Document #3500

Establishment of the Physician–Patient Relationship

CMA Legal Counsel, January 2019

The following discusses the laws affecting a physician's discretion to refuse to establish a physician–patient relationship. For information on the laws governing termination of the physician–patient relationship and patient abandonment, *see* CMA O'N-CALL document #3503, "Termination of the Physician–Patient Relationship." For information on the laws governing discrimination on the basis of disability, *see* CMA ON-CALL document #6002, "Disabled Patients: Health Care Services." For information specific to HIV-infected patients, *see* CMA ON-CALL document #6006, "Discrimination: HIV-Infected Patients." For more information on managed care contract termination, *see* CMA ON-CALL document #7051, "Contract Termination by Physicians and Continuity of Care Provisions."

WHEN IS PHYSICIAN–PATIENT RELATIONSHIP ESTABLISHED?

Patient's Reasonable Expectation of Care

1. How do I know if a physician–patient relationship has been established?

Whether a physician–patient relationship exists depends on the specific facts and circumstances of each situation. (1 Cal. Med. Malprac. L. & Prac. §1:2 (2014 ed.).) The basic question is whether a patient reasonably believes that the physician will provide necessary medical care to that patient. (*Id.*) (citing *Kramer v. Policy Holders' Life Insurance Assn.* (1935) 5 Cal.App.2d 380, 382).) As a general rule, a physician–patient relationship is established when a physician conducts the initial history and physical examination. However, depending on the circumstances, such a relationship may exist even earlier. Some jurisdictions have held that a relationship exists when a physician gives a patient an appointment for a specific medical service (*Lyons v. Grether* (Va. 1977) 239 S.E. 2d 103), when a physician agrees by telephone to see a patient (*Bienz v. Cent. Suffolk Hosp.* (N.Y. App. Div. 1990) 163 A.D. 2d 269), or even based on a telephone call for consultation from another physician for their patient (*Mead v. Legacy Health Sys* (2012) 352 Ore. 267). In practice, however, California generally has not found that a mere telephone conversation is enough to establish a physician–patient relationship. *See Barton v. Owen* (1977) 71 Cal.App.3d 484. The key question is whether a patient entrusted themselves to the care of the physician, and whether that physician accepted the case.

California courts have yet to decide when a physician–patient relationship has been established in many particular circumstances. A standard exists, however, for analyzing whether or not an attorney–client relationship is established and could arguably be applied to a case involving the physician–patient relationship. (1 Cal. Med. Malprac. L. & Prac. §1:2 (2014 ed.) In the attorney–client analysis, the courts will look for the intent and conduct of the parties (*Lister v. State Bar of California* (1990) 51 Cal.3d 1117), the existence of a written agreement (*Setzer v.*

Robinson (1962) 57 Cal.2d. 213) and whether or not the advice was sought from the attorney in the attorney's professional capacity (*People v. Gionis* (1995) 9 Cal.4th 1196).

Ethical Guidelines

The AMA's Council on Ethical and Judicial Affairs has issued opinions related to physician–patient relationships, as reflected in the following AMA Policies:

E-1.1.1 Patient–Physician Relationships

> The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.
>
> A patient–physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).
>
> However, in certain circumstances a limited patient–physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:
>
> (a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
>
> (b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
>
> (c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient–physician relationship exists.
>
> AMA Principles of Medical Ethics: I, II, IV, VIII. (Last modified 2017.)

AMA's Principles of Medical Ethics set out physicians' ethical obligation to support access to medical care for all people (Principle IX), an obligation that physicians share with all who are involved in providing and financing health care, including the medical profession as a whole, health care facilities and payers, and public policymakers. Yet, lack of health insurance and inability to pay out of pocket mean that many individuals do not have access to care. (CEJA Rep. 2, A-09.) Based on these principles, in 2009, AMA adopted the following policy:

E-11.1.4 Financial Barriers to Health Care Access

> Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.
>
> In view of this obligation,
>
> (a) Individual physicians should:
>
> > (i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through free-standing facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.
> >
> > (ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.
>
> (b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.
>
> (c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.

(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.

AMA Principles of Medical Ethics: I, II, VI, VII, IX. (Last modified 2017.)

Patient Care Committee Evaluations

2. Does a physician–patient relationship exist when I evaluate a patient as a member of a patient care committee?

No. Courts have recognized the importance of patient care committees in providing objective review and guidance when there are tensions between medical and ethical issues that arise between patients, providers, healthcare entities, patient's families and other healthcare decisionmakers and have found that patient care committee members do not have a patient–physician relationship with the patient and thus, have no duty of care to the patient. For instance, in *Alexander v. Scripps Memorial Hospital La Jolla* (2018) 23 Cal.App.5th 206, the estate and family of a deceased 70-year old woman with terminal pancreatic cancer who died days after being transferred from a nursing facility to a hospital brought an action against various doctors and the hospital alleging, among other things, that failure to follow the patient's advance health care directive resulted in her death. The woman, Elizabeth Alexander, had an advance health care directive which indicated that she wanted all measures taken to prolong her life. However, her physicians opined that advanced life support measures would be medically ineffective and harmful. Given the tension between the patient's directive and her treating physicians' opinion, the situation was considered by the hospital's patient care committee, which included a team of physicians who provide recommendations and ethical guidance. After reviewing the pertinent records and observing the patient, the committee recommended against advanced life support measures. The patient's family then requested that she be transferred to another facility, but the patient died before the transfer. The patient's family and estate sued the physicians and hospital, but the trial court dismissed their claims. On appeal, the court held that physician members of the patient care committee did not have a physician–patient relationship with the patient. Specifically, the court found that even though committee members evaluated the patient's medical history, provided an opinion on what constituted medically ineffective care, and made recommendations when the treating physicians' plan of care was inconsistent with the patient's directives, the committee members did not treat the patient and thus, they did not have a physician–patient relationship with the patient sufficient to impose upon them a duty of care. Recognizing the important role of ethics committees in patient care, the court also found that the immunities provided to health care providers under the Health Care Decisions Law (Probate Code §§4735, 4740) apply to institutions that act in good faith and in accordance with generally accepted health care standards in declining to comply with an individual health care directive that would require medically ineffective care.

