
Erika Miller

Follow this and additional works at: https://open.mitchellhamline.edu/mhlr

Part of the Medical Jurisprudence Commons, and the Torts Commons

Recommended Citation
Available at: https://open.mitchellhamline.edu/mhlr/vol46/iss3/6

This Note is brought to you for free and open access by the Law Reviews and Journals at Mitchell Hamline Open Access. It has been accepted for inclusion in Mitchell Hamline Law Review by an authorized administrator of Mitchell Hamline Open Access. For more information, please contact sean.felhofer@mitchellhamline.edu.

© Mitchell Hamline School of Law
TORTS: JUST WALK AWAY: HOW AN OVERBROAD FORESEEABILITY OF HARM STANDARD COULD KILL “CURBSIDE CONSULTATIONS” — WARREN V. DINTER, 926 N.W.2D 370 (MINN. 2019)

Erika E. Miller*

I. INTRODUCTION

II. HISTORY OF RELEVANT LAW
   A. The General Standards for Negligence in Minnesota
   B. The History of the “Foreseeability of Harm” Standard and Professional Liability in Minnesota
   C. Other States’ Use of the Physician-Patient Relationship
   D. Nurse Practitioner Practice Authority in Minnesota, Pre- and Post-Warren
   E. The Legal Evolution of Advanced Practice Providers

III. THE WARREN DECISION
   A. Factual Background
   B. Lower Courts’ Decisions
   C. Minnesota Supreme Court’s Decision—Majority Opinion
   D. Minnesota Supreme Court’s Decision—Dissenting Opinion

IV. ANALYSIS
   A. Uncertainty Ahead: Creating a Duty from Curbside Consultations
      1. Background on Curbside Consultations
      2. The Value of Curbside Consultations to Health Care Practitioners and Patients
      3. The Tenuous Future of Curbside Consultations in Minnesota Under Warren
      4. The Case of the Curbside Hospitalist
   B. The Foreseeability of Harm Standard Favored by Minnesota Courts Should Be Narrowly Constrained to Avoid Unintended Consequences
      1. Foreseeability of Harm: Finding the Balance Between Overbroad and Just Right
      2. Potential Unintended Consequences of an Overbroad Foreseeability of Harm Standard
         a. The Patient Protection and Affordable Care Act
         b. The Medicare Access and CHIP Reauthorization Act

Published by Mitchell Hamline Open Access, 2020
I. INTRODUCTION

In Warren v. Dinter, the Minnesota Supreme Court held that a physician who consulted with a nurse practitioner regarding the nurse practitioner’s patient had a duty to the patient. The court reasoned that this duty existed because it was foreseeable that the patient would rely on information provided to the nurse practitioner by the physician. This decision was based on one hundred years of medical malpractice precedent in Minnesota, where courts have consistently held that even if no

---

1 J.D. candidate, Mitchell Hamline School of Law, May 2022. I would like to thank Professor Mike Steenson for serving as my faculty advisor and providing valuable guidance and expertise throughout the writing and editing process.

1 Warren v. Dinter, 926 N.W.2d 370 (Minn. 2019).

1 MINN. STAT. § 148.171, subdiv. 3 (2019). Nurse practitioners (sometimes abbreviated as “NP”) are also referred to as “advanced practice registered nurses.” Id.

Nurse practitioner practice includes: (1) health promotion, disease prevention, health education, and counseling; (2) providing health assessment and screening activities; (3) diagnosing, treating, and facilitating patients’ management of their acute and chronic illnesses and diseases; (4) ordering, performing, supervising, and interpreting diagnostic studies . . . (5) prescribing pharmacologic and nonpharmacologic therapies; and (6) consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient.

Id. § 148.171, subdiv. 11.

Warren, 926 N.W.2d at 377.
physician-patient relationship exists, a physician may still have a duty to a party if it is foreseeable that the party would rely on the physician’s advice and be harmed. This case note argues that while Warren used a standard consistent with a century’s worth of jurisprudence in Minnesota, the court’s application of the standard in Warren was overbroad. Accordingly, Warren will have significant, lasting, and detrimental implications for medical professionals and others.

This case note begins with a historical overview of the law relevant to medical malpractice claims in Minnesota and other states. The history section also includes a brief chronicle of nurse practitioner practice authority in Minnesota and an overview of the legal evolution of both nurse practitioners and physician assistants. Section III provides a summary of the facts and procedural history of Warren. Finally, Section IV offers an analysis of several issues created by Warren, including how the decision may affect certain communications between physicians and their colleagues, whether the foreseeability of harm standard should be narrowly construed, and what the medical malpractice implications of Warren may be for physicians, nurse practitioners, and physician assistants. The analysis explains how Warren could lead to unintended consequences and confusion among health care providers and other professionals and provides guidance for mitigating these issues. The section concludes with potential solutions for health care practitioners and other professionals who are wary of Warren’s holding.

II. HISTORY OF RELEVANT LAW

This history section begins with the elements of general negligence, professional negligence, and medical malpractice claims in Minnesota. Next, it discusses the history of the use of the foreseeability of harm standard

---

1 The term “physician-patient relationship” is used throughout this article. However, the term may also be used to describe the relationship between patients and health care professionals who are not physicians, including nurse practitioners (and other nurses), physician assistants, and other professionals who provide health care services to patients. Likewise, the term “physician” may be used in this article in the interest of brevity, although, contextually, the term may imply both physicians and non-physicians, advanced practice providers (like nurse practitioners), and physician assistants.

2 Warren, 926 N.W.2d at 377.

3 Physician assistants (sometimes abbreviated as “PAs”) are discussed in this case note because they have historically had relationships with physicians—similar to those of nurse practitioners and physicians—and they often provide the same health care services to patients. Nurse practitioners and physician assistants are often treated similarly to one another under state and federal laws, and many of the legal ramifications for nurse practitioners in cases like Warren will likely impact physician assistants as well. See discussion infra Section II.E.
in medical malpractice and other professional liability cases in the state. This is followed by an analysis of other states’ approaches to medical malpractice, which typically require a physician-patient relationship between the plaintiff and the defendant. A brief history of nurse practitioner practice authority in Minnesota, both pre- and post-

**A. The General Standards for Negligence in Minnesota**

In Minnesota, four elements must be met for a showing of general negligence: (1) the existence of a duty of care by the defendant; (2) defendant’s breach of that duty; (3) a resulting injury to the plaintiff; and (4) that defendant’s breach was the proximate cause of the plaintiff’s injury. Slightly different elements may be required in cases related to professional negligence. For example, in a case related to legal malpractice, a plaintiff must show: (1) the existence of an attorney-client relationship; (2) either negligent action or breach of contract by the attorney; (3) the attorney’s negligent action or breach of contract was the proximate cause of damages incurred by the plaintiff; and (4) but for the attorney’s actions, the plaintiff would have been successful in his or her claim.

A medical malpractice claim in Minnesota has the same elements as a general negligence claim. While a showing of legal malpractice in Minnesota requires some kind of relationship to exist between the plaintiff and the attorney, a showing of medical malpractice does not require the existence of a physician-patient relationship. Instead, the plaintiff must show the existence of a duty running from the health care provider to the plaintiff. This duty arises when it is reasonably foreseeable that an injury could occur if medical advice is negligently given.

---

1. Funchess v. Cecil Norman Corp., 632 N.W.2d 666, 672 (Minn. 2001).
3. Warren, 926 N.W.2d at 375 (citing Molloy v. Meier (Molloy II), 679 N.W.2d 711, 717 (Minn. 2004)).
4. Id.
5. Molloy II, 679 N.W.2d at 717 (citing Plutshack v. Univ. of Minn. Hosp. & Clin., 316 N.W.2d 1, 8 (Minn. 1982)). Warren refers to this case as “Molloy II” to differentiate it from the Minnesota Court of Appeals’ decision in Molloy v. Meier (Molloy I), 660 N.W.2d 444 (Minn. App. 2003), also cited in Warren. See Warren, 926 N.W.2d at 375.
6. Molloy II, 679 N.W.2d at 719 (citing Skillings v. Allen, 143 Minn. 323, 325, 173 N.W. 663, 663–64 (1919); Togstad, 291 N.W.2d at 686). Relying on Skillings, the Warren court expanded on Minnesota’s use of foreseeability instead of requiring a physician-patient relationship and stated that everyone, including professionals like physicians, is “responsible
B. The History of the “Foreseeability of Harm” Standard and Professional Liability in Minnesota

Minnesota courts have a long tradition of using a “foreseeability of harm” standard to determine whether a physician has a legal duty of care to a party in the absence of an established physician-patient relationship. The use of this standard sets Minnesota apart from the majority of other U.S. jurisdictions, which base a physician’s duty to a party on the existence of such a relationship. Minnesota’s jurisprudence in this area may be traced back to the decision in Skillings v. Allen, where the court held that a physician treating a child who was hospitalized with scarlet fever owed a duty to the child’s parents when he advised them it was safe to visit their daughter, even though she remained contagious. The court reasoned the physician should have foreseen that the parents would rely on the physician’s assurance, and as such, he had a duty to act with due care to protect the parents’ health.

Today, Minnesota courts continue to focus on foreseeability of harm in medical malpractice cases that involve injury to a party who does not have a physician-patient relationship with the defendant. For instance, in Molloy v. Meier (Molloy II), the court drew from the holdings in Skillings and other cases and stated, “A duty arises where it is reasonably foreseeable that [a party] would be injured” if the defendant were negligent. This decision also represented the court’s conscious choice to reject any attempts to narrowly construe the Skillings foreseeability of harm standard, which would cause Skillings to apply only in cases involving some kind of relationship, for the direct consequences of [their] negligent acts whenever [they are] placed in such a position with regard to another that it is obvious that if [they do] not use care in [their] own conduct [they] will cause injury to that third party.”

---

5 Miller: Torts: Just Walk Away: How an Overbroad Foreseeability of Harm St
physician-patient or otherwise." Specifically, as noted in the Warren decision, the court used Molloy II to overturn McElwain v. Van Beek, which held the foreseeability of harm standard was only relevant when a contractual relationship existed between the physician and the party.

Minneapolis’s use of the foreseeability of harm standard in professional negligence matters extends beyond medical malpractice. For instance, Minnesota courts have broadly drawn the attorney-client relationship to create a duty that is “derived from the professional relationship,” even if no explicit or contractual relationship exists. Specifically, in Togstad v. Vesely, Otto, Miller & Kellec, the court held that an attorney who completed a consultation with a potential client had a duty to act with due care in offering legal advice because, even though no attorney-client relationship had been established, it was foreseeable that the potential client would rely on the attorney’s advice and be harmed if the advice was negligently provided. Since the 1919 Skillings decision, Minnesota courts, on multiple occasions, have approved of the utility of the foreseeability of harm standard in various legal questions regarding a professional’s duty to a third party. It should be little surprise, then, that this once again occurred in Warren.

