A.D.2d 75, 718 N.Y.S.2d 340 (2001), where the decedent had a physical exam as part of application for life insurance. He was explicitly advised that the tests were not for the purpose of treatment or evaluation by the medical technician. The EKG results were abnormal but nobody told the decedent, who died two months later of a myocardial infarction. The court, 4–1, held that no duty of disclosure existed, since there were no misleading statements, decedent had been told not to rely on the tests, and there was no showing that he relied in any way. See also Dugan v. Mobile Medical Testing Services, 265 Conn. 791, 830 A.2d 752 (2003); Green v. Walker, 910 F.2d 291 (5th Cir.1990) (physician-patient relationship should include employees examined by a company physician for employment purposes; "[t]his relationship imposes upon the examining physician a duty to conduct the requested tests and diagnose the results thereof, exercising the level of care consistent with the doctor's professional training and expertise, and to take reasonable steps to make information available timely to the examinee of any findings that pose an imminent danger to the examinee's physical or mental well-being.")

In Webb v. T.D., 287 Mont. 68, 951 P.2d 1008 (1997), the court articulated a compound duty on physicians retained by third parties to do independent medical examinations: 1. to exercise ordinary care to discover those conditions which pose an imminent danger to the examinee's physical or mental well-being and take reasonable steps to communicate to the examinee the presence of any such condition; 2. to exercise ordinary care to assure that when he or she advises an examinee about her condition following an independent examination, the advice comports with the standard of care for the health care provider's profession.

I. THE CONTRACT BETWEEN PATIENT AND PHYSICIAN

A. EXPRESS AND IMPLIED CONTRACT

DINGLE v. BELIN

Court of Appeals of Maryland, 2000.
358 Md. 354, 749 A.2d 157.

The issue before us was characterized by the Court of Special Appeals in this case as one of "ghost surgery." The more precise question is whether a surgeon who is employed by a patient to perform certain surgery and who agrees, as part of that employment, to do the actual cutting, leaving to assisting residents a subordinate role, may be held liable for breach of contract, distinct from negligence in the performance of the surgery or negligence associated with the failure to obtain informed consent from the patient, if the surgeon attends and participates in the surgery but permits a resident to do that cutting.

* * *

BACKGROUND

On June 29, 1993, Ms. Belin, employed petitioner, Lenox Dingle, a general surgeon with operating privileges at Mercy Hospital in Baltimore, to perform a laparoscopic cholecystectomy—the removal of her gall bladder

through a small incision in her abdomen. In brief, the surgery involves making the incision and inserting at least three ports into the abdomen. Carbon dioxide is introduced into the abdomen to expand the area and make it more visible. A camera, inserted through one of the ports, displays the interior on two high-definition television monitors. Observing the monitor, one physician, through another port, retracts the organs and tissues in order to isolate the gall bladder and the structures that connect it to other organs and tissues, and a second physician, also observing the monitor, cuts and clips those connecting structures and removes the gall bladder through a port.

The surgery occurred at Mercy on July 2. Dr. Dingle was assisted by a medical student and by a resident, Dr. Magnuson, who was just beginning her fourth year of residency training. The student was responsible for operating the camera, which was done properly. Dr. Dingle did the retractions, exposing the field. Dr. Magnuson dissected the gall bladder and removed it. She and Dr. Dingle regarded the surgery as routine, without incident. There was, however, a problem. One of the connecting structures that needed to be dissected was the cystic duct, which runs from the gall bladder to the common bile duct. The common bile duct runs from the liver to the intestines. Instead of dissecting the cystic duct, Dr. Magnuson dissected and clipped the common bile duct, which resulted in the drainage of bile into Ms. Belin's abdomen. That, in turn, led to a great deal of pain and discomfort and to the need for extensive corrective surgery at Johns Hopkins Hospital.

In November, 1996, after having waived arbitration pursuant to Maryland Code, § 3-2A-06(b) of the Courts and Judicial Proceedings Article, respondent filed suit against Dr. Dingle, Dr. Magnuson, and Mercy Hospital in the Circuit Court for Baltimore City. The amended complaint now before us contained four counts—negligence based on the lack of informed consent, battery, negligence in the performance of the surgery, and breach of contract. Aside from the negligence alleged as part of the lack of informed consent, Dr. Dingle was not charged with any separate negligence in delegating duties or responsibilities to Dr. Magnuson. The claim of general negligence focused solely on the actual conduct of the surgery.