Independent Medical Evaluations

3. Does a physician–patient relationship exist when I evaluate a patient for an employer or insurance company?

A physician evaluating a patient for a third party probably would not be held liable for failing to diagnose, or inform an examinee of a health condition. A sufficient physician–patient relationship has probably not been established to give rise to such liability, because the patient has no reason to believe that the physician is acting primarily for their benefit. (California Tort Guide §9.69 (3d ed. Cal. CEB).) For example, a California Court of Appeal ruled that a physician could not be held liable for making a negligent medical report on behalf of an employer in a worker's compensation proceeding, even though the employee had allegedly relied, to his detriment, on the report. (*Keene v. Wiggins* (1977) 69 Cal.App.3d 308.) The court noted, however, that had the physician gone beyond just preparing the report and, for example, volunteered or otherwise attempted to serve or benefit the worker, a physician–patient relationship would have been established. (*Id.*)

While a full physician–patient relationship might not be established between a physician hired by a third party and an examinee, that physician may still be liable for any new or aggravated injury caused by negligently performing the evaluation (*Mero v. Sadoff* (1995) 31 Cal.App.4th 1466). In *Mero*, a lawsuit was permitted for back injuries allegedly suffered from

being strapped and maneuvered improperly during an examination of a separate work-related injury performed for the examinee's employer. Another examinee, who suffered adverse employment consequences as a result of allegedly negligently-processed alcohol tests, sued the laboratory and third party administrator of drug and alcohol tests for negligence because there is no threshold issue of establishing the existence of a physician–patient relationship. The court found that the laboratory owed a duty to the individuals whose specimens they test, even if the test is performed at the behest of a third party. (*Quisenberry v. Compass Vision, Inc.* (S.D.Cal. 2007) 618 F.Supp.2d 1223.) A negligently prepared medical-legal report may also cause a physician to be liable for resulting additional attorney's fees. *See Brousseau v. Jarrett* (1977) 73 Cal.App.3d 864, 871.

California's Attorney General had been in the process of issuing an opinion as to whether a medical consultant employed by the State of California to evaluate a long-term disability claim has established a physician–patient relationship with the claimant, but the issue was withdrawn on February 4, 2014 before an opinion was published. *See* Ops.Cal.Atty.Gen.10-207. CMA filed comments with the Attorney General's office explaining that California law and principles of medical ethics recognize the establishment of a patient–physician relationship in circumstances where the patient has a reasonable expectation of receiving medical services over time from the physician and that therefore there is no patient–physician relationship between a long-term disability claimant and a state-employed or retained evaluating medical consultant.

Utilization Review

4. Does a physician–patient relationship exist when I perform utilization review?

It is possible. A physician performing utilization review may be found to have a physician–patient relationship with the person whose medical records are being reviewed and, thus, owe the patient a duty of care. In *Palmer v. Superior Court* (2002) 103 Cal.App.3d 953, the appellate court concluded that the hospital's medical director, who determined that requested prostheses were not medically necessary, "was acting as a health care provider as to the medical aspects of that decision." (*Id.* at p. 969.) The appellate court explained that the medical director's utilization review decision amounted to medical care, and was not purely administrative, because the utilization review had to "be conducted by medical professionals, and they must carry out these functions by exercising medical judgment and applying clinical standards." (*Id.* at p. 972.)

However, the scope of the duty owed depends on the facts of each situation. For instance, in *King v. CompPartners, Inc.* (2016) 243 Cal.App.4th 685, plaintiffs alleged that injury resulted when Mr. King suffered multiple seizures caused by suddenly stopping a medication that a physician performing utilization review deemed medical unnecessary, without warning the patient to taper down from the medication. The trial court dismissed the complaint but the court of appeal held that the trial court should have granted plaintiffs leave to amend their complaint because given the allegation that the utilization review physician was the only physician involved in the decision that the medication was not medically necessary, it was possible that, when more details are provided, plaintiffs could support their conclusion that the scope of that physician's duty included some form of warning to plaintiff of, or protecting plaintiff from, risk of seizures. (*King v. CompPartners, Inc.* (2016) 243 Cal.App.4th 685.)

The California Supreme Court has granted review of the appellate court ruling in the King case with a decision expected in 2018. In the meantime, the appellate court's decision is not binding precedent.