C. Other States’ Use of the Physician-Patient Relationship

While Minnesota does not require the existence of a physician-patient relationship to establish a health care professional’s duty to a party, many other states do require such a relationship. However, there are

---

* Warren, 926 N.W.2d at 377.
* McElwain v. Van Beek, 447 N.W.2d 442, 446 (Minn. Ct. App. 1989). As noted by the court in Warren, the Skillings court held that, even if there were no contractual relationship between the physician and the patient’s parents, the result would be the same because the potential harm was foreseeable to the physician. Skillings, 143 Minn. at 327, 173 N.W. at 663. It was this foreseeability that created the duty, not the presence of a contractual obligation to the parents. Id.
* Warren, 926 N.W.2d at 376.
* Togstad v. Vesely, Otto, Miller & Kellec, 291 N.W.2d 686, 693 (Minn. 1980).
* Id. at 689-90.
* See, e.g., id. at 686 (a lawyer’s duty to a potential client); see also Molloy II, 679 N.W.2d 711 (Minn. 2004) (a physician’s duty to a child’s parent).
* Warren, 926 N.W.2d at 377.
varying approaches for determining when a physician-patient relationship exists. For instance, many states require a physician-patient relationship to be consensual on each side, whereby the patient seeks out the physician’s care and the physician agrees to treat the patient. Several courts have held that such consent by a physician to treat a patient must be express, meaning that the physician must take some affirmative action or otherwise knowingly treat the patient. A few courts have held that a physician-patient relationship requires a contractual agreement either with the patient or with the physician’s employer.

The situation is less clear when it comes to a physician’s duty to a third party or a party who is not explicitly the physician’s patient. Several courts have held that if a physician provides a consulting opinion about a patient’s care by reviewing x-ray films, lab results, or patient records, an implied physician-patient relationship is created. This can be true even if


8 Id.; see also Huddle v. Heindel, 821 S.E.2d 61, 65 (Ga. Ct. App. 2018) (stating that a physician-patient relationship is consensual when the patient "knowingly seeks the assistance of the physician and the physician knowingly accepts [her] as a patient"); Kundert, 964 N.E.2d at 675 (explaining that the physician-patient relationship “cannot be established where a patient does not seek that physician’s medical advice and the physician does not knowingly accept that person as a patient” (citation omitted)); Thayer, 792 N.E.2d at 925 (providing the three factors that Indiana courts consider to determine whether a consensual physician-patient relationship exists: (1) whether the physician made a recommendation to the patient regarding a condition or treatment; (2) whether the physician provided or participated in the patient’s treatment; and (3) whether the physician acted in such a way that the patient could infer that a physician-patient relationship had been established).

9 See Gallardo v. United States, 752 F.3d 865, 870 (10th Cir. 2014) (applying Colorado law in stating a physician’s duty comes from an “express or implied contractual relationship”).

10 See Oja v. Kin, 581 N.W.2d 739, 744 (Mich. Ct. App. 1998) (holding that a contractual relationship between a physician and the physician’s employer could have created a duty in the physician if the patient had proven that he was the intended beneficiary of the contract).

11 See, e.g., Sterling v. Johns Hopkins Hosp., 802 A.2d 440, 448 (Md. Ct. Spec. App. 2002) (holding that a physician-patient relationship was implied between a patient and a consulting, on-call physician when the physician viewed the patient’s lab results and x-ray films because the physician (1) participated in the patient’s diagnosis; (2) participated in the patient’s treatment or prescribed a course of treatment for the patient; and (3) owed a duty to the
the consulting physician never examined, met, or even knew the name of the patient.32

Still, the premise that a physician-patient relationship may exist by implication is not absolute. There are several instances where courts have held that certain activities are not enough to constitute an implied physician-patient relationship—in which case, no duty exists.33 Such cases often involve either brief consultations or informal conversations between physicians rather than formal requests for specific medical advice. These informal discussions are often referred to as “curbside consultations.”34

32 See, e.g., Mackey v. Sarroca, 35 N.E.3d 631, 637–38 (Ill. App. Ct. 2015) (stating that a physician may have a duty to a patient when there is a “special relationship,” including instances when the physician is asked by a colleague to take some action on the patient’s behalf, such as conducting tests or reviewing or interpreting test results, even when the consulting physician has never seen the patient, so long as the consulting physician has taken “some affirmative action to participate in the care, evaluation, diagnosis, or treatment of a specific patient”); Gillespie v. Univ. of Chi. Hosps., 900 N.E.2d 737, 740 (Ill. App. Ct. 2008) (providing that a consensual physician-patient relationship may exist when the physician is contacted by someone acting on the patient’s behalf or when the physician performs services for the patient—even when the physician did not meet or interact with the patient); Wheeler v. Yette Kersting Mem’l Hosp., 866 S.W.2d 32, 39–40 (Tex. App. 1993) (holding that an on-call physician who reviewed a patient’s status with a nurse over the phone and provided a medical decision sought by the nurse established an implied physician-patient relationship even though the physician did not actually examine the patient).

33 See, e.g., Pham v. Black, 820 S.E.2d 209, 212 (Ga. Ct. App. 2018) (holding that a hospitalist physician who refused to admit a patient after consulting with the patient’s treating physicians did not have a physician-patient relationship with—or a duty to—the patient because the physician did not meet the patient or participate in the patient’s diagnosis or treatment); Harper v. Hippensteel, 994 N.E.2d 1233, 1238 (Ind. Ct. App. 2013) (holding that a physician who was in a collaborative practice agreement with a nurse practitioner such that he reviewed five percent of her patient records did not have a physician-patient relationship with the nurse practitioner’s patient even though he was required by law to be available to the nurse practitioner for consultative purposes); Irvin v. Smith, 31 P.3d 934, 941 (Kan. 2001) (“A physician who gives an ‘informal opinion,’ ... at the request of a treating physician, does not owe a duty to the patient because no physician-patient relationship is created.”).

34 Although the decision does not define the term, Irvin is one of a handful of cases that specifically uses the term “curbside consultation.” Irvin, 31 P.3d at 943. The Irvin court acknowledged that curbside consultations are “medically important but legally ambiguous” and noted that courts have been reluctant to extend the traditional physician-patient

facility, staff, or patient for whom the physician served in an on-call capacity); Thomas, 973 N.Y.S.2d at 346 (finding that a physician-patient relationship is implied “when a physician gives advice to a patient, even if the advice is communicated through another health care professional”); Kelley v. Middle Tenn. Emergency Physicians, P.C., 133 S.W.3d 387, 593 (Tenn. 2004) (explaining that a physician-patient relationship “may arise out of a consultation by the patient’s primary physician with another physician when that consultation is for the treatment of that patient,” with consultation including activities like reviewing patient records and discussing diagnosis and treatment (citation omitted)).
Finally, it is important to note—particularly in light of the fact pattern and questions raised in Warren—that some courts have acknowledged an increased emphasis on team-based health care, in which multiple physicians work together to diagnose and treat a patient.\footnote{In Mead v. Legacy Health System, the court stated that in today’s health care system, where physicians work together to provide care to individual patients, whether a physician’s expression of an opinion constitutes a diagnosis [and has therefore established a physician-patient relationship with the patient by implication] will vary depending on, among other things, the customary practice within the relevant medical community, the degree and the level of formality with which one physician has assumed (or the other physician has ceded) responsibility for the diagnosis or treatment, the relative expertise of the two physicians, and the reasonable expectations, if any, of the patient under the circumstances. In our view, the standard should not be whether a judge or a jury would classify a statement as a diagnosis or the provision of treatment. Rather, it should be whether a physician who has not personally seen a patient either knows or reasonably should know that he or she is diagnosing a patient’s condition or treating the patient. 283 P.3d 904, 910 (Or. 2012). Likewise, in Kelley, 133 S.W.3d at 596, the court stated that today’s health care system is increasingly complex, with several physicians participating in patient diagnosis when they may not have ever interacted with the patient. As such, it is “simply unrealistic to apply a narrow definition of the physician-patient relationship in determining whether such a relationship exists for purposes of a medical malpractice case.” Id. However, unlike the result in Mead, in Kelley, the court held that a physician-patient relationship could exist between the consulting physician and the patient. See id. at 598. See Mead, 283 P.3d at 910; see also Kelley, 133 S.W.3d at 596. See Meghan C. O’Connor, The Physician-Patient Relationship and the Professional Standard of Care: Reevaluating Medical Negligence Principles to Achieve the Goals of Tort Reform, 46 TORT TRIAL & INS. PRAC. L.J. 109, 132 (2010) (stating that a clearer definition relationship to include these “informal consultations.” Id. The court also found that holding physicians responsible for information exchanged during curbside consultations would be contrary to public policy as it would chill efforts to improve patient care through the exchange of medical knowledge. Id. While the case law does not explore curbside consultations at length, there are several journal articles that discuss these interactions. These articles (and their conclusions) are discussed further infra Part IV.} In these cases, courts have held that a physician-patient relationship may be implied between a physician and a party, who is not explicitly the physician’s patient, based on an analysis of multiple factors, including whether the physician in question took some affirmative action to knowingly participate in the patient’s diagnosis or treatment.\footnote{In Mead v. Legacy Health System, the court stated that in today’s health care system, where physicians work together to provide care to individual patients, whether a physician’s expression of an opinion constitutes a diagnosis [and has therefore established a physician-patient relationship with the patient by implication] will vary depending on, among other things, the customary practice within the relevant medical community, the degree and the level of formality with which one physician has assumed (or the other physician has ceded) responsibility for the diagnosis or treatment, the relative expertise of the two physicians, and the reasonable expectations, if any, of the patient under the circumstances. In our view, the standard should not be whether a judge or a jury would classify a statement as a diagnosis or the provision of treatment. Rather, it should be whether a physician who has not personally seen a patient either knows or reasonably should know that he or she is diagnosing a patient’s condition or treating the patient. 283 P.3d 904, 910 (Or. 2012). Likewise, in Kelley, 133 S.W.3d at 596, the court stated that today’s health care system is increasingly complex, with several physicians participating in patient diagnosis when they may not have ever interacted with the patient. As such, it is “simply unrealistic to apply a narrow definition of the physician-patient relationship in determining whether such a relationship exists for purposes of a medical malpractice case.” Id. However, unlike the result in Mead, in Kelley, the court held that a physician-patient relationship could exist between the consulting physician and the patient. See id. at 598. See Mead, 283 P.3d at 910; see also Kelley, 133 S.W.3d at 596. See Meghan C. O’Connor, The Physician-Patient Relationship and the Professional Standard of Care: Reevaluating Medical Negligence Principles to Achieve the Goals of Tort Reform, 46 TORT TRIAL & INS. PRAC. L.J. 109, 132 (2010) (stating that a clearer definition relationship to include these “informal consultations.” Id. The court also found that holding physicians responsible for information exchanged during curbside consultations would be contrary to public policy as it would chill efforts to improve patient care through the exchange of medical knowledge. Id. While the case law does not explore curbside consultations at length, there are several journal articles that discuss these interactions. These articles (and their conclusions) are discussed further infra Part IV.} Some legal commentators have suggested that since, in most states, a physician-patient relationship forms the foundation of a medical malpractice claim, the manner in which this relationship is established should be more uniformly defined to better prevent the filing of frivolous lawsuits.\footnote{In Mead v. Legacy Health System, the court stated that in today’s health care system, where physicians work together to provide care to individual patients, whether a physician’s expression of an opinion constitutes a diagnosis [and has therefore established a physician-patient relationship with the patient by implication] will vary depending on, among other things, the customary practice within the relevant medical community, the degree and the level of formality with which one physician has assumed (or the other physician has ceded) responsibility for the diagnosis or treatment, the relative expertise of the two physicians, and the reasonable expectations, if any, of the patient under the circumstances. In our view, the standard should not be whether a judge or a jury would classify a statement as a diagnosis or the provision of treatment. Rather, it should be whether a physician who has not personally seen a patient either knows or reasonably should know that he or she is diagnosing a patient’s condition or treating the patient. 283 P.3d 904, 910 (Or. 2012). Likewise, in Kelley, 133 S.W.3d at 596, the court stated that today’s health care system is increasingly complex, with several physicians participating in patient diagnosis when they may not have ever interacted with the patient. As such, it is “simply unrealistic to apply a narrow definition of the physician-patient relationship in determining whether such a relationship exists for purposes of a medical malpractice case.” Id. However, unlike the result in Mead, in Kelley, the court held that a physician-patient relationship could exist between the consulting physician and the patient. See id. at 598. See Mead, 283 P.3d at 910; see also Kelley, 133 S.W.3d at 596. See Meghan C. O’Connor, The Physician-Patient Relationship and the Professional Standard of Care: Reevaluating Medical Negligence Principles to Achieve the Goals of Tort Reform, 46 TORT TRIAL & INS. PRAC. L.J. 109, 132 (2010) (stating that a clearer definition relationship to include these “informal consultations.” Id. The court also found that holding physicians responsible for information exchanged during curbside consultations would be contrary to public policy as it would chill efforts to improve patient care through the exchange of medical knowledge. Id. While the case law does not explore curbside consultations at length, there are several journal articles that discuss these interactions. These articles (and their conclusions) are discussed further infra Part IV.} There is currently a lack of consistency in establishing when a
physician-patient relationship is formed and what factors are relevant for determining whether such a relationship exists. This inconsistency may cause medical malpractice claims to be adjudicated based on vague standards, allowing plaintiffs in states that require a physician-patient relationship for such claims to essentially bypass this requirement altogether.