* * *

The claims for breach of contract and lack of informed consent were both based on the assertion that, when Ms. Belin employed Dr. Dingle, she insisted, and he agreed, that, although he would be assisted in the surgery by one or more residents, he would do the actual cutting and removal of the gall bladder. * * *

* * *

It was undisputed that Drs. Dingle and Magnuson both participated in the surgery, that Dr. Dingle did the necessary retractions, and that Dr. Magnuson performed the dissections and removed the gall bladder. It was also undisputed that Ms. Belin had no contact whatever with Dr. Magnuson before the surgery, although she was aware that one or more residents would be assisting Dr. Dingle.

The evidence regarding the alleged contract and what Dr. Dingle said and agreed to do was in sharp dispute. Ms. Belin testified that she told Dingle "that I wanted him to be the one that was going to cut me and identify the

gall bladder and take it out," that he advised her that he could not do the surgery by himself, and that she said she understood "but if you have a resident in there, I just want that person to maybe suture me up." She added, "I want you to be the one to do my surgery. And he agreed." Ms. Belin informed the jury that, as a surgical technician who worked at Mercy, she was aware that it was a teaching hospital and that surgeons often allowed residents to play a major role in surgery, and she did not want her surgery to be used for training purposes.

The written consent that Ms. Belin signed authorized Dr. Dingle "and/or such assistants as may be selected and supervised by him" to perform the laparoscopic cholecystectomy. The form has a place for "Special remarks or comments by patient," which was left blank. There was no indication on the written consent form, in other words, of any allocation between Dr. Dingle and the assistants selected and supervised by him as to what, precisely, each was to do during the surgery. Dr. Dingle denied that he ever had the conversation testified to by Ms. Belin and stated that he never would have agreed to the conditions she alleged. Although at one point he said that, to satisfy those conditions, the surgery would have to have been performed at another hospital, Dr. Dingle indicated that, if faced with that demand, he would have offered Ms. Belin only two options—"allow me to do what I thought was best unrestricted, or to get another surgeon."

The evidence was essentially undisputed that the particular surgery requires three medical participants—one to operate the camera, one to do the necessary retractions, and one to do the dissection and removal. It would thus not have been possible for Dr. Dingle to do both the retraction and the dissection and removal, as Ms. Belin said he agreed to do. * * *

* * *

* * * The evidence indicated that that procedure was followed in Ms. Belin's case—that Drs. Dingle and Magnuson consulted and agreed on where the cuts were to be made and the clips applied.

* * *

We granted certiorari principally to consider whether a physician who, as part of his or her contractual undertaking with a patient, agrees to an allocation of tasks between the physician and other physicians, may be liable for breach of contract if that agreement is violated.

Discussion

* * *

Sorting Out Causes of Action

* * *

The courts, in proper cases, have recognized a number of different causes of action that might lie against a health care provider when a medical procedure or course of therapy produces unintended and harmful results or fails to produce the positive results reasonably anticipated by the patient. These actions, often bearing the common appellation of "malpractice," differ in their underlying theory, in some of the elements that must be proved, and

in the kind of damages that may be recovered. Most are tort-based, sounding either in battery or in negligence of one kind or another, and, occasionally, in misrepresentation or fraud; some are contract-based. When they are pursued either alternatively or in combination, care must be taken to keep the actions separate and not to allow the theories, elements, and recoverable damages to become improperly intertwined.

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."[]. The relationship that spawns the malpractice claim is thus ordinarily a contractual one. Largely because of the greater facility offered by tort-based actions for recovering damages for non-economic loss—predominantly pain, suffering, and disfigurement—malpractice actions have traditionally been tort-based, the tort arising from the underlying contractual relationship. [ ]

* * *

Unlike the traditional action of negligence, a claim for lack of informed consent focuses not on the level of skill exercised in the performance of the procedure itself but on the adequacy of the explanation given by the physician in obtaining the patient's consent. * * *