Ethical Guidelines

The AMA's Council on Ethical and Judicial Affairs takes the position that under these circumstances and when acting as an "Independent Medical Examiner," a "limited patient–physician relationship" exists. AMA Policy states the following:

E-1.2.6 Work-Related & Independent Medical Examinations

> Physicians who are employed by businesses or insurance companies, or who provide medical examinations within their realm of specialty as independent contractors, to assess individuals' health or disability face a conflict of duties. They have responsibilities both to the patient and to the employer or third party.
>
> Such industry-employed physicians or independent medical examiners establish limited patient–

physician relationships. Their relationships with patients are confined to the isolated examination; they do not monitor patients' health over time, treat them, or carry out many other duties fulfilled by physicians in the traditional fiduciary role.

In keeping with their core obligations as medical professionals, physicians who practice as industry-employed physicians or independent medical examiners should:

(a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.

(b) Explain that the physician's role in this context is to assess the patient's health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.

(c) Protect patients' personal health information in keeping with professional standards of confidentiality.

(d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.

AMA Principles of Medical Ethics: I. (Last modified 2017.)

For more information on the obligation of physicians performing employment physicals and other examinations on behalf of other business interests, *see* CMA ON-CALL document #4201, "Employer Access to Medical Records/Employment Physicals."

Peers as Patients

5. Are there special considerations for establishing a physician–patient relationship with a fellow physician?

Yes. Generally, the same rules will apply to establishing a physician–patient relationship with a fellow physician as with a non-physician. However, the AMA has identified various ethical concerns that physicians should consider before entering into such a relationship. Those concerns are set forth in the following policy:

E-10.3 Peers as Patients

The opportunity to care for a fellow physician is a privilege or physician-in-training and may represent a gratifying experience and serve as a show of respect or competence. However, physicians must recognize that providing medical care for a fellow professional can pose special challenges for objectivity, open exchange of information, privacy and confidentiality, and informed consent.

In emergencies or isolated rural settings when options for care by other physicians are limited or where there is no other qualified physician available, physicians should not hesitate to treat colleagues.

Physicians must make the same fundamental ethical commitments when treating peers as when treating any other patient. Physicians who provide medical care to a colleague should:

(a) Exercise objective professional judgment and make unbiased treatment recommendations despite the personal or professional relationship they may have with the patient.

(b) Be sensitive to the potential psychological discomfort of the physician-patient, especially when eliciting sensitive information or conducting an intimate examination.

(c) Respect the physical and informational privacy of physician-patients. Discuss how to respond to inquiries about the physician-patient's medical care from colleagues. Recognize that special measures may be needed to ensure privacy.

(d) Provide information to enable the physician-patient to make voluntary, well-informed decisions about care. The treating physician should not assume that the physician-patient is knowledgeable about his or her medical condition.

Physicians-in-training and medical students (when they provide care as part of their supervised training) face unique challenges when asked to provide or participate in care for peers, given the circumstances of their roles in residency programs and medical schools. Except in emergency situations or when other care is not

available, physicians-in-training should not be required to provide medical care for fellow trainees, faculty members, or attending physicians if they are reluctant to do so.

AMA Principles of Medical Ethics: VI. (Last modified 2017.)

Patients' Spouses

6. I am a gynecologist. Does my physician–patient relationship with my patients create any duty to their husbands?

This question has been addressed in *Shin v. Kong* (2000) 80 Cal.App.4th 498. In *Shin*, the husband of a wife artificially inseminated with her physician's sperm sued the physician for failure to obtain the husband's consent for the procedure. The court dismissed the case, ruling that there was no physician–patient relationship between the husband and physician and, therefore, the physician had no duty to obtain consent from the husband for, or to inform the husband of, the procedure. (The court did not comment on the propriety of the physician acting as the sperm donor.)

Under certain circumstances, such as with respect to certain contagious diseases, the physician may have a duty to warn a patient's husband. For a detailed discussion of a physician's duty to warn, *see* CMA ON-CALL document #3675, "Physician's Duty to Protect."

Patients' Partners

7. Am I obligated to provide treatment to my patient's sex partner with whom I do not have a physician–patient relationship?

The AMA's Council on Ethical and Judicial Affairs issued a report concluding that, while medical care within a patient–physician relationship is preferred, physicians should recognize Expedited Partner Therapy as a valid tool for promoting public health when appropriately indicated. The report offers several guidelines for use when establishing whether Expedited Partner Therapy is appropriate. The Council's Opinion, as adopted into AMA Policy, is as follows:

E-8.9 Expedited Partner Therapy

Expedited partner therapy seeks to increase the rate of treatment for partners of patients with sexually transmitted infections through patient-delivered therapy without the partner receiving a medical evaluation or professional prevention counseling.

Although expedited partner therapy has been demonstrated to be effective at reducing the burden of certain diseases, such as gonorrhea and chlamydia, it also has ethical implications. Expedited partner therapy potentially abrogates the standard informed consent process, compromises continuity of care for patients' partners, encroaches upon the privacy of patients and their partners, increases the possibility of harm by a medical or allergic reaction, leaves other diseases or complications undiagnosed, and may violate state practice laws.

Before initiating expedited partner therapy, physicians should:

(a) Determine the legal status of expedited partner therapy in the jurisdiction in which they practice.

(b) Seek guidance from public health officials.

(c) Engage in open discussions with patients to ascertain partners' ability to access medical services.