However, the case law reviewed in this section shows that it is difficult to establish precisely when a physician-patient relationship is formed. While courts appear eager to create a definition for this relationship, no single test has emerged as the clear favorite. In light of this uncertainty, compelling arguments have been made for finding a middle ground. In other words, according to this viewpoint, courts should neither allow a brief phone call between physicians to create a physician-patient relationship, nor require a comprehensive physical exam before such a relationship is established.

Other commentators have gone further, arguing that a physician-patient relationship should not be required for a finding of medical negligence. This argument centers on the idea that, in the modern health care system, more patients may actually be “nonpatients” who may not be able to show a physician-patient relationship but have had some interaction with a physician that has allegedly led to harm. While these “nonpatients” could arguably still sue a physician for ordinary negligence, the applicable standard of care (that of a reasonable person versus that of a reasonable physician in a particular field of medicine) may be less favorable. Under this argument, removing the requirement of a traditional physician-patient relationship could allow for relief where it otherwise may be lacking. This view, which allows for the use of a foreseeability of harm standard, rather

---

38 Id.; see also Valarie Blake, When Is a Patient-Physician Relationship Established?, 14 AM. MED. ASSN. J. ETHICS 403, 404-05 (2012) (illustrating that the determination of a physician-patient relationship often depends on the situation and state law).
39 O’Connor, supra note 37, at 111.
41 Id.
42 See Patrick D. Blake, Note, Redefining Physicians’ Duties: An Argument for Eliminating the Physician-Patient Relationship Requirement in Actions for Medical Malpractice, 40 GA. L. REV. 573, 612 (2006) (noting that a balancing test based on multiple factors may be more appropriate than a strict, direct-contact test for determining whether a physician-patient relationship exists).
43 Id. at 575.
44 Id. at 576-77.
45 Id.
than a required physician-patient relationship," is similar to that used by Minnesota courts.

D. Nurse Practitioner Practice Authority in Minnesota, Pre- and Post-Warren

The events leading to the Warren decision took place at an interesting time for Minnesota nurse practitioners. In 2014, when Simon first examined Warren, Simon, like all nurse practitioners in Minnesota, was required to designate a collaborating physician.\(^4\) Collaborating physicians and nurse practitioners were expected to enter into "collaborative management plans," which set forth the process by which the nurse practitioner would consult with the physician while still retaining primary responsibility for the patient’s care.\(^5\) Nurse practitioners were also required to enter into a written agreement with a physician as a condition of obtaining the authority to prescribe medications and medical devices.\(^6\)

However, in 2015, Minnesota enacted new legislation that removed both the collaborative plan and prescriptive authority agreement requirements from the law.\(^7\) This, combined with provisions in the new law establishing a licensure process for nurse practitioners, resulted in nurse practitioners gaining full and independent practice authority in the state.\(^8\)

E. The Legal Evolution of Advanced Practice Providers

Warren addressed an issue of growing importance in today’s discussions about health care delivery: the expanding practice authority of advanced practice providers like nurse practitioners and physician assistants in many states. Minnesota licenses both nurse practitioners\(^9\) and physician assistants\(^10\) to provide health care services to patients. Nurse practitioners are nurses who have completed a master’s or doctorate-level education.\(^11\) In

---

\(^4\) Id. at 599.
\(^5\) MINN. STAT. § 148.171, subdiv. 6 (2014).
\(^6\) Id. subdiv. 6–7.
\(^7\) MINN. STAT. § 148.235, subdiv. 2 (2014).
\(^9\) Id.
\(^10\) MINN. STAT. § 148.211, subdiv. 1(a) (2019).
\(^11\) MINN. STAT. § 147A.02 (2019).
addition to obtaining state licensure, nurse practitioners are nationally certified in clinical focus areas that include, among other areas, family medicine, adult primary care, acute care, pediatrics, psychiatry, and women’s health. Nurse practitioners commonly practice in hospitals, clinics, emergency rooms, urgent cares, nursing homes, and other settings. In Minnesota, a nurse practitioner’s scope of practice includes educating and counseling patients on health care and disease prevention, health screening, and assessment; diagnosing and treating patient illnesses; ordering, performing, and interpreting diagnostic tests; and prescribing medications and medical devices. As of March 2020, there are more than 290,000 nurse practitioners licensed in the United States and more than 9000 licensed in Minnesota.

On the other hand, physician assistants are medical providers who have completed a master’s degree. A handful of doctorate-level educational programs are also available for physician assistants. Unlike nurse practitioners, who have a clear path to entering the profession as a registered nurse, physician assistants often come from varied backgrounds within other areas of health care, bringing professional experience as medical assistants, paramedics, athletic trainers, or other patient-facing providers. Physician assistants practice in hospitals, medical offices, community health centers, retail clinics, nursing homes, correctional institutions, and other settings. Physician assistants in Minnesota take patient histories; perform physical examinations; order and perform

---

56 AM. ASS’N OF NURSE PRACTITIONERS, supra note 54.
57 MINN. STAT. § 148.171, subdiv. 11 (2019).
58 AM. ASS’N OF NURSE PRACTITIONERS, supra note 55.
62 AM. ACAD. OF PHYSICIAN ASSISTANTS, supra note 60.
63 Id.
diagnostic and therapeutic procedures; counsel patients on disease management and prevention; transmit and execute specific patient orders; prescribe, administer, and dispense medications; and assist in surgery. As of March 2020, there are more than 140,000 physician assistants licensed in the United States and more than 3300 licensed in Minnesota.

Nurse practitioners and physician assistants are widely seen as occupying an important space in health care delivery. This recognition is increasingly leading to the inclusion of nurse practitioners and physician assistants in federal and state legislation meant to increase access to health care services. For instance, the Patient Protection and Affordable Care Act (Affordable Care Act) defined “primary care practitioners” as physicians, nurse practitioners, and physician assistants. Recent federal legislation has also authorized nurse practitioners and physician assistants to provide federally regulated, medication-assisted treatment for opioid use disorder and supervise cardiac and pulmonary rehabilitation programs for Medicare patients.

Similarly, state legislatures are increasingly enacting laws to expand the roles of these providers. As of 2019, twenty-two states (including Minnesota) and the District of Columbia have enacted legislation authorizing full

---

64 MINN. STAT. § 147A.09, subdiv. 2 (2019).
65 AM. ACAD. OF PHYSICIAN ASSISTANTS, supra note 60.
68 See Christopher Cheney, More States Pushing for Autonomy in Scope-of-Practice Battle, HEALTH LEADERS (May 1, 2019), https://www.healthleadersmedia.com/clinical-care/more-states-pushing-autonomy-scope-practice-battle [https://perma.cc/TR8Y-W55G] (“Advanced practice practitioners have been equally insistent on gaining expanded scope of practice across the country. For example, in several states, laws that expand scope of practice for physician assistants (PA), nurse practitioners (NP), and advanced practice registered nurses (APRN) have already been adopted.”).
practice authority for nurse practitioners. This generally means that nurse practitioners in these jurisdictions are able to diagnose, treat, and manage patients’ health conditions and prescribe medications without being required to enter into a career-long supervisory or collaborative agreement with another health care provider such as a physician.

Likewise, states are enacting legislation to reduce regulatory burdens on physician assistant practice, including removing restrictions on prescribing medications, allowing practice-level decision-making about physician assistants’ scope of practice, and removing the statutory requirement that a physician assistant have a specific relationship with a physician or other health care professional. In Minnesota, physician assistants have full prescriptive authority (including Schedule II-V controlled medications), and many decisions regarding a physician assistant’s role are made at the practice site. While physician assistants must have a written practice agreement with a supervising physician, the physician need not be physically present while the physician assistant is providing care. In early 2019, legislation to remove additional barriers to physician assistant practice was introduced in the Minnesota Senate.