Although, as in Sard v. Hardy, claims based on lack of informed consent usually involve allegations that the physician failed to make adequate disclosure of a material risk or collateral effect of the contemplated procedure or of an available alternative not carrying that risk or effect, the duty is not so limited. Risks, benefits, collateral effects, and alternatives normally must be disclosed routinely, but other considerations, at least if raised by the patient, may also need to be discussed and resolved. See Aaron D. Twerski & Neil B. Cohen, The Second Revolution in Informed Consent: Comparing Physicians to Each Other, 94 NW. U.L.REV. 1 (1999); Johnson v. Kokemoor, 199 Wis.2d 615, 545 N.W.2d 495 (1996). One of those considerations, in an expanding era of more complex medical procedures, group practices, and collaborative efforts among health care providers, may be who, precisely, will be conducting or superintending the procedure or therapy. This may be especially important with respect to surgical procedures, which usually involve collaboration between the chosen surgeon and other medical professionals who may be unknown to the patient. The physician, as Dr. Dingle indicated was the case here, may be unwilling to accept limitations on the actual performance of the surgery, but, if the identity of the persons who will be performing aspects of the surgery is important to the patient, the matter must be discussed and resolved.

Despite Dr. Dingle's protestation to the contrary, a physician who agrees to a specific allocation of responsibility or a specific limitation on his or her discretion in order to obtain the consent of the patient to the procedure and then, absent some emergency or other good cause, proceeds in contravention of that allocation or limitation has not obtained the informed consent of the patient. We do not see this result as having the pernicious effects suggested by

Dr. Dingle, of permitting patients to "choreograph" surgery and unduly restrict the flexibility that the surgeon must retain. Precisely as Dr. Dingle stated was the case here, the surgeon does not have to agree to any such limitations, and, presumably, few, if any, of them will so agree. The issue is raised only when there is a claim that such an agreement was made and, without good cause, violated.

Notwithstanding the existence of these tort-based actions, courts have universally recognized that, except in emergency or gratuitous situations, the relationship between doctor and patient is a contractual one, either expressly or by implication, and, from that premise, many have held that, as an alternative to tort-based actions, a separate action for breach of the contract may lie when the doctor acts in contravention of a contractual undertaking, at least in some settings. Those actions are often founded either on a breach of warranty theory, alleging a warranty by the physician of a particular result, or on a promise independent of a medical procedure. * * * [ ]

* * *

Actions for breach of contract have been founded on a variety of alleged promises and commitments. Most have alleged a promise to cure, or to cure within a certain period of time, or of some other particular result. [ ] Others * * * have been based on a commitment to do a certain procedure, to deliver a child by means of a Caesarean section. [ ]

* * *

[The court discusses the law of other states, and several cases that have allowed a breach of contract claim when a physician has agreed to do a procedure and then does not.]

We draw a number of conclusions from this judicial landscape. Because the doctor-patient relationship is normally a contractual one, it is permissible for the parties, if they choose to do so, to define with some precision the role that the doctor is to play. The parties may well have conflicting interests in that regard—the doctor wanting as much flexibility and discretion as possible and the patient, if choosing the physician because of some special confidence in that physician's particular abilities, desiring that the selected physician oversee and personally perform the most difficult part of the procedure. As noted in footnote 3 above, the medical community itself recognizes the interest that the patient has in the matter and the need for disclosure and agreement if there is likely to be a significant participation by other persons. The lack of a clear understanding prior to the procedure may well engender a later finding that informed consent was not obtained. A violation of an understanding so reached may constitute the lack of informed consent, negligent delegation, and a breach of the contract, not to mention the risk of a claim of misrepresentation or fraud. It would be prudent, of course, for the written consent form presented to the patient either to set forth any special understanding in this regard or note affirmatively that there is no such understanding.

The scenarios in which these claims can arise are too varied to attempt any complete analysis of how they all may relate, one to another. In the context of this case, it will suffice to say that a doctor who partially abandons his or her patient by improperly delegating to others professional tasks that

the doctor was engaged personally to do and agreed personally to do may be liable for traditional professional negligence, lack of informed consent, and breach of contract, depending in part on the nature of the consequences that flow from that abandonment.

The problem for Ms. Belin in this case is that the one issue, common and central to both her claim of lack of informed consent and her claim for breach of contract was, in fact, submitted to the jury, which necessarily found against her. There was no question as to how the surgery proceeded—what Dr. Dingle did and what Dr. Magnuson did; nor was there any claim by Ms. Belin that Dr. Dingle failed to advise her of material risks, of collateral consequences, or of alternative therapies. [ ] The only issue, as to both the informed consent and breach of contract claims, was whether Dr. Dingle ever agreed to the allocation of functions claimed by Ms. Belin. As noted, plaintiff's counsel made clear to the jury, in the context of the informed consent claim, that, to render a defendants' verdict, the jury would have to disbelieve Ms. Belin's version of her conversation with Dr. Dingle. It obviously did so. The breach of contract claim asserted by Ms. Belin could not survive in the face of that finding.