(d) Initiate expedited partner therapy only when the physician reasonably believes that a patient's partner(s) will be unwilling or unable to seek treatment within the context of a traditional patient–physician relationship.

When initiating expedited partner therapy, physicians should:

(e) Instruct patients regarding expedited partner therapy and the medications involved.

(f) Answer any questions the patient has.

(g) Provide to patients educational materials to share with their partners that:

(i) encourage the partner to consult a physician as a preferred alternative to expedited partner therapy;

(ii) disclose the risk of potential adverse drug reactions;

(iii) disclose the possibility of dangerous interactions between the medication delivered by the patient and other medications the partner may be taking;

(iv) disclose that the partner may be affected by other sexually transmitted diseases that may be left untreated by the medication delivered by the patient.

(h) Make reasonable efforts to refer the patient's partner(s) to appropriate health care professionals.

AMA Principles of Medical Ethics: VII. (Last modified 2017.)

Managed Care Patients

8. Does a patient's enrollment in a managed care plan in itself establish a physician–patient relationship?

In general, a patient's mere enrollment in a managed care plan, before he or she has selected his or her particular physicians, does not establish a physician–patient relationship. However, once a physician is designated as a person's primary care physician, or begins receiving a capitation payment, then a physician–patient relationship may be established even before the patient's first office visit. If concerned about whether or not a physician–patient relationship has been established with a patient in a plan, physicians should discuss the matter with their malpractice carriers or personal attorneys. Physicians should also be aware that managed care contracts typically circumscribe or eliminate physicians' discretion as to whether they will establish a relationship with a patient of a plan they contract with, should the patient so desire.

SCOPE OF OBLIGATIONS

General or Limited Relationships

9. What services must I provide to a patient once a physician–patient relationship has been established?

A physician's services can be either general or limited to a particular purpose, time or place. Except in emergency situations, a physician can agree with the patient to limit the nature of the services to be provided. If a physician has a policy that he or she will not continue to provide services to a patient after treatment for the patient's condition has been completed or after a particular period of time has passed, the physician should communicate that policy clearly, preferably both before the physician–patient relationship is established and again when the relationship terminates. Furthermore, the agreement should be documented in the patient's medical record.

Whether and to what extent a physician's services have been limited will be a question of fact to be determined in each case. The patient's reasonable expectations will no doubt be an important factor. For example, if a primary care physician gives a patient a general check-up or yearly examination, the patient may well think of the physician as his or her ongoing caregiver. This may also be true even if a primary care physician treats a patient for a specific problem. By contrast, a patient probably anticipates that a specialist's services are limited to his or her specialty. However, the patient may expect that the specialist will provide subsequent services for similar or related problems within the physician's specialty.

Physicians should be aware that once the physician–patient relationship has been terminated, if the physician later provides further treatment to the patient, prior agreements between the physician and patient (for example, arbitration agreements, fee agreements, etc.), may not remain valid and should be re-executed.

Obligations to Patients Seen On-Call to the Emergency Department

10. If I provide care to a patient in a hospital emergency room or other emergency situation, am I obligated to continue to treat the patient after the emergency has passed?

This question arises frequently, particularly since both California and federal law require hospitals with emergency rooms to accept and treat all emergent patients, regardless of such characteristics as sex, race, physical disability, or financial condition. However, the courts have not yet definitely resolved the question, and the answer may well depend on the facts of the specific situation. The primary issue will be whether the patient has established a relationship with the hospital, the physicians staffing the emergency department, or an individual on-call physician, giving rise to a patient's reasonable expectation that the party with whom the relationship is established will provide follow-up care. As noted above, physicians are best advised to define with the patient and document the scope of their relationship clearly if they intend it to be limited to stabilizing treatment. For more information, *see* CMA ON-CALL document #5001, "Emergency Transfer Laws: Medical Staff and On-Call Requirement."

11. Are there special rules governing hospital discharge?

Hospital discharge policies may affect the scope of an on-call physician's services. Hospitals must have written discharge policies which include the following requirements:

- Appropriate arrangements for post-hospital care must be made prior to discharge for patients "who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning." This must include counseling of the patient and family members or interested persons the hospital determines to be necessary to prepare the patient for post-hospital care.
- Each patient admitted to the hospital must be provided with an opportunity to identify one family caregiver who may assist in post-hospital care. That information must be recorded in the patient's medical chart. For discharge planning purposes, "family caregiver" means a relative, friend, or neighbor who provides assistance related to an underlying physical or mental disability but who is unpaid for those services.
  - For a patient who is unconscious or otherwise incapacitated upon admission, the hospital must provide the patient or patient's legal guardian with an opportunity to designate a caregiver within a specified time period, at the discretion of the attending physician, following the patient's recovery of consciousness or capacity. All attempts to have the patient or legal guardian designate a caregiver and any related declination to do so must be promptly documented in the patient's medical record.
- The patient's designated family caregiver must be notified of the patient's discharge or transfer to another facility as soon as possible and no later than upon issuance of a discharge order by the patient's attending physician. If the hospital cannot contact the designated caregiver, the lack of contact must not interfere with, delay or otherwise affect the medical care provided to the patient or an appropriate discharge of the patient. The hospital must promptly document the attempted notification in the patient's medical record. The patient, or for an incapacitated patient, the patient's legal representative, and the family caregiver must be informed of 1) the continuing health care requirements following discharge, and 2) each medication dispensed at the time of discharge.
  - The hospital must provide an opportunity for the patient and his or her designated family caregiver to engage in the discharge planning process, which must include providing information and, when appropriate, instruction regarding the post-hospital care needs of the patient. This information must include, but is not limited to, education and counseling about the patient's medications, including dosing and proper use of medication delivery devices, when applicable. The information must be provided in a culturally competent manner and in a language that is comprehensible to the patient and caregiver, consistent with the requirements of state and federal law, and must include an opportunity for the caregiver to ask questions about the post-hospital care needs of the patient.
- A transfer summary must be given to the patient or the patient's legal representative and accompany a patient being transferred to a skilled nursing facility, intermediate care facility or distinct part skilled nursing or intermediate care service unit of the hospital.
- The transfer summary must be signed by the physician and must include "essential information relative to the patient's diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirements, rehabilitation potential, known allergies and treatment plan."