The move towards increased practice authority for advanced practice providers is partially due to current and projected physician shortages. For instance, Minnesota is expected to need more than 1100 additional primary care physicians by 2030. This is an increase of nearly 30% over the 2010 workforce. Nationwide, it is expected that there will be a shortage of 74

702 MITCHELL HAMLINE LAW REVIEW [Vol. 46:3


73 Id. Some states authorizing full practice authority require nurse practitioners to enter into a supervisory or collaborative agreement with another health care provider until the nurse practitioner has attained a certain amount of practice experience. Id. Minnesota requires nurse practitioners to complete 2080 hours in a collaborative agreement with either a physician or an experienced nurse practitioner prior to advanced practice licensure. MINN. STAT. § 148.211, subdiv. 1c (2019).


76 Id. at 2.

between 21,000 and 55,000 primary care physicians by 2032.\(^8\) Meanwhile, the number of nurse practitioners and physician assistants are expected to nearly double by 2032.\(^9\) As a result, advanced practice providers are expected to help mitigate the physician shortage.

III. THE WARREN DECISION

A. Factual Background

Susan Warren went to an Essentia Health clinic with a variety of symptoms, including fever, chills, and abdominal pain.\(^8\) Sherry Simon, a nurse practitioner, examined Warren.\(^9\) Simon ordered a blood test for Warren and, upon examining the results, found an elevated white blood cell count and other atypical markers, which Simon believed were indicative of an infection requiring hospitalization.\(^10\)

Simon wrote a letter for Warren’s employer, documenting Warren’s illness and stating that Warren would be unable to work.\(^11\) Since the Essentia health care system did not have a local hospital, Simon contacted the Fairview Range Medical Center to request Warren’s admission.\(^12\) This action was consistent with standard practice at Essentia.\(^13\) Simon was


\(^{9}\) Id. at 23.

\(^{10}\) Warren v. Dinter, 926 N.W.2d 370, 377 (Minn. 2019).

\(^{11}\) Id.

\(^{12}\) Id.

\(^{13}\) Id. at 372. The Warren majority used this letter to show that Simon had already reached a conclusion regarding whether Warren should be hospitalized. Id. at 379. Therefore, according to the majority, Simon’s conversation with Dinter was not a curbside consultation in which Simon sought to “pick a colleague’s brain about a diagnosis.” Id. Rather, Simon called Dinter solely as part of the protocol for requesting patient admission at Simon’s facility. Id.

\(^{14}\) Id. at 372.

\(^{15}\) Id. at 372-73.
connected with one of the three hospitalists.\footnote{Hospitalists, AM. ACAD. OF FAMILY PHYSICIANS, https://www.aafp.org/practice-management/administration/hospitalists.html [https://perma.cc/9NNY-KGVN] (last visited Sep. 5, 2019). Hospitalists are physicians who primarily provide patient care in a hospital setting. Id. They often assess a patient’s condition prior to or at the time of admission to a hospital. Id. A hospital or health care system may employ a hospitalist for the primary purpose of admitting patients. See Hospital Medicine, AM. COLL. OF PHYSICIANS, https://www.acponline.org/about-acp/about-internal-medicine/general-internal-medicine/hospital-medicine [https://perma.cc/4T7H-MZH2] (last visited Sep. 5, 2019).} Dr. Richard Dinter, at Fairview.\footnote{Warren, 926 N.W.2d at 372.}

Simon and Dinter spoke for approximately ten minutes.\footnote{Id. at 373.} At trial, they disagreed on the specifics of the diagnostic information shared by Simon during this call.\footnote{Id.} They also disagreed about whether Simon requested Warren to be hospitalized or whether Simon asked Dinter’s opinion regarding potential hospitalization.\footnote{Id.} However, both agreed that Dinter told Simon that Warren’s elevated white blood cell count was likely due to uncontrolled diabetes.\footnote{Id.} They both also agreed that Dinter advised Simon to “get that issue under control and see Warren the following Monday.”\footnote{Id.} However, Simon claimed Dinter told her Warren did not need to be hospitalized, while Dinter claimed he responded to Simon’s question with, “to what end[?]”\footnote{Id.}

After her call with Dinter, Simon spoke with her collaborating physician, Dr. Jan Baldwin, in hopes that Baldwin would be able to assist Simon with her request to hospitalize Warren.\footnote{See MINN. STAT. § 148.171, subdiv. 6 (2014). At the time of Warren’s initial visit to Simon, Simon was subject to Minnesota laws requiring nurse practitioners to have ongoing “collaborative management” by a physician. Id. This arrangement required nurse practitioners to establish a relationship with a physician practicing in a similar area of health care such that the nurse practitioner could consult with the physician as necessary to advance patient care. Id. subdivs. 6–7.} Like Dinter, Baldwin advised Simon that diabetes could be the cause of Warren’s abnormal blood test results.\footnote{Warren, 926 N.W.2d at 372.} Simon informed Warren that she had been advised by a hospitalist (Dinter) that Warren did not require immediate hospitalization.\footnote{Id.} Simon discussed the diabetes diagnosis with Warren,
prescribed medication, scheduled a follow-up appointment, and released Warren to her home. Warren was found dead three days later due to sepsis caused by an untreated staph infection.

B. Lower Courts’ Decisions

Warren’s son sued Dinter, claiming Dinter was negligent in telling Simon that he did not believe Warren needed to be hospitalized. Dinter moved for summary judgment on the grounds that he did not have a duty to Warren, as Simon had only contacted Dinter due to his role as a hospitalist, and, therefore, his advice to Simon was a one-time, “professional courtesy.” Dinter also argued that his actions (or omissions) were not a proximate cause of Warren’s death.

The trial court granted Dinter’s motion for summary judgment on the duty issue, holding that the phone call between Simon and Dinter was “an informal conversation between medical colleagues,” which did not create a physician-patient relationship between Dinter and Warren. The trial court denied summary judgment on the causation issue, stating that there was still a remaining question of fact regarding Warren’s cause of death.

---

100 Id.
101 Id. Justice Anderson expanded on Warren’s recent health history in his dissenting opinion. When Warren presented to Simon, complaining of “three days of worsening of symptoms with fevers, chills, abdominal pain, cough, and shortness of breath,” Warren had also explained to Simon that she had experienced approximately three weeks’ worth of exposure to welding smoke at her job. Id. at 380–81 (Anderson, J., dissenting). However, Simon told Dinter that her examination of Warren was “essentially normal” and that Warren did not have a fever and appeared to be “in no apparent distress.” Id. at 381. Simon had also called Warren’s employer and poison control and came to the belief (which she expressed to Dinter) that the welding smoke was “no longer part of the issue.” Id. Simon preliminarily believed that Warren had an infection, due largely to her high white blood-cell count. Id. However, Simon also found that Warren’s blood sugar was high, and her sodium was low. Id. Simon told Dinter that Warren’s case was “confusing” because her chief complaint was smoke inhalation, yet she had myriad other symptoms, including some that Simon did not mention to Dinter, such as abdominal distention. Id. Although Simon relayed substantial patient information to Dinter, she did not share with him any of Warren’s medical records or test results. Id. According to Simon, her conversation with Dinter lasted less than ten minutes. Id.
102 Id. at 374 (majority opinion).
103 Id.
104 Id.
105 Id.
106 Id.
Warren’s son appealed, arguing that, in Minnesota, a duty may exist even in the absence of a physician-patient relationship under the foreseeability of harm standard. The court of appeals affirmed the trial court’s decision, holding that Dinter did not consent to either treating Warren or being held responsible for her care. The court also noted that this case was distinct from both Skillings v. Allen and Molloy v. Meier (Molloy II), in which the foreseeability of harm standard was used to extend a duty to a third party from an existing physician-patient relationship. Here, there was no existing relationship connecting Dinter and Warren to create such a duty. Therefore, according to the court of appeals, Dinter had no duty to Warren.

C. Minnesota Supreme Court’s Decision—Majority Opinion

Warren’s son appealed again, and the Minnesota Supreme Court reversed the lower courts’ decisions. The reason for the reversal was twofold. First, the court determined the court of appeals had misconstrued the holding in Skillings as requiring a contractual relationship to establish a physician’s duty to a third party. Second, the court noted that using the foreseeability of harm standard to determine a physician’s duty, absent a physician-patient relationship, had worked in Minnesota for one hundred years, and there appeared to be no reason to depart from this principle.

The court then applied the foreseeability of harm standard to determine whether it was foreseeable to Dinter that Warren would rely upon and be harmed by his statements to Simon regarding Warren’s potential hospitalization. The court noted that this danger must be “objectively reasonable to expect . . . not simply . . . within the realm of any

---

108 Id. at *3.
109 Id. at *4 (distinguishing Molloy v. Meier (Molloy II), 679 N.W.2d 711, 713-14, 717 (Minn. 2004), and Skillings v. Allen, 143 Minn. 323, 325, 173 N.W. 663, 663–664 (1919)).
110 Id.
111 Id.
112 Id.
113 Id.
114 Id. at 377.
115 Id.
116 Id. at 377–78 (“We must ‘apply the principles of negligence law set forth in Skillings and Togstad and conclude that the duty arises where it is reasonably foreseeable’ that Warren ‘would be injured if the advice is negligently given,’” (quoting Molloy II, 679 N.W.2d at 720)).
Using this standard, the court found it reasonable to conclude Dinter could have foreseen that Warren would rely upon his conversation with Simon. The court also held that there was sufficient evidence to show Dinter’s conversation with Simon constituted a breach in the standard of care of a hospitalist, and, therefore, it was a proximate cause of Warren’s death.

The court acknowledged Dinter’s and the dissent’s argument that the conversation between Dinter and Simon was simply a curbside consultation and not a formal medical opinion by Dinter. However, the court was not persuaded by this argument, pointing to Dinter’s status as a hospitalist and Simon’s status as a nurse practitioner and noting that Simon was asking for Warren’s admission to the hospital—not for advice on Warren’s diagnosis. As such, the court declined to address the legal status of curbside consultations any further.