Notes and Questions

1. The physician-patient relationship can be considered initially as a contractual one. Physicians in private practice may contract for their services as they see fit, and retain substantial control over the extent of their contact with patients. Physicians may limit their specialty, their scope of practice, their geographic area, and the hours and conditions under which they will see patients. They have no obligation to offer services that a patient may require that are outside the physician's competence and training; or services outside the scope of the original physician-patient agreement, where the physician has limited the contract to a type of procedure, to an office visit, or to consultation only. They may transfer responsibility by referring patients to other specialists. They may refuse to enter into a contract with a patient, or to treat patients, even under emergency conditions. Hiser v. Randolph, 126 Ariz. 608, 617 P.2d 774, 776 (1980). Just being the on-call physician is not sufficient in many states to create the physician-patient relationship. Prosise v. Foster, 261 Va. 417, 544 S.E.2d 331 (2001).

2. Physicians may also expressly contract with a patient for a specific result. Stewart v. Rudner, 349 Mich. 459, 84 N.W.2d 816, 822–23 (1957) (couple contracted with physician to have wife's child delivered by Caesarian section, as she had had two stillbirths and was worried about normal vaginal delivery; the court held that "a doctor and his patient * * * have the same general liberty to contract with respect to their relationship as other parties entering into consensual relationship with one another, and a breach thereof will give rise to a cause of action."). Courts will sometimes allow parol evidence to fill in the terms of these contracts, where the patient has signed other consent forms. Murray v. University of Penn. Hospital, 340 Pa.Super. 401, 490 A.2d 839 (1985) (court allowed parol evidence to show the existence of an oral agreement to guarantee the prevention of future pregnancies by a tubal ligation).

See Grubbs v. Barbourville Family Health Ctr., 120 S.W.3d 682 (Ky. 2003)(court allowed a breach of contract claim against physician for his failure to report accurately the results of an ultrasound test that revealed fetal medical conditions).

3. Once the physician-patient relationship has been created, physicians are subject to an obligation of "continuing attention." Ricks v. Budge, 91 Utah 307, 64 P.2d 208 (1937). Refusal to continue to treat a patient is abandonment, and it may also be malpractice. See, e.g., Tierney v. University of Michigan Regents, 257 Mich.App. 681, 669 N.W.2d 575 (2003)(treating gynecologist withdrew from treating plaintiff after she filed suit against another member of the medical group). Termination of the physician-patient relationship, once created, is subject in some jurisdictions to a "continuous treatment" rule to determine when the statute of limitations is tolled. Treatment obligations cease if the physician can do nothing more for the patient, or ceases to attend the patient. See Jewson v. Mayo Clinic, 691 F.2d 405 (8th Cir.1982).

4. An express written contract is rarely drafted for specific physician-patient interactions. An implied contract is usually the basis of the relationship between a physician and a patient. A physician who talks with a patient by telephone may be held to have an implied contractual obligation to that patient. Bienz v. Central Suffolk Hospital, 163 A.D.2d 269, 557 N.Y.S.2d 139 (1990). Likewise, a physician, such as a pathologist, who renders services to a patient but has not contracted with him, is nonetheless bound by certain implied contractual obligations. When the physician evaluates information provided by a nurse and makes a medical decision as to a patient's status, a doctor-patient relationship may be established. Wheeler v. Yettie Kersting Memorial Hospital, 866 S.W.2d 32 (Tex.App.1993). Merely scheduling an appointment is not by itself sufficient to create a relationship. Jackson v. Isaac, 76 S.W.3d 177 (Tex.App. 2002).

5. When a physician treating a patient consults by telephone or otherwise with another physician, some courts are reluctant to find a doctor-patient relationship created by such a conversation. The concern is that such informal conferences will be deterred by the fear of liability. See Reynolds v. Decatur Memorial Hosp., 277 Ill.App.3d 80, 214 Ill.Dec. 44, 49, 660 N.E.2d 235, 240 (1996) ("It would have a chilling effect upon practice of medicine. It would stifle communication, education and professional association, all to the detriment of the patient.") Others find a duty in such a consultation. See e.g. Diggs v. Arizona Cardiologists, Ltd., 198 Ariz. 198, 8 P.3d 386 (App. 2000), where a cardiologist informally consulting with a physician about a patient has a duty to that patient, even though no contractual relationship exists.