Further, a hospital must provide every patient anticipated to be in need of long-term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. At a minimum, this information must include contact information for the area agency on aging serving the patient's county of residence, local independent living centers or other information appropriate to the needs and characteristics of the patient.

The discharge planning policies adopted by a hospital must ensure that planning is appropriate to the condition of the patient being discharged from the

hospital and to the discharge destination and meets the needs and acuity of the patients. Discharge planning requirements do not require a hospital to adopt a discharge policy that would delay discharge or transfer of a patient or to disclose information if the patient has not provided legally sufficient consent for disclosure of protected health information. (Health & Safety Code §1262.5.) CMA policy supports the development of hospital policies and procedures that support continuity of patient care. (HOD 613-15.) Discharge planning policies are an important component in promoting that continuity of care.

Homeless Patients

In 2006, due to increasing concern about lack of resources for the homeless in some counties, the California legislature passed a law that specifically prohibits hospitals from transferring a homeless patient from one county to another for the purpose of receiving supportive services. (Health & Safety Code §1262.4.)

Effective January 1, 2019, hospitals are required to include as part of their hospital discharge policy, a written homeless patient discharge planning policy and process. The policy and process must include:

- Inquiry about a patient's housing status;
- Help for the patient to prepare for return to the community by connecting the patient with available community resources and informing the patient of available placement options;
- Unless the patient is being transferred to another licensed facility, identification of a post-discharge destination for the patient, with preference given to a sheltered destination with supportive services; and
- Information regarding the discharge in a culturally competent manner and in a language understood by the patient.

(Health & Safety Code §1262.5(n).)

The hospital must document all of the following before discharging a homeless patient:

- That the treating physician has determined that the patient is clinically stable for discharge, including an assessment of whether the patient is alert and oriented to place, time, and person and that the physician has communicated to the patient post-discharge medical needs;
- That the patient has been offered a meal (unless medically contraindicated);
- If the patient's clothing is inadequate, that the hospital offered the patient weather-appropriate clothing;
- That the patient has been referred to a source of follow up care (if medically necessary);
- That the patient has been provided with any necessary prescription, and, for hospitals with a pharmacy, an appropriate supply of all necessary medication;
- That the patient has been offered or referred for screening for infectious diseases common to the region;
- That the patient has been offered appropriate vaccinations;
- That the treating physician has provided medical screening and that if the screening indicates that follow-up behavioral health care is needed, that the patient has been treated or referred as appropriate. In this event, the hospital shall make a good faith effort to contact one of the following:
- The patient's health plan, if applicable;
- The patient's primary care provider, if the patient has identified one; or
- Another appropriate provider, including, but not limited to, the coordinated entry system.
- That the patient has been screened for and provided assistance for enrolling in any health insurance coverage for which he or she is eligible; and
- That the hospital offered the patient transportation after discharge to the identified post-discharge destination, if it is within 30 minutes or 30 miles from the hospital.

(Health & Safety Code §1262.5(o).)

Effective July 1, 2019, hospitals are required to develop a written policy for coordinating services and referrals for homeless patients with health care providers, the county behavioral health agency, health care and social services agencies in the region, and nonprofit social services providers to assist in ensuring appropriate patient discharge. The plan must be updated annually and must include: 1) a list

of local homeless shelters, including hours and additional information; 2) the hospital's procedures for homeless patient discharge referrals to other services; 3) the contact information for the homeless shelter's intake coordinator; and 4) training protocols for discharge staff. (Health & Safety Code §1262.5(p).) Also beginning July 1, 2019, hospitals must maintain a log of homeless patients discharged and the destinations to which they were released as well as evidence of completion of the discharge protocol in the log or patient medical record. (Health & Safety Code §1262.5(q).)

PHYSICIAN'S RIGHT TO SELECT PATIENTS

There are many personal characteristics and circumstances that may have a conscious or unconscious effect on a physician's desire to establish a physician–patient relationship with any given individual. Many of those characteristics and circumstances are specifically addressed in non-discrimination laws but there are likely many others factors, not categorically addressed in current non-discrimination laws, that can have a similar influence. CMA policy acknowledges that implicit bias, meaning "the positive or negative perceptions, feelings, and stereotypes that impact our comprehension and behaviors in an unconscious way," exists and may impact patient care. CMA supports further studies on the impact of implicit biases on patient care and strategies for educating medical students, residents and physicians on deconstructing those biases, such as including implicit bias training in medical school curriculums and continuing medical education programs. (HOD 610-15.) As discussed below, established principles of medical ethics also address physicians' prerogative in selecting patients.