The court’s 5-2 holding remanded the case to the trial court for further proceedings consistent with its opinion. In doing so, the court noted that while the subject matter of the case (the duty of a hospitalist to another health care provider’s patient) was a question of first impression, the underlying issue—whether summary judgment should have been granted

---

117 Warren, 926 N.W.2d at 378 (quoting Foss v. Kinade, 766 N.W.2d 317, 322 (Minn. 2009)).
118 Id.
119 See id. (referring to expert testimony that Dinter’s statements to Simon were not consistent with the standard of care for a hospitalist and noting that if Warren had been admitted to the hospital as requested by Simon, she may have survived the infection).
120 See discussion infra Section IV.A.
121 Warren, 926 N.W.2d at 378.
122 Id. at 388 n.3. The court noted that while Simon had the authority under her collaboration agreement with Baldwin to provide care to Warren, Simon did not have the ability to admit Warren to the hospital. Id. This may be due to limitations on Baldwin’s scope of practice under Minnesota law at that time, see discussion infra Section II.D., or it may be due to the hospital’s credentialing and privileging process. See MINN. HOSP. ASS’N, MEDICAL STAFF CREDENTIALING (2016), https://www.mnhospitals.org/Portals/0/Documents/Trustees/briefs-resources/credential.pdf [https://perma.cc/7WMF-HUAL] (explaining the processes used by health care facilities to assure that medical staff are qualified to provide health care services and undertake only those services for which they are qualified). Credentialing and privileging often involve the collection of information similar to that required for licensure (e.g., proof of identity, proof of education, and a background check). This process is completed by each facility prior to a practitioner being cleared to provided services therein. Id. Regardless, Simon required Dinter’s sign-off to admit Warren to that particular hospital at that time. Warren, 926 N.W.2d at 388 n.3.
123 Id. at 379.
124 Id.
125 Id. at 380.
on the issue of duty—was not. According to the court, when facts related to foreseeability (and, therefore, duty) are disputed, or there are differing reasonable inferences from facts that are not in dispute (i.e., a “close call”), summary judgment should be denied, and the fact finder should determine the outcome.

D. Minnesota Supreme Court’s Decision—Dissenting Opinion

In his dissenting opinion, Justice G. Barry Anderson spent significant time on the concept of curbside consultations, arguing discussions between colleagues are vital to patient care and, therefore, should have been addressed by the majority. Moreover, Justice Anderson warned that allowing one-time conversations between health care professionals to create a duty to a patient who is unknown to the consulting professional could have a chilling effect on the exchange of ideas related to patient diagnosis and treatment. As such, he argued the court’s holding could be detrimental to both patients and professionals.

The dissent also disagreed with the finding that Dinter should have foreseen Warren’s reliance on, and ultimate harm from, his statements to Simon. Specifically, Justice Anderson argued that Dinter could not have foreseen that his statements during a ten-minute phone call would prevent Simon (who did have a duty to Warren) from taking further action to verify her diagnosis of Warren or from finding alternative means of admitting Warren to the hospital. As part of this argument, the dissent emphasized that Dinter did not make the final determination regarding Warren’s treatment or hospitalization. For instance, Simon sought a second opinion from Baldwin, her collaborating physician. Yet, despite other available treatment options, Simon “yield[ed] control over her patient to the hospitalist, . . . defer[ing] to the hospitalist’s views on how to treat the

---

126 Id.
127 Id.
128 Id. at 387 (Anderson, J., dissenting).
129 Id.
130 Id.
131 Id. at 382.
132 Id.
133 Id. at 383.
134 Id.
135 Id. Baldwin testified that while it was unusual for a hospitalist to decline another professional’s request to admit a patient, in those situations, the professional may still direct the patient to go to the emergency room for observation. Id. The dissent used this testimony to illustrate the idea that despite Dinter’s belief that Warren did not require hospitalization, Simon could have taken alternative actions to assure Warren received adequate care. Id.
IV. ANALYSIS

This section begins with an overview of the utility of curbside consultations and a discussion of how Warren may put these valuable communications at risk. The subsequent analysis advocates for a narrow construction of the foreseeability of harm standard in medical malpractice cases. This is followed by a discussion of how Warren illustrates the implications of the changing relationship between physicians and advanced practice providers, particularly on the question of who is liable for patient care. The section concludes with some suggestions for health care practitioners and other professionals seeking to protect themselves from liability in the wake of Warren.

A. Uncertainty Ahead: Creating a Duty from Curbside Consultations

This section discusses the concept of curbside consultations, or informal consults between physicians and other health care professionals. It first examines the utility of these communications and the differences between curbside and formal consultations. Second, it discusses the reasons health care professionals rely on informal discussions with colleagues when treating patients. The section goes on to describe potential consequences of the Warren decision when it comes to curbside consultations. Finally, it addresses special considerations relevant to hospitalists, and why even when a physician takes a gatekeeper role, his interactions with other professionals should in some cases be considered informal.

1. Background on Curbside Consultations

The Warren court was clear in its holding that it did not believe it was necessary to address the legal implications of curbside consultations. That is because, in the majority’s view, the conversation between Simon and Dinter was not an informal discussion. Still, the court noted that other states have addressed curbside consultations between health care professionals and acknowledged that creating a duty out of these
conversations could limit practitioners’ willingness to engage with their colleagues. Yet, it remains unclear how Minnesota courts will treat curbside consultations in the future.

Curbside consultations are informal conversations between physicians (or physicians and other health care professionals) that include an exchange of information regarding patient care. These conversations are not generally known to the patient, and no payment is made to the consulting professional. They tend to happen “opportunistically” or in passing, rather than via a formal meeting or appointment. These interactions are distinct from formal consultations, which involve a referral and examination of the patient by the consulting professional.

While formal consultations can result in a physician-patient relationship, informal or curbside consultations do not. Curbside consultations also do not cause the consulting physician to be responsible for the care of the patient in question. This is largely because the role of the consulting professional is indirect. In a typical curbside consultation, a conversation regarding the patient’s history, symptoms, or condition may occur, but the consulting physician does not generally see the patient’s records, view the patient’s test results, or examine the patient.

2. The Value of Curbside Consultations to Health Care Practitioners

---

11. Id. The amici curiae’s brief—jointly submitted by the Minnesota Hospital Association, the Minnesota Medical Association, and the American Medical Association—expanded on this point. The brief noted that “[w]hen faced with a constellation of symptoms and attempting to formulate a diagnosis and treatment plan, physicians should be encouraged to seek out colleagues with different experience or backgrounds to assist them in analyzing the medical information.” Brief for Minn. Hosp. Ass’n et al. as Amici Curiae Supporting Respondents at 4, Warren v. Dinter, 926 N.W.2d 370 (Minn. 2019) (No. A17-0555), 2018 WL 4003503, at *4 [hereinafter Minn. Hosp. Ass’n Brief]. The brief further explained that “accepting Appellant’s argument—that a provider who offers an informal suggestion or ideas to an independent provider about her patient now has a physician-patient relationship with that person—would chill those important conversations and be detrimental to patient care in Minnesota.” Id. at 6.

and Patients

There are many reasons why a physician or other health care professional may choose to engage in curbside consultations instead of formally referring a patient to another provider. Researchers who observed the informal consulting practices of physicians reported that physicians engage in these conversations to:

- confirm a suspected diagnosis or planned course of action (e.g., to “bounce ideas off their practice partners”);
- get quick answers to questions about symptoms or treatment options;
- informally learn more about a symptom or condition from a practitioner in a particular specialty;
- explore the necessity of referring the patient for a formal consultation;
- triage patients in a particular practice setting (e.g., determining which patients should see which providers in an emergency room);
- seek out emotional support from colleagues during difficult cases or in advance of tough conversations with a patient or the patient’s family;
- create bonds or relationships with their colleagues;
- seek out like-minded practitioners or colleagues with similar treatment styles;
- confirm their own clinical knowledge; and
- investigate the appropriateness of transferring a patient to another practitioner.\(^{151}\)

These observations largely track physicians’ stated reasons for engaging in curbside consultations.\(^{152}\) Physicians view curbside consultations as a means of providing better patient care and fulfilling what they see as professional obligations to their colleagues.\(^{153}\) However, some physicians may feel pressure to engage in curbside consultations because they are so prevalent in the profession.\(^{154}\) This leads to an occasional characterization of curbside consultations as a “necessary evil”—a useful tool for the most part, but one which may come with risks.\(^{155}\)

3. The Tenuous Future of Curbside Consultations in Minnesota

---

\(^{150}\) Perley, supra note 142, at 139.
\(^{151}\) Id. at 139–41.
\(^{152}\) Id. at 141.
\(^{153}\) Id.
\(^{154}\) Id.
\(^{155}\) Id.
\(^{156}\) Id.
Under Warren

The *Warren* decision has seemingly placed curbside consultations on the riskier side of the balance. When paired with the foreseeability of harm standard, it is extremely difficult to determine whether professionals who engage in one-off discussions could be found negligent in the event a patient is harmed. For instance, the majority opinion in *Warren* argued that Dinter, as a hospitalist, should have foreseen that Simon (and, as a result, Warren) would rely on his decision not to admit Warren.\(^\text{156}\) It, therefore, followed that Dinter should have foreseen Warren would be harmed if the comments he made to Simon were negligently offered.\(^\text{157}\) Although the court noted that it did not intend this decision to apply to curbside consultations, it also declined to define such discussions.\(^\text{158}\) As such, it remains uncertain where Minnesota courts will draw the line between what is foreseeable to a consulting physician and what is not.

Courts in other jurisdictions have attempted to address this issue by holding that curbside consultations do not expose a consulting physician to potential liability.\(^\text{159}\) For instance, in *Irvin v. Smith*, the Kansas Supreme Court held that a physician providing an “informal opinion” to another physician does not create a physician-patient relationship and does not owe a duty to the patient.\(^\text{160}\) The court provided several examples of informal opinions, including a “gratuitous” conversation with a treating physician in which some patient details were omitted,\(^\text{161}\) an opinion in which the treating

\(^\text{156}\) Warren v. Dinter, 926 N.W.2d 370, 380 (Minn. 2019).
\(^\text{157}\) Id.
\(^\text{158}\) Id. at 379. The majority opinion did not create a formal definition of “curbside consultations” for health care practitioners engaging in such activities in the future. See id. However, it provided a few hints. In particular, the court seemed to characterize a curbside consultation as an informal discussion in which a professional “pick[s] a colleague’s brain about a diagnosis.” Id. Notably, the court did not definitively state whether it would exempt a practitioner who engaged in the court’s vision of a curbside consultation from liability in future cases. Id. It simply noted that other states had exempted such practitioners. Id.
\(^\text{159}\) See, e.g., Reynolds v. Decatur Mem’l Hosp., 600 N.E.2d 235, 239 (Ill. Ct. App. 1996) (“A doctor who gives an informal opinion at the request of a treating physician does not owe a duty of care to the patient whose case was discussed.”); Millard v. Corrado, 14 S.W.3d 42, 49 (Mo. Ct. App. 1999) (holding that “a physician-patient relationship is created only where the physician personally examines the patient,” while allowing for hands-off liability where a contractual relationship between physician and patient exists); Lopez v. Aziz, 852 S.W.2d 303, 307 (Tex. Ct. App. 1993) (“To expose physicians . . . to liability for simply conferring with a colleague would be detrimental in the long run to those seeking competent medical attention and is contrary to the public policy of [Texas].”).
\(^\text{161}\) Id. (citing Oliver v. Brock, 342 So. 2d 1, 4 (Ala. 1976)).
The physician was told to act “as he saw fit,” and a discussion in which the consulting physician had no role in examining or treating the patient. However, the Irvin court noted that an informal opinion may become formal when the consulting physician “assumes the role of treating the patient.” In other words, when the consulting physician affirmatively acts in a way that could be viewed as consenting to participate in the patient’s care, the physician forms a physician-patient relationship and owes a corresponding duty to the patient. Still, the court maintained that a case in which the consulting physician did not examine the patient, review the patient’s records, speak to the patient, enter any patient orders, or do anything other than speak about the patient’s condition in general terms did not result in the physician assuming a treatment role and, therefore, the physician did not have a duty.

