

Consistent with this theory, making it more difficult to bring a claim would potentially decrease the number of successful suits against doctors. If claims are reduced, the cost of malpractice insurance may be lowered. Also motivated to combat rising premiums, political leaders have begun to introduce legislation focused on helping doctors and the health care sector.[263] Maryland's Governor, Robert Ehrlich, proposed legislation in 2004 that "include[d] some limits on lawyers [sic] fees and restrictions on the way economic damages are computed . .

257. Discouraging communication would hinder the practice of medicine greatly, especially in areas where communication and transfer between hospitals is essential. The competing policy concern, allowing negligent doctors to escape liability because an implied duty was not established, may also create problems because doctors may lower their standard of care realizing that they may not be held liable in discussing a transfer situation over the phone. This, however, would be less widespread than an expansion of duty where a "chilling effect" would befall the practice of medicine.

258. *Bush Argues for Cap on Medical Malpractice Awards*, MANAGED CARE WKLY DIG., Aug. 26, 2002, *available at* 2002 WL 25803333. The article points out that President Bush is a proponent of tort reform in medical malpractice suits. The intended goal is to decrease jury awards, which will in turn decrease malpractice insurance premiums. Some claim that the nation's health care industry faces an impending crisis as "the result has been closed practices and rising healthcare costs overall as doctors defensively prescribe unnecessary tests and treatments, and fewer physicians entering high-risk areas." *Id.*

259. *Maryland Governor To Propose Limits on Claims*, HEALTH & MED. WK.,, Dec. 1, 2003, *available at* 2003 WL 65966149; Tom Ramstack, *Doctors' Careers on Life Support*, WASH. TIMES, Sept. 1, 2003, *available at* http://www.washtimes.com/business/2003031-10245-9582r.htm (last visited June 10, 2004).

260. *Maryland Governor To Propose Limits on Claims*, *supra* note 259; Vaishali Honawar, *Special Session for Malpractice Law?*, THE CAPITAL, June 9, 2004, at A1.

261. Sterling v. Johns Hopkins Hosp., 802 A.2d 440, 444-45 (Md. Ct. Spec. App. 2002).

262. *Id.*

263. *See Bush Argues for Cap on Medical Malpractice Awards*, *supra* note 258.

."[264] The proposal died on the Maryland Senate floor, but Erlich plans to continue to make the legislation a priority.[265] Although doctors and lawyers differ on exactly who is to blame for high malpractice premiums,[266] some argue decreasing the amount of claims paid to plaintiffs alleviates some of the high insurance costs.[267] Faced with such issues gaining national attention and a world where communication between doctors occurs freely and through a variety of channels, courts are forced to refine their theories of duty by implication. In this environment, *Sterling* may forestall expanding medical malpractice liability in situations where it is argued that duty is created through an implied physician-patient relationship.

V. CONCLUSION

In closing, *Sterling* may demonstrate that restricting duty through an implied physician-patient relationship in a transfer situation limits the malpractice liability of physicians in Maryland. The degree to which the *Sterling* decision serves to limit medical liability remains to be seen. It is clear, however, that if duty is not proven the prima facie case of a medical malpractice suit cannot survive and the defendant is entitled to summary judgment as a matter of law. Intuitively then, by limiting the factual scenarios that evince the creation of a physician-patient relationship, the number of claims that survive summary judgment will decrease.

Considering the potential impact of *Sterling*, not much scholarly discussion exists regarding the creation of duty as a result of an implied physician-patient relationship. For now, *Sterling's* reasoning does not seemed threatened because the Court of Appeals of Maryland denied Sterling's petition of certiorari.[268] With many physicians leaving practice around the country due to high insurance costs, protecting doctors in the context of transfer situations is particularly important, as patients are freely transferred within the same region to different facilities that provide specialized care. Nevertheless, *Sterling* stands as an important case serving to limit the liability of doctors in Maryland.

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264. *Maryland Governor to Propose Limits on Claims*, *supra* note 259.

265. Honawar, *supra* note 260.

266. Kenneth Jost, *Medical Malpractice: Are Lawsuits Out of Control?*, CQ WKLY., Mar. 15, 2003, at 640. Doctors charge that the legal system, which allows the filing of too many meritless claims, is to blame for high malpractice insurance rates. Lawyers argue that it is not the legal system, but the insurance companies, who "raise medical liability premiums to offset low returns on investments."

267. *See id.*

268. Sterling v. Johns Hopkins Hosp., 802 A.2d 440 (Md. Ct. Spec. App. 2002), *cert. denied*, 808 A.2d 808 (Md. 2002).