12. Do I have to treat every patient who asks me for medical treatment?

No. Unless you have signed a contract that limits your rights in this regard, you are free to close your practice to new patients, to limit your area of practice to a certain specialty or sub-specialty, to limit the number of health plans you participate in or even decide not to participate in any. However, the AMA's Council on Judicial and Ethical Affairs has developed ethical guidelines, adopted as AMA Policy, for physicians who exercise their prerogative of choosing whom to serve as follows:

E-1.1.2 Prospective Patients

As professionals dedicated to protecting the well-being of patients, physicians have an ethical obligation to provide care in cases of medical emergency. Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care. Nor may physicians decline a patient based solely on the individual's infectious disease status. Physicians should not decline patients for whom they have accepted a contractual obligation to provide care.

However, physicians are not ethically required to accept all prospective patients. Physicians should be thoughtful in exercising their right to choose whom to serve.

A physician may decline to establish a patient–physician relationship with a prospective patient, or provide specific care to an existing patient, in certain limited circumstances:

(a) The patient requests care that is beyond the physician's competence or scope of practice; is known to be scientifically invalid, has no medical indication, or cannot reasonably be expected to achieve the intended clinical benefit; or is incompatible with the physician's deeply held personal, religious, or moral beliefs in keeping with ethics guidance on exercise of conscience.

(b) The physician lacks the resources needed to provide safe, competent, respectful care for the individual. Physicians may not decline to accept a patient for reasons that would constitute discrimination against a class or category of patients.

(c) Meeting the medical needs of the prospective patient could seriously compromise the physician's ability to provide the care needed by his or her other patients. The greater the prospective patient's medical need, however, the stronger is the physician's obligation to provide care, in keeping with the professional obligation to promote access to care.

(d) The individual is abusive or threatens the physician, staff, or other patients, unless the physician is legally required to provide emergency

medical care. Physicians should be aware of the possibility that an underlying medical condition may contribute to this behavior.

AMA Principles of Medical Ethics: I, VI, VIII, X. (Last modified 2017.)

Discrimination Prohibited

13. Are there laws that limit my right to refuse to become someone's physician?

Yes. The law prohibits illegal discrimination. It is both illegal and unethical for a physician to discriminate on the basis of sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language or immigration status. (Civil Code §51.) This prohibition covers these characteristics of potential patients and of their "partners, members, stockholders, directors, officers, managers, superintendents, agents, employees, business associates, suppliers or customers." (Civil Code §51.5.) The courts have expressly held that the services of physicians are covered by these laws (*Washington v. Blampin* (1967) 226 Cal.App.2d. 604.) However, discrimination which is medically appropriate, for example, a pediatrician only agreeing to see children, or an obstetrician women, is not prohibited. *See generally Vaughan v. Hugo Neu Proler International* (1990) 223 Cal.App.3d. 1612. *See also* AMA Policy E-1.1.2 set forth above.

Moreover, physicians are subject to disciplinary action for refusing, in whole or in part, or aiding or inciting another licensee to refuse to perform the licensed services to a patient or prospective patient because of that persons' race, color, sex, religion, ancestry, disability, marital status or national origin. (Business & Professions Code §125.6.) Significantly, this law has been clarified to provide that this basis for discipline does not prevent a physician from: 1) considering any of those characteristics set forth in Civil Code §51, above, if that consideration is medically necessary and for the sole purpose of determining the appropriate diagnosis or treatment, or 2) refusing to perform an activity for which he or she is not qualified to perform. (*Id.*) For more information, *see* CMA ON-CALL document #6002, "Disabled Patients: Health Care Services."

Because of recent events involving terrorism, the AMA has issued policy reminding physicians of their ethical obligations in this regard:

H-65.978 Non-Discrimination in Responding to Terrorism

Our AMA: (1) affirms its commitment to work with appropriate agencies and associations in responding to terrorist attacks; and (2) opposes discrimination or acts of violence against any person on the basis of religion, culture, nationality, or country of education or origin in the nation's response to terrorism. (Res. 1, I-01; Modified: CSAPH Rep. 1, A-11.)

Medi-Cal or Medicare Patients

14. Does this mean I have to accept Medi-Cal or Medicare patients?

Physicians, like all professionals, have an ethical obligation to serve the underprivileged. However, absent a contract, a physician has no legal duty to accept Medi-Cal or Medicare patients.

It should be noted that many physicians may desire to serve the indigent but are reluctant to accept Medi-Cal patients out of fear that these patients are more likely to have untoward medical outcomes (because, for example, they may have inadequate nutrition or living environments) and will bring lawsuits as a result. However, both state and national studies have disproved this myth. One study out of Maryland (reported June 12, 1999, in JAMA) showed that the percentage of overall malpractice claims filed by Medicaid patients was significantly lower that the percentage of the state population enrolled in Medicaid. In addition, these patients were not more likely than private-pay patients to file malpractice claims involving obstetric services. A study performed at the behest of the American College of Obstetricians and Gynecologists (ACOG), District IX, has also confirmed this finding. *See Obstetrical Malpractice Suits Among Medi-Cal Patients in Relation to the General OB Patient Population in California: An Executive Summary of a Study by the American College of Obstetricians and Gynecologists, District IX, December 1989. See also* Burstein, H., et al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socio-Economic Status*, 270 JAMA 1697 (Oct. 13, 1993); United States General Accounting Office, *Medical Malpractice:*

Medicare/Medicaid Beneficiaries Account for Relatively Small Percentage of Malpractice Losses (Aug. 1993). Such studies demonstrate that physicians may perform a public service by accepting Medicaid patients **without** subjecting themselves to additional potential malpractice liability.