4. The Case of the Curbside Hospitalist

While the majority in Warren did not consider the conversation between Dinter and Simon to be a curbside consultation, the facts of the case show that the conversation had many of the elements of this type of informal discussion. Dinter had not met, examined, or spoken with Warren. He did not review Warren’s patient records or read her test results. Dinter’s only role in Warren’s care was hearing from Simon some (but not all) of Warren’s symptoms over the course of a ten-minute telephone call and offering his opinion that Warren’s symptoms indicated uncontrolled diabetes not warranting hospitalization.

The majority believed Dinter’s offered opinion and denial of admission was enough of an affirmative action to show that Dinter had assumed a treatment role, thereby creating a duty to Warren. However, the case was not so clear-cut. Dinter did not suggest a specific course of action to Simon. Instead, he gave his initial opinion and left it to Simon to

---

162 Id. (citing Hill v. Kokosky, 463 N.W.2d 265, 267 (Mich. Ct. App. 1990)).
163 Id. (citing Lopez, 852 S.W.2d at 306).
165 Id. at 941–42.
166 Id. at 942–43.
168 Id.
169 Id.
170 Id. at 382.
determine what additional steps to take. Notably, Simon’s subsequent action—calling Baldwin, her collaborating physician—shows that Simon did not initially take Dinter’s opinion as an instruction. Rather, Simon’s request that Baldwin help her have Warren admitted shows Simon understood there were other ways to get Warren the care she believed Warren required. Baldwin later confirmed that there were other potential treatment options available to Simon, including requesting that Warren visit an emergency room. Yet, Simon—the health care practitioner who was responsible for Warren’s care—opted not to pursue any of these options and released Warren despite her apparent feeling that more should be done.

The court held that Dinter should have foreseen Simon, having received advice from two physicians, would, as Justice Anderson phrased it, “fail to make reasonable treatment decisions regarding her patient.” Under the majority’s view, health care practitioners must weigh the benefit of engaging their colleagues in curbside consultations against the risk that they may be liable for any decisions made as a result of—or in spite of—these conversations. This holding could have a chilling effect on the valuable interactions physicians and other health care practitioners share with their colleagues, which would, in turn, limit collaboration and teamwork in medical settings. Just as alarmingly, it could prove to be detrimental to patient care by closing off an important source of clinical knowledge—other health care practitioners.

B. The Foreseeability of Harm Standard Favored by Minnesota Courts Should Be Narrowly Construed to Avoid Unintended Consequences

Several issues may arise when Minnesota’s foreseeability of harm standard is read too broadly. Viewing the potential unintended

---

...
consequences of an overbroad reading of this standard through the lens of current federal laws, including the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act, the resolution of these issues may not be as simple as requiring a physician-patient relationship for a medical malpractice action.

1. Foreseeability of Harm: Finding the Balance Between Overbroad and Just Right

The Warren court declined to join the majority of states that require some kind of physician-patient relationship as part of a medical malpractice claim.\(^{179}\) However, as noted in Justice Anderson’s dissent, the use of the foreseeability of harm standard in medical malpractice cases is not generally problematic.\(^{180}\) The results are only troublesome when the concept of foreseeability is applied too broadly.\(^{181}\)

For instance, the cases cited by the majority in Warren, including Skillings, Togstad, and Molloy II,\(^{182}\) all involved conversations between a professional and a layperson (e.g., a patient’s parents or a potential legal client).\(^{183}\) Conversely, Warren involved a conversation between two healthcare professionals.\(^{184}\) According to Justice Anderson, it was foreseeable that the laypeople in Skillings, Togstad, and Molloy II would rely upon any advice they drew from their personal conversations with a professional—whether a relationship existed or not.\(^{185}\) However, it was not foreseeable that a third party who was uninvolved in a conversation between two professionals would similarly rely on (or even be aware of) any information gleaned from such a discussion.\(^{186}\)

Justice Anderson’s dissent also noted that Simon’s actions were not foreseeable to Dinter under Foss v. Kincade, where the court acknowledged

\(^{179}\) Id. at 377.

\(^{180}\) Id. at 386 (Anderson, J., dissenting).

\(^{181}\) Id.

\(^{182}\) Id. at 376–77 (citing Molloy II, 679 N.W.2d 711, 714 (Minn. 2004) (conversation between a physician and the patient’s parent); Togstad v. Vesely, 291 N.W.2d 686, 690 (Minn. 1980) (conversation between an attorney and a potential client); Skillings v. Allen, 143 Minn. 323, 324, 173 N.W. 663 (Minn. 1919) (conversation between a physician and the patient’s parent)).

\(^{183}\) Id. at 376 (Anderson, J., dissenting).

\(^{184}\) Id.

\(^{185}\) Id.

\(^{186}\) Id. at 387. In a typical conversation between professionals, Justice Anderson notes, the subject of the discussion is often unaware of the conversation. This is true even if the professional seeking the advice wraps information from his or her colleague into a final decision about the subject of the discussion.
cases in which “the realm of possible harm is much larger than the realm of reasonably foreseeable harm.”

Accordingly, “[w]hen determining whether a danger is foreseeable, we ‘look at whether the specific danger was objectively reasonable to expect, not simply whether it was within the realm of any conceivable possibility.’” Harms which are not “objectively reasonable to expect” are “too remote to create liability.”

For instance, in the case of Foss, the court held that while the defendants knew it was possible that their bookcase could be tipped over if it were not secured to the wall, it was unreasonable to expect them to “make a laundry list of common household items with which a three-year-old could conceivably injure himself” before inviting the child and his family into their home. This is because the law does not require homeowners to “take every precaution to guard against every possible eventuality.” It is only necessary that homeowners guard against actions that are objectively reasonable to foresee.

Interestingly, the majority opinion in Warren also quotes this passage. In doing so, the majority seemingly argues that the specific danger—that Simon would rely on Dinter’s opinions, casting off her own judgment and forgoing further testing or efforts to hospitalize Warren even when she believed something was very wrong with her—was “objectively reasonable” for Dinter to expect. The majority bases this argument on Dinter’s role as a hospitalist responsible for determining whether a patient should be admitted to the facility. However, while Dinter’s decision not to admit Warren may have foreclosed one avenue of continued treatment, it did not require Simon to abandon all options. Simon remained Warren’s primary provider of care, and she had the authority to pursue alternative means of care for her patient. It seems unlikely that Dinter could have foreseen his opinion—his initial “no” to hospitalization—would have

---

188 Id. at 322 (quoting Whiteford ex rel. Whiteford v. Yamaha Motor Corp., U.S.A., 582 N.W.2d 916, 918 (Minn. 1998)).
189 Id.
190 Id. at 323.
191 Id.
192 Id.
193 Warren v. Dinter, 926 N.W.2d 370, 378 (Minn. 2019).
194 Id.
195 Id.
196 Id. at 382 (Anderson, J., dissenting).
197 Id. at 383.
prevented Simon from trusting her clinical knowledge and ordering additional testing or treatment.\textsuperscript{198}

That said, Warren appears to be a case in which “reasonable persons might differ as to the foreseeability of [an] injury.”\textsuperscript{199} The Minnesota Supreme Court has typically held that these “close cases” are an issue for the jury.\textsuperscript{200} Therefore, while both the majority and the dissenting opinion claim to have the correct view of foreseeability under Foss, the ultimate decision regarding whether Simon’s action (or inaction) should have been foreseeable to Dinter is left to the jury.\textsuperscript{201} This would likely be true even if there is no “explicit factual dispute in the record.”\textsuperscript{202}

Still, Justice Anderson’s reading of this standard appears to provide more guidance on the issue of foreseeability of harm during a curbside consultation than does the majority’s interpretation. When two professionals have an informal conversation about patient care, there could be many reasonably foreseeable outcomes. The conversation could lead to the treating professional (in this case, Simon) asking additional questions, ordering more tests, seeking out a formal consultation between the consulting physician and the patient, or requesting a referral to another provider with more experience in a certain area of medicine. However, it is unreasonable to require the consulting professional to expect that his opinion would cause the treating professional to suspend all other methods of caring for her patient, as was the case in Warren.\textsuperscript{203}

\textsuperscript{198} Id.
\textsuperscript{199} See Montemayor v. Sebright Prods., Inc., 898 N.W.2d 623, 625 (Minn. 2017).
\textsuperscript{201} Warren, 926 N.W.2d at 378 (quoting Domagala v. Rolland, 805 N.W.2d 14, 27 (Minn. 2011)) (citing Fenrich v. Blake School, 920 N.W.2d 193, 205 (Minn. 2018); Senogle v. Carlson, 902 N.W.2d 38, 48 (Minn. 2017); Montemayor, 898 N.W.2d at 629; Foss v. Kincade, 766 N.W.2d 317, 322-23 (Minn. 2009); Whiteford ex rel. Whiteford v. Yamaha Motor Corp., U.S.A., 582 N.W.2d 916, 918 (Minn. 1998)).
\textsuperscript{202} Steenson, supra note 200, at 46 (quoting Montemayor, 898 N.W.2d at 629). Arguably, there is a factual dispute in Warren because Simon and Dinter disagreed about the extent to which they discussed Warren’s condition during their telephone call. Warren, 926 N.W.2d at 373. Yet, even if there were no factual dispute, reasonable minds could differ regarding whether Dinter should have foreseen Simon’s subsequent actions. See Steenson, supra note 200, at 46.
\textsuperscript{203} Warren, 926 N.W.2d at 383 (Anderson, J., dissenting). The court did not consider whether Simon’s decision to send Warren home, despite the existence and availability of other treatment options, constituted an intervening or superseding cause of Warren’s death. It is likely that the majority in Warren believed Simon’s actions should have been foreseeable to Dinter, and, therefore, even if this was an intervening cause, the court would have found that it could not be a superseding cause. See Steenson, supra note 200, at 38. Minnesota’s jury instruction echoes this idea by requiring a superseding cause to meet four requirements:
2. Potential Unintended Consequences of an Overbroad Foreseeability of Harm Standard

It is important that courts do not create unintended consequences for health care professionals who engage in clinical discussions with their colleagues by using an overbroad interpretation of foreseeability of harm. Health care practices, systems, facilities, and payors are increasingly encouraging—and even incentivizing—collaboration among health care professionals. These policies tend to have two goals: limiting health care costs and improving quality of care.

a. The Patient Protection and Affordable Care Act

The Affordable Care Act, signed into law in 2010, created a Medicare Shared Savings Program, which incentivized the use of Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs). (1) it occurred after the original act of negligence; (2) it did not occur due to the original negligent act; (3) it altered the “natural course of events by making the result different from what it would have been;” and (4) the original negligent party could not have reasonably anticipated the action. 4 MINN. PRAC., JURY INSTR. GUIDES—CIVIL CIVJIG 27.20 (6th ed. 2014). Even if the court believed that Simon’s action was an intervening or superseding cause, the result may be the same for Dinter, as the court has held that superseding causes are “adequately taken into consideration in the comparative-fault formula.” Montemayor, 898 N.W.2d at 631 (quoting Bilotta v. Kelley Co., 346 N.W.2d 616, 625 (1984)).


[Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and avoiding medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program.] Accountable Care Organizations (ACOs), CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 2, 2019), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/ [https://perma.cc/MER5-G9N3].

“Patient Protection and Affordable Care Act § 3502(a) (codified as amended at 42 U.S.C. § 256a-1 (2018)); see also Mantel, supra note 204, at 247–48. The U.S. Department of Health and Human Services, through the Agency for Healthcare Research and Quality (AHRQ), defines PCMHs as a model of primary care delivery which includes five key features: (1) comprehensive patient care, including preventive, acute, and chronic care, delivered by a team of practitioners that include physicians, nurse practitioners, physician
ACOs are health care entities that consist of teams of providers who are accountable to both patients and each other in streamlining and coordinating patient care. ACOs are performance-driven, and they receive shared financial incentives when they improve patient outcomes (e.g., by limiting hospital admissions) while meeting cost and quality measures. Similarly, PCMHs use health care provider teams to offer primary care services that are “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.”

The success or failure of these models largely depends on providers’ ability to communicate with one another about patient care. Effective use of ACOs and PCMHs—both of which are intended to improve patient care outcomes and help reduce health care spending—would be nearly impossible to implement and manage if health care providers feared they could be held liable for even the most cursory conversation about the care of a participating patient.

---

assistant, and other health care professionals; (2) patient-centered focus, which includes the patient’s individual health as well as his or her “unique needs, culture, values, and preferences;” (3) coordination of care, through which the “medical home” serves as the patient’s primary provider which brings in additional specialists when necessary; (4) accessibility of care, including reduced wait times, increased service hours, immediate appointments for urgent issues, and 24-hour services via telecommunications; and (5) improved quality and safety, with an emphasis on shared decision-making between health care providers, patients, and families and improved data collection and measurement. Defining the PCMH, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP’T OF HEALTH & HUMAN SERVS., https://pcmh.ahrq.gov/page/defining-pcmh [https://perma.cc/RZ9B-BU36] (last visited Sept. 23, 2019).

207 Morrell & Krouse, supra note 205, at 244.
208 Id.
210 Id. at 244, 248. The Affordable Care Act included many other provisions that are meant to incentivize collaboration among health care providers, including increased funding for community health centers, which focus on outreach to underserved communities. Id. at 236, 288. The authors also note that the Affordable Care Act’s goal of insuring more individuals means that demand for health care services will increase. See id. at 287. This will require an all-hands-on-deck approach where physicians and non-physician providers like nurse practitioners and physician assistants work together to assure those who need care are able to receive it. See id.
b. The Medicare Access and CHIP Reauthorization Act

In 2015, Congress passed legislation that created new, “value-based” payment models for the federal Medicare program.\footnote{Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 101(c) (codified at 42 U.S.C. § 1395w-4 (2018)).} These models are meant to improve quality, outcomes, and cost-effectiveness rather than simply paying providers on a per-visit, per-procedure basis.\footnote{See Quality Payment Program Overview, CTRS. FOR MEDICARE & MEDICAID SERVS., https://qpp.cms.gov/about/qpp-overview [https://perma.cc/52UH-BAJ2] (last visited Sept. 23, 2019); MIPS Overview, CTRS. FOR MEDICARE & MEDICAID SERVS., https://qpp.cms.gov/mips/overview [https://perma.cc/3M8C-MVPH] (last visited Sept. 23, 2019).} A key component of value-based payment for health care services is the streamlining of patient care, particularly for patients with multiple or complex health conditions.\footnote{Cynthia D. Smith et al., Implementing Optimal Team-Based Care to Reduce Clinician Burnout, NAT’L ACAD. OF MED. (Sept. 17, 2018), https://nam.edu/implementing-optimal-team-based-care-to-reduce-clinician-burnout/ [https://perma.cc/P2VP-LN2P].} The average Medicare beneficiary visits two primary care providers and five specialty care providers each year, plus additional health professionals who offer diagnostic services—such as imaging and bloodwork—and pharmacy services.\footnote{Id.} However, Medicare beneficiaries with chronic or complex conditions may require exponentially more visits and increasingly specialized providers.\footnote{Id.} These patients, in particular, can benefit from modernized payment models which allow teams of providers to work together to treat the patient in an efficient manner.\footnote{Id.}

Research supports the implementation of policies that increase the use of value-based, team-provided health care for Medicare beneficiaries.\footnote{Id.} Moreover, health care practices using these care models have shown increased clinician productivity.\footnote{Id.} However, \textit{Warren} raises questions about how far “foreseeability” will travel in a practice that emphasizes team-based care. Would a conversation between a primary care provider and a specialty provider about a patient create a duty in the consulting physician? If the provider who asked the question subsequently opted not to continue care, would the provider who answered it be responsible? The implications of the \textit{Warren} decision could be far-reaching.


\newpage
Many states have intentionally or unintentionally foreclosed the issue of an overbroad application of foreseeability in medical malpractice cases by requiring the existence of a physician-patient relationship, direct patient contact, or other expressions of consent by the consulting physician to be clinically responsible for the patient’s care before a duty is created. However, as a handful of courts have noted, the changing nature of health care—particularly, the emphasis on team-based care—has further complicated determinations about the existence of a true physician-patient relationship.

While federal interest in reducing health care spending bears significant responsibility for this shift, other factors in the health care marketplace have contributed as well. Although small, physician-owned practices once dominated the U.S. health care system, reforms meant to increase efficiency and lower health care costs have led to an increase in large-group- or hospital-owned health care conglomerates. Gone are the days of physicians opening their own solo practices. In fact, the percentage of physicians who are in private practice has decreased from over 72% in 1988 to just under 46% in 2018.

As a result, today’s physicians have been thrust into practice settings where they are surrounded by a large number of colleagues, and they are expected to deliver health care services seamlessly, as a team. In these environments, it may be difficult to ascertain who has a physician-patient relationship with a patient and who does not.

Arguably, in these settings, Minnesota’s “foreseeability of harm” standard may be more effective in establishing whether a health care
provider has a duty to a patient than the more common physician-patient relationship standard. However, to prevent unintended consequences, foreseeability must be narrowly construed. Justice Anderson’s approach in Warren seems to strike the proper balance by focusing on the foreseeability of the “specific danger,” as illustrated in Foss. This standard would benefit both patients and health care professionals while continuing to encourage a professional exchange of ideas through collaboration.

C. Warren Illustrates the Legal and Policy Implications of the Evolving Role of Advanced Practice Providers

Warren illustrates legal and policy questions surrounding the increased practice authority of advanced practice providers. This section considers physicians’ legal responsibility from collaborating with or supervising nurse practitioners and physician assistants. Additionally, it discusses the responsibility of physicians who practice alongside advanced practice providers with whom they do not have a legal collaborative or supervisory relationship.

1. The Argument for Limiting Physician Responsibility for Advanced Practice Providers

The Warren decision illustrates what is likely to become a more common question as advanced practice providers continue to grow in number and authority: to what degree, if any, should physicians be held responsible for care provided by a nurse practitioner or physician assistant? In Warren, the court ultimately held that Dinter, who had neither seen Simon’s patient nor reviewed the patient’s records, could nonetheless be liable for the patient’s death.


Minn. Hosp. Ass’n Brief, supra note 141, at 5. (“Patients ultimately benefit from . . . informal discussions and brainstorming sessions among providers by receiving improved care.”) The brief goes on to state: Discouraging these informal discussions by assigning liability to providers who offer input and suggestions on an informal basis would only serve to harm patients. The better position is one recognized and adopted by the Court of Appeals, where a physician providing an informal consultation to an independent treating provider does not assume a physician-patient relationship with that patient. To hold otherwise would be contrary to the majority of other states who have considered this policy issue, and would stifle and discourage the robust practice of medicine in Minnesota to the detriment of patient care.

Warren v. Dinter, 926 N.W.2d 370, 380 (Minn. 2019).
received appropriate care despite Dinter’s refusal to admit her. For instance, Simon could have ordered further testing or directed Warren to seek emergency room care, but she declined to do so. This result has correctly caused physicians to fear the extent to which they can be held responsible for care provided by another practitioner.

As nurse practitioners and physician assistants gain more autonomy, their relationship with physicians will continue to change. This is particularly true in the case of nurse practitioners, who have completely severed their legal ties to physicians in states like Minnesota that have enacted full practice authority legislation. While Warren came at a time of change for the advanced practice nursing profession, nurse practitioners in Minnesota are now considered to be autonomous. As noted in the Minnesota Hospital Association’s amici curiae brief supporting Dinter, holding a physician responsible for the autonomous act of a nurse practitioner after the enactment of full practice authority legislation violates the spirit of this change.

That said, there is a compelling argument for limiting physicians’ responsibility for care provided by advanced practice providers, like physician assistants, who do not currently have full practice authority in Minnesota. Simon’s collaborative relationship with Baldwin at the time of the events leading to Warren’s death was similar to that of a physician assistant and supervising physician today, in which physician assistants have a legal tie to their supervising physician. This is accomplished by stating that the physician is “responsible” for the health care services rendered by the provider.

However, this provision does not mean that the supervising or collaborating physician is solely responsible for the care provided by the advanced practice provider. Rather, physician assistants who practice under a supervisory agreement with a physician remain liable for their own

---

230 Id. at 382–83 (Anderson, J., dissenting).
231 Id. at 382.
233 Id. at 10–12.
234 Id. at 12.
235 Id.
236 Id.
237 See MINN. STAT. § 147A.01, subdiv. 24 (2019) (providing that, in Minnesota, a supervising physician “oversee[s] the activities of, and accept[s] responsibility for, the medical services rendered by a physician assistant”).
238 Id.
actions and omissions. Holding physicians responsible for the autonomous decisions of advanced practice providers is counterproductive and may expose physicians to unnecessary liability.