6. When a patient goes to a doctor's office with a particular problem, he is offering to enter into a contract with the physician. When the physician examines the patient, she accepts the offer and an implied contract is created. The physician is free to reject the offer and send the patient away, relieving herself of any duty to that patient. See, e.g., Childs v. Weis, 440 S.W.2d 104 (Tex.Civ.App.1969). Some courts state as a starting principle that "* * * [a]s a practical matter, health professionals cannot be required to obtain express consent before each touch or test they perform on a patient. Consent may be express or implied; implied consent may be inferred from the patient's action or seeking treatment or some other act manifesting a willingness to submit to a particular course of treatment * * *." Jones v. Malloy, 226 Neb. 559, 412 N.W.2d 837, 841 (1987). But see Tisdale v. Pruitt, infra, for judicial difficulties with contextual consent.

7. The apparent voluntariness of the physician-patient relationship and its reciprocity, i.e., a fee for a service, or consideration, make the relationship look like a traditional contract. In other ways, however, the analogy to a contract is limited. First, the terms of the contract are largely fixed in advance of any bargaining, by standard or customary practices that the physician must follow at the risk of liability for malpractice. The exact nature of the work to be done by the

physician is usually left vaguely defined at best. The relationship seems closer to quasi-contract, where we impute to both the physician and the patient standard intentions and reasonable expectations. See Robert Goodin, Protecting the Vulnerable 63, 64–65 (1985).

Second, professional ethics impose fiduciary obligations on physicians in a variety of ways, as the cases in Section II reveal. Courts often look outside the parameters of contract law analysis in judging the obligations of a physician to treat a patient. The courts stress that the physician's obligation to his patient, while having its origins in contract, is governed also by fiduciary obligations and other public considerations "inseparable from the nature and exercise of his calling * * *." Norton v. Hamilton, 92 Ga.App. 727, 89 S.E.2d 809, 812 (1955) (doctor withdrew from case at time when wife was in premature labor; while husband searched for a substitute, wife delivered child). See Chatman v. Millis, 257 Ark. 451, 453 517 S.W.2d 504, 505 (1975) (malpractice action requires a doctor-patient relationship, a duty owed from doctor to patients, although "[w]e do not flatly state that a cause for malpractice must be predicated upon a contractual agreement between a doctor * * * and patient * * *."). For a history of this fiduciary duty, see Michelle Oberman, Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal–Fetal Conflicts, 94 N.W.U.L.Rev. 451 (2000).

Third, professionals are constrained in their ability to withdraw from their contracts by judicial caselaw defining patient abandonment. A doctor who withdraws from the physician-patient relationship before a cure is achieved or the patient is transferred to the care of another may be liable for abandonment. To escape liability, the physician must give the patient time to find alternative care. See Norton v. Hamilton, 92 Ga.App. 727, 89 S.E.2d 809 (1955). Implied abandonment is a negligence-based theory judged by the overall conduct of the physician. See Meiselman v. Crown Heights Hosp., 285 N.Y. 389, 34 N.E.2d 367 (1941); Ascher v. Gutierrez, 533 F.2d 1235 (D.C.Cir.1976).

8. Trust in Medical Relationships. Trust has been proposed as a unifying theme in analyzing medical ethics, professionalism, and the doctor-patient relationship generally. In the words of Mark Hall, "[t]rust is the core, defining characteristic of the doctor-patient relationship—the "glue" that holds the relationship together and makes it possible. Preserving, justifying, and enhancing trust is a prominent objective in health care law and public policy and is the fundamental goal of much of medical ethics." Mark Hall, Law, Medicine, and Trust, 55 Stan. L. Rev. 463, 470–71 (2002). Hall concludes as follows:

> This article has sought to establish the following foundational truths about medical care delivery:
>
> (1) Trust is essential and unavoidable in medical relationships. Patients need and want to trust, and without trust medical relationships never form or are entirely dysfunctional.
>
> (2) Beyond the mechanics of forming and conducting treatment relationships, trust confers therapeutic benefit by activating non-specific or self-healing mechanisms, or by enhancing the effects of active therapies. Medical trust has this unique instrumental value because of its strong emotional content, which results from the deep vulnerability of illness that gives rise to trust.
>
> (3) Law can (and does) enforce trust-related expectations, punish violations of trust, facilitate the psychology of trust, and undermine trust. These effects occur both through direct regulation and through the law's

expressive function and its relationship with social and professional norms.