Sexual Orientation

15. Can I refuse to treat patients based on their sexual orientation?

No. Although until January 1, 2006, the Unruh Act statute (Civil Code §51) did not specifically list sexual orientation as one of the protected classifications, the courts have interpreted the law to prohibit discrimination based on sexual orientation. (*Stoumen v. Reilly* (1951) 37 Cal.2d 713.) Since January 1, 2006, Civil Code §51 specifically prohibits discrimination based upon sexual orientation or marital status.

Additionally, if the reason a physician does not wish to treat homosexuals is because of fear of HIV, the laws prohibiting discrimination based on physical disability will probably apply. Moreover, participation agreements with Medicare or Medi-Cal do, and contractual agreements with third party payors typically will, prohibit such discrimination.

Note also that the AMA's Ethical Guideline proscribes discrimination based on sexual orientation and calls for routine testing of adult patients for HIV, as follows:

AMA Policy E-1.1.2 Prospective Patients

…Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care. Nor may physicians decline a patient based solely on the individual's infectious disease status…

AMA Policy H-65.965 Support of Human Rights and Freedom

> Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; … (Last modified 2017.)

AMA Policy E-8.1, Routine Universal Screening for HIV, provides:

> Physicians' primary ethical obligation is to their individual patients. However, physicians also have a long-recognized responsibility to participate in activities to protect and promote the health of the public. Routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health.
>
> Medical and social advances have enhanced the benefits of knowing one's HIV status and at the same time have minimized the need for specific written informed consent prior to HIV testing. Nonetheless, the ethical tenets of respect for autonomy and informed consent require that physicians continue to seek patients' informed consent, including informed refusal of HIV testing.
>
> To protect the welfare and interests of individual patients and fulfill their public health obligations in the context of HIV, physicians should:
>
> (a) Support routine, universal screening of adult patients for HIV with opt-out provisions.
>
> (b) Make efforts to persuade reluctant patients to be screened, including explaining potential benefits to the patient and to the patient's close contacts.
>
> (c) Continue to uphold respect for autonomy by respecting a patient's informed decision to opt out.
>
> (d) Test patients without prior consent only in limited cases in which the harms to individual autonomy are offset by significant benefits to known third parties, such as testing to protect occupationally exposed health care professionals or patients.

(e) Work to ensure that patients who are identified as HIV positive receive appropriate follow-up care and counseling.

(f) Attempt to persuade patients who are identified as HIV positive to cease endangering others.

(g) Be aware of and adhere to state and local guidelines regarding public health reporting and disclosure of HIV status when a patient who is identified as HIV positive poses significant risk of infecting an identifiable third party. The doctor may, if permitted, notify the endangered third party without revealing the identity of the source person.

(h) Safeguard the confidentiality of patient information to the greatest extent possible when required to report HIV status.

AMA Principles of Medical Ethics: I, VI, VII. (Last modified 2017.)

Note that situations involving HIV raise special concerns and obligations regarding informed consent, reporting and the duty to warn.

Finally, Probate Code §4716 requires that physicians treat domestic partners the same as spouses for consent purposes.

For more information, *see* CMA ON-CALL document #6006, "Discrimination: HIV-Infected Patients."

Marital Status

16. Can I refuse to treat patients based on their marital status?

No. Civil Code §51 prohibits discrimination based not only upon sexual orientation but marital status as well. Prior to this legislation, the California Supreme Court considered marital status discrimination in the context of an Unruh Act claim by a lesbian couple who were registered domestic partners. The plaintiffs alleged that a country club committed marital status discrimination in violation of the Unruh Act by refusing to extend to them certain benefits it extended to its married members. At the time, the Unruh Act (California's general anti-discrimination law) did not specifically prohibit discrimination based on marital status. However, the Supreme Court ruled that, "the Unruh Act prohibits discrimination against domestic partners registered under the Domestic Partner Act [of 2003] in favor of married couples." (*Koebke v. Bernardo Heights Country Club* (2005) 36 Cal.4th 824.) The *Koebke* court left open the issue of whether or not the Unruh Act extended to discrimination based on marital status generally. That issue was resolved with the passage of legislation making marital status discrimination under the Unruh Act illegal.

Genetic Information

17. What constitutes genetic information under the Unruh Civil Rights Act?

The Unruh Civil Rights Act was amended effective January 1, 2012 to prohibit discrimination on the basis of genetic information. For purposes of the Act, genetic information is defined to include not only the genetic tests of the individual but also the genetic tests of family members of the individual and the manifestation of a disease or disorder in family members of the individual. Genetic information may include any request for, or receipt of, genetic services or participation in clinical research that includes genetic services, by an individual or any family member of the individual. (Civil Code §51(b).)