2. The Potential Effects of Warren on Physicians and Advanced Practice Providers Who Are Not in a Legal Collaborative Relationship

In Warren, the court held that Dinter, a physician with no legal tie to Simon, was nonetheless legally responsible for Simon’s patient. The court used Dinter’s role as a hospitalist to cast him as a “gatekeeper” who should have foreseen that his refusal to admit Warren, if negligent, would cause her harm. This holding could cause physicians who provide any kind of guidance, advice, or one-off instruction to be held liable for independent decisions made by an advanced practice provider. This potential result would be devastating to the delivery of health care, both in Minnesota and in states that find Warren to be persuasive. Advanced practice providers who are supervised by, or collaborate with, physicians typically enter into a written practice agreement that affirms the relationship, defines the roles and duties of each party, and sets forth the terms and expectations related to supervision or collaboration. Physicians and advanced practice providers willingly enter into these agreements, with each party understanding its roles and responsibilities therein.

However, if physicians who have not chosen to enter a specific supervisory or collaborative agreement with an advanced practice provider run the risk of being liable for the care provided by those providers, these physicians may begin refusing, even incidentally, to work alongside them. This, in turn, would lead physicians to refer advanced practice providers

---

240 Id.
241 Id. at 8, 13.
243 Id. at 380.
244 Minn. Hosp. Ass’n Brief, supra note 141, at 13.
245 See MINN. STAT. § 147A.01, subdiv. 17a (2019) (requiring physician assistants to enter into a “delegation agreement” with a supervising physician). The delegation or practice agreement must set forth the physician assistant’s scope of practice, including the physician assistant’s role in patient care and the categories of medications and medical devices that the physician may prescribe. Id. The agreement must also describe the method of supervision. Id. Supervision does not require the physician’s constant physical presence, but the physician assistant and supervising physician must be able to be easily contacted via telecommunication. Id. subdiv. 24.
246 Minn. Hosp. Ass’n Brief, supra note 141, at 13.
247 Id. at 14.
back to their supervising or collaborating physicians rather than engaging in collaborative discussion. In cases where time is of the essence, a delay caused by fear of liability could mean the difference between life and death.

D. How Can Health Care Practitioners Protect Themselves from Liability Post-Warren?

The Warren decision raises concerns among many in the health care community—in Minnesota and elsewhere. In the wake of this holding, physicians and other health care practitioners should be mindful of the potential liability they could incur by collaborating too closely on patient care. What follows are some courses of action that health care providers (and other professionals) can take to limit their risk post-Warren, categorized based on the role of the consulting practitioner.

1. For Gatekeepers

Practitioners who are in a “gatekeeper” role, similar to Dinter’s role as a hospitalist, are most likely to be at risk due to the Warren decision. Justice Anderson’s dissent suggests that hospitalists who fear liability of the kind assigned to Dinter must “refuse to take calls from other professionals to discuss potential hospitalization of those professionals’ patients.”

---

248 Id.
249 See, e.g., Christopher Johnson, How a Minnesota Supreme Court Decision Could Affect Curbside Consults, KEVINMD.COM (May 16, 2019), https://www.kevinmd.com/blog/2019/05/how-a-minnesota-supreme-court-decision-could-affect-curbside-consults.html [https://perma.cc/YSJ9-4AAP] (arguing that the court’s use of foreseeability of harm is “chilling” because a consulting physician may not have been provided all of the relevant patient details, particularly if the patient’s condition relates to a different field of medicine); MN Supreme Court Rules Physician-Patient Relationship Is Not Necessary to Sue Docs for Malpractice, MINN. MED. ASS’N (Apr. 18, 2019), https://www.mnmed.org/news-and-publications/News/MN-Supreme-Court-Rules-Physician-Patient-Relations [https://perma.cc/K98K-FM62] (stressing that the decision may hinder physicians’ ability to collaborate with colleagues and quoting the General Counsel of the association-endorsed medical liability insurer, COPIC, in stating that the “expansive language” in the decision “raise[s] concerns”); MN Supreme Court: Warren v. Dinter, MINN. MED. GRP. MGMT. ASS’N (June 26, 2019), https://www.mmmga.org/news/458203/MN-Supreme-Court-Warren-v.-Dinter.htm [https://perma.cc/T3UH-2ZWD] (reporting that the decision raises concerns for physicians and that the Minnesota Medical Association and the Minnesota Hospital Association have created task forces to study the issue).
However, such an overcorrection would certainly harm patients. Instead, these practitioners should operate under the assumption that if they provide any kind of advice, guidance, or commentary about a patient to a colleague, that colleague will rely upon the advice. Hospitalists must also assume they have a duty to their colleagues’ patients because it is foreseeable that if their advice is negligently given, a patient could be harmed.

2. For Other Collaborators

Other, non-gatekeeper practitioners should also exercise caution. When a colleague asks for an opinion about treating a patient who is unknown to the consulting practitioner, the consulting practitioner should make sure to understand as many details of the patient’s condition and history as possible, especially if the consulting practitioner believes the advice will strongly weigh on the colleague’s course of action.

However, increasing the consulting practitioner’s knowledge about the patient (e.g., by sharing test results or patient records) could constitute the tipping point between a curbside consultation and a consultation viewed as more formal by the court. Consulting practitioners should, therefore, have

---

252 See id. (stating that the decision in *Warren* “is unlikely to serve Minnesotans well, particularly those who may have access to primary health care but lack access to a deep network of medical specialists”).

253 Ellis, *supra* note 250.

254 *Id.*

255 Some commentators have written that the holding in *Warren* is unlikely to affect true curbside consultations. *See id.* Instead, it is argued that this decision will have the greatest effect on cases that involve a practitioner in a gatekeeper role. *Id.* (stating that a “gatekeeper” practitioner should assume, in the aftermath of *Warren*, that their “advice and guidance will be relied upon.”) However, it has also been noted that the lack of guidance by the court regarding the definition of “curbside consultation” has resulted in uncertainty about where the line will be drawn between foreseeable and not foreseeable. *Id.*

256 *See id.* (“If, however, a healthcare provider is asked to opine regarding a course of treatment for a patient that is unknown to them, they ought to exercise caution about the advice they provide to their colleagues and make sure they understand the nature and extent of the medical issue because the advice and guidance they provide may ultimately be determinative.”).

257 Thaddeus Pope, *Curbside Consults: New Liability Risks to Avoid When You Are Not a Patient’s Physician*, ASCO POST (June 25, 2019), https://www.ascopost.com/issues/june-25-2019/new-liability-risks-to-avoid-when-you-are-not-a-patient-s-physician/ [https://perma.cc/ZMA5-36XN]. An informal, curbside consultation usually has several key features: (1) it involves brief, non-specific information, without much detail; (2) it does not involve direct patient interaction (in person or otherwise); (3) it does not involve the consulting physician’s review of the patient’s record or participation in formulating the patient’s care plan; (4) it results in the offering of mostly academic advice; and (5) it is not
a “low threshold” for recommending a formal patient consultation, whether with themselves or another professional. 258 When in doubt, practitioners should step back from an informal discussion and recommend a more formal consult. 259

3. For All Consulting Practitioners

Some recommendations stemming from the Warren decision apply to health care practitioners in any situation. First and foremost, practitioners should understand the laws of the jurisdiction in which they practice. 260 If there is still a lack of clarity (and post-Warren, this will likely be the case), practitioners should look to the policies set by their employers (e.g., hospitals or medical groups) or their liability insurance carriers. 261 Practitioners should also use Warren as a reminder that, in Minnesota, a duty may exist to a patient even if a traditional physician-patient relationship has not been created. This means that any type of communication about a patient, whether in person, via email, in a phone call, or through any other means, could create such a duty, depending on the situation. 262

Additionally, practitioners should keep detailed records of any consultations they provide to their colleagues—curbside or otherwise. 263 Warren involved conflicting accounts of what information Simon had provided to Dinter and exactly what Dinter had recommended (or not recommended). 264 Record-keeping on both sides could help resolve any questions regarding the nature and extent of a conversation between professionals.

Finally, practitioners should consult with their professional associations for assistance in navigating the Warren decision. For example, the Minnesota Medical Association has released initial suggestions for Minnesota physicians, focusing on how to avoid liability due to curbside

---

258 Ellis, supra note 250.
259 Pope, supra note 257.
261 “See id.
262 Ellis, supra note 250.
263 “See id.
264 Warren v. Dinter, 926 N.W.2d 370, 373 (Minn. 2019).
While these forms of guidance do not constitute legal advice, they can be useful in establishing best practices.

4. For Professionals Outside Health Care

In his dissent, Justice Anderson cautioned that the *Warren* decision could have effects that reach into professions beyond health care. Curbside consultations are not unique to medicine; in fact, they are frequently used by lawyers, accountants, and other professionals to get an informal second opinion on a matter involving a client. As was the case in *Warren*, the clients of these consulting professionals are generally unaware of these professional-to-professional conversations. Yet, under this decision, it is possible that these professionals could also unwittingly create a duty to a client when a colleague consults them.

As a result, professionals outside health care should also use caution when engaging in informal, curbside discussions. In particular, the Minnesota Medical Association’s advice—to clearly state when a conversation is informal, keep informal conversations brief and limited in scope, and recommend formal consultations when appropriate—likely translates well to other professionals who find themselves in situations similar to Dinter’s. Additionally, other professionals would be well-served to keep detailed notes of any informal consultations in which they choose to participate.

V. CONCLUSION

*Warren* considered whether a conversation between a treating nurse practitioner and a consulting physician was enough to create a duty to the
patient in the physician. The court applied an established foreseeability of harm standard and concluded that the consulting physician should have foreseen that the nurse practitioner’s patient would rely on the content of this conversation and be harmed if the physician negligently provided any advice. The court declined to address the legal status of one-time curbside consultations between health care professionals.

The decision in Warren could have the unintended consequence of impeding collaboration between colleagues in health care settings and, ultimately, negatively impact patient care. The decision has also created uncertainty among health care providers and professionals outside of health care alike. Therefore, professionals should take precautionary measures to appropriately reduce liability and consult with their employing entities and professional associations for further guidance.
Mitchell Hamline Law Review
The Mitchell Hamline Law Review is a student-edited journal. Founded in 1974, the Law Review publishes timely articles of regional, national and international interest for legal practitioners, scholars, and lawmakers. Judges throughout the United States regularly cite the Law Review in their opinions. Academic journals, textbooks, and treatises frequently cite the Law Review as well. It can be found in nearly all U.S. law school libraries and online.
mitchellhamline.edu/lawreview