(4) These legal attitudes toward trust sometimes come into conflict because enforcing trust or punishing its violations can also weaken the psychological foundations of trust.

(5) Striking the best compromise among competing legal stances toward trust often requires subtlety, complexity, and detailed empirical information about the psychology of trust.

(6) Honoring these principles may require that formal legal rights be softened somewhat with the therapeutic reality of trust.

As you examine the problems of quality, access, control, and patient personhood during your examination of health law, consider Hall's unifying theory of trust, and consider whether it helps to explain the law's reaction to physicians, hospitals, and managed care plans. Does it work best as a unifying principle for the law's treatment of physicians?

B. PHYSICIANS IN INSTITUTIONS

Physicians who practice in institutions must provide health care within the limits of the health plan coverage or their employment contracts with the institution. In this case, the contact between the physician and the patient is preceded by an express contract spelling out the details of the relationship. Physicians who are members of a health maintenance organization or a health plan have a duty to treat plan members as a result of their contractual obligation to the HMO. In these situations, the express contract is between the physician and the health plan, and the subscriber and the plan, with an implied contract between the subscriber and the treating physician.

HAND v. TAVERA

Court of Appeal of Texas, San Antonio, 1993.
864 S.W.2d 678.

OPINION

In this medical malpractice case, plaintiff Lewis Hand appeals from a take-nothing summary judgment rendered on the sole ground that defendant Dr. Robert Tavera owed him no duty because the two never had a physician-patient relationship. We conclude that Tavera did not refute the existence of a physician-patient relationship as a matter of law, and therefore we reverse and remand for further proceedings.

* * * Hand went to the Humana Hospital (Village Oaks) emergency room complaining of a three-day headache. The emergency-room physician (Dr. Boyle) was told that Hand had a personal history of high blood pressure and that his father had died of an aneurism. Boyle observed that Hand's symptoms rose and fell with his blood pressure, which Boyle was able to reduce periodically with medication. After two or three hours of observation, Boyle decided that Hand should be admitted to the hospital, a decision that required approval from another doctor. Hand had presented a Humana Health Care Plan card, and the front desk told Boyle that defendant Tavera was the doctor responsible that evening for authorizing such admissions. Boyle briefed Tavera by telephone and recommended hospitalization, but ultimately Tavera disagreed with Boyle and concluded that Hand could be treated as an

outpatient. Boyle said Tavera told him that Hand's problems "should be controlled by outpatient medication and follow-up in the office" and he also "recommended something for pain." Hand was sent home, where he suffered a stroke a few hours later. He and his wife brought this lawsuit against the hospital, Tavera, and Boyle. Eventually Hand nonsuited Boyle and settled with the hospital.

Tavera moved for summary judgment on the sole ground that he and Hand never established a physician-patient relationship and therefore he owed Hand no duty. Thus this appeal does not present the question whether Tavera's conduct constituted negligence that proximately caused Hand's damages.

Hand argues first that as a member in the Humana Health Care Plan, Tavera owed him a duty of care. There is summary judgment evidence that Hand had Humana Health Care Plan coverage and that Tavera was designated as the doctor acting for the Humana plan that night. The following clauses in the contract between Humana and Southwest Medical Group (which employed Tavera) obligated its doctors to treat Humana enrollees as they would treat their other patients:

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

Thus the contracts in the record show that the Humana plan brought Hand and Tavera together just as surely as though they had met directly and entered the physician-patient relationship. Hand paid premiums to Humana to purchase medical care in advance of need; Humana met its obligation to Hand and its other enrollees by employing Tavera's group to treat them; and Tavera's medical group agreed to treat Humana enrollees in exchange for the fees received from Humana. In effect, Hand had paid in advance for the services of the Humana plan doctor on duty that night, who happened to be Tavera, and the physician-patient relationship existed. We hold that when the health-care plan's insured shows up at a participating hospital emergency room, and the plan's doctor on call is consulted about treatment or admission, there is a physician-patient relationship between the doctor and the insured.

* * *

Tavera also argues that Hand is a third party who cannot assert rights under the Tavera–Humana contract, which expressly provides that it creates no third-party beneficiaries. But Hand does not assert rights under the Humana–Tavera contract in isolation or seek to recover for breach of contract; instead he contends that the entire health-care plan arrangement