Immigration Status

18. Does the Unruh Civil Rights Act protect individuals on the basis of their citizenship or immigration status?

Yes. Effective January 1, 2016, the Unruh Civil Rights Act protects from discrimination in accommodations, advantages, facilities, privileges, or services in all business establishments all individuals on the basis of citizenship, primary language and immigration status. (Civil Code §51.) Verification of immigration status and any discrimination based upon verified immigration status, where required by federal law, does not constitute a violation of the Act. (Civil Code §51(g).) This prohibition is not to be construed to require the provision of services or documents in a language other than English beyond that which is otherwise required by other provisions of federal, state, or local law. (Civil Code §51(h).) For more information about the requirement of providing interpretive services, *see* CMA ON-CALL document #6003, "Language Interpreters."

Actual versus Perceived Characteristics

19. Must an individual actually have a particular characteristic to have a discrimination claim under the Unruh Civil Rights Act?

No. Under the Unruh Civil Rights Act, sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language or immigration status include not only actual characteristics but by definition, also include a perception that the person has any particular characteristic or characteristics within these listed categories or that the person is associated with a person who has, or is perceived to have, any particular characteristic or characteristics within the listed categories. (Civil Code §51(e)(6).)

Conscience Protections

20. Can I be required to perform a sterilization if my conscience does not allow me to perform a sterilization?

On February 23, 2011, the U.S. Department of Health and Human Services (HHS) issued revised "conscience" regulations, effective March 25, 2011, that reaffirmed already existing federal health care provider conscience protection statutes which prohibit entities that, among other things, receive funds from HHS from discriminating against any physician (and other health care professionals) in the employment, promotion, termination, or extension of staff or other privileges because the physician refused to perform or assist in the performance of a lawful sterilization procedure, abortion, or any "lawful health service or research," on the grounds that doing so would be contrary to the physician's religious beliefs or moral convictions. (45 C.F.R. §§88.1 *et seq*.)

The federal conscience regulations may conflict with the California Supreme Court decision in *North Coast Women's Medical Care Group, Inc. v. San Diego County* (2008) 44 Cal.4th 1145. In *North Coast*, the court held that physicians who provide fertility services cannot cite their religious freedom and free speech rights to excuse their refusal to provide fertility services to a person because of the person's sexual orientation. According to the court, the "First Amendment's right to the free exercise of religion does not exempt… physicians from conforming their conduct to the Act's (California's Unruh Civil Rights Act) antidiscrimination requirements even if compliance poses an incidental conflict with defendants' religious beliefs." (*Id*. at 967.) Accordingly, a conflict may arise between the regulations and California law (for example where an entity covered by the conscience regulations cannot accommodate a health professional's religious objection without discriminating against a patient because of her sexual orientation). Federal regulations ordinarily preempt any state law that conflicts with the regulations or frustrates the purposes thereof. *See City of New York v. F.C.C.* (1988) 486 U.S. 57 (F.C.C. regulations preempt state laws governing cable television standards). Consequently, at least where there is a direct conflict between the requirements of the federal regulations and California law, it is likely that the federal regulations, if enforced, would preempt California law.

21. Because of my religious beliefs can I refuse to provide medical services to a patient based on her sexual orientation?

The California Supreme Court in *North Coast*, 44 Cal.4th at 1150, held that physicians' religious freedom and free speech rights do not exempt physicians from complying with the Unruh Civil Rights Act's prohibition against discrimination based on a person's sexual orientation. The medical group in the *North Coast* case provided fertilization services but refused to provide such services to an unmarried patient who is gay and instead referred the patient to another physician who was not a member of the North Coast medical group. According to the Court's reasoning, such a refusal, if based on a person's sexual orientation, would violate the antidiscrimination provisions of the Unruh Civil Rights Act. The Court noted, however, that to "avoid any conflict between their religious beliefs and the state Unruh Civil Rights Act's anti-discrimination provisions, defendant physicians can simply refuse to perform the IUI medical procedure at issue here for any patient of North Coast, the physician's employer." (*Id*. at 1159.) The Court further noted that physicians can also avoid such a conflict by ensuring that "every patient requiring IUI receives 'full and equal' access to that medical procedure" through a "North Coast physician lacking defendants' religious objections." (*Id*.) Left largely unanswered, however, is whether a sole practitioner who lacks the opportunity to ensure the patient's treatment by another member of the same medical practice can refuse to provide

treatment and instead refer the patient to another physician. Indeed, Justice Baxter noted that he was not certain that the balancing of competing interests "would produce the same result in the case of a sole practitioner." (*Id*. at 1162.) "At least where the patient could be referred with relative ease and convenience to another practice, I question whether the state's interest in full and equal medical treatment would compel a physician in sole practice to provide a treatment to which he or she has sincere religious objections." (*Id*.) Justice Baxter, however, cautioned that these issues were not before the court and the majority did not express any views on them.

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 44,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, use CMA's online health law library, CMA ON-CALL, or refer to the *California Physician's Legal Handbook* (CPLH). CPLH is a comprehensive health law and medical practice resource containing legal information including current laws, regulations and court decisions that affect the practice of medicine in California. Written and updated by CMA's Center for Legal Affairs, CPLH is available in an eight-volume, softbound print format, or as an online subscription to www.cplh.org. To order your copy, call (800) 882-1262 or visit CMA's website at www.cmadocs.org.