STATE OF MINNESOTA
IN COURT OF APPEALS
A17-0555

Justin Warren,
Appellant,

vs.

Richard Dinter, et al.,
Respondents.

Filed January 16, 2018
Affirmed; motion denied
Smith, Tracy M., Judge
Dissenting, Hooten, Judge

St. Louis County District Court
File No. 69HI-CV-16-325

Sam Hanson, Robert J. King, Benjamin E. Gurstelle, Amarachi Ihejirika, Briggs and Morgan, P.A., Minneapolis, Minnesota (for appellant)

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Considered and decided by Larkin, Presiding Judge; Hooten, Judge; and Smith, Tracy M., Judge.

U N P U B L I S H E D O P I N I O N

SMITH, TRACY M., Judge

Appellant Justin Warren sued respondents Dr. Richard Dinter and Range Regional Health Services for medical malpractice following the death of appellant's mother, Susan Warren. The district court granted summary judgment to respondents on the ground that

Dr. Dinter did not owe a duty of care to Ms. Warren. The district court rejected respondents' alternative argument for summary judgment based on causation, concluding that a genuine issue of material fact exists on that issue. On appeal, appellant argues that the district court erred in concluding that Dr. Dinter did not have a duty, while respondents argue, on conditional cross-appeal, that the district court erred in concluding that a factual issue exists regarding causation. Because we agree that Dr. Dinter did not owe a duty of care to Ms. Warren, we affirm.

FACTS

On the morning of August 8, 2014, Ms. Warren went to Essentia Health Hibbing Clinic (Essentia), complaining of abdominal pain, fever, chills, and other symptoms. She was examined by Nurse Practitioner (N.P.) Sherry Simon, had her blood drawn for testing, and was sent home. Once the blood tests were completed, N.P. Simon called Ms. Warren and asked her to return to Essentia for additional testing that afternoon. Based on the results of that testing (as well as the prior tests, examination, and health history), N.P. Simon believed that Ms. Warren needed to be admitted to a hospital.

Respondent Range Regional Health Services does business as Fairview Range Medical Center (Fairview), which is a hospital in Hibbing. Fairview is a separate legal entity from Essentia and is not affiliated with the Essentia clinic. Dr. Dinter is a hospitalist at Fairview; a hospitalist is a physician who provides care for patients in a hospital setting.

As a nurse practitioner, N.P. Simon did not have admitting privileges at Fairview. Fairview and Essentia had no contract between them. However, typical practice, when an Essentia employee believed that a patient needed hospitalization, was for the employee to

call Fairview, ask to speak to a hospitalist there, and have the Fairview hospitalist make the admission determination. N.P. Simon followed this practice.

Based on her belief that Ms. Warren needed to be admitted, N.P. Simon called Fairview and was connected with Dr. Dinter, one the three hospitalists on duty at that time. N.P. Simon described Ms. Warren's symptoms to Dr. Dinter. Based on the information that N.P. Simon orally provided, Dr. Dinter told her that it sounded like Ms. Warren had "a diabetes that's out of control" and that she should "treat the diabetes and see [Ms. Warren] back in [a] follow-up [visit]." Dr. Dinter specifically told N.P. Simon that Ms. Warren "did not need to be hospitalized," and recommended that N.P. Simon follow up with Ms. Warren on Monday, three days later.[1]

After N.P. Simon concluded her phone conversation with Dr. Dinter, she remained concerned that Ms. Warren needed hospitalization, so she consulted her collaborating physician at Essentia, Dr. Jan Baldwin. As N.P. Simon's collaborating physician, Dr. Baldwin was responsible for addressing any concerns or questions from N.P. Simon about a case. According to Dr. Baldwin, although she had admitting privileges at Fairview, her normal procedure was to have the Fairview hospitalists do admissions of her adult patients. Although she occasionally admitted her adult obstetrics patients directly,

[1] There is a factual dispute as to what N.P. Simon relayed to Dr. Dinter and what Dr. Dinter advised. For purposes of summary judgment, "[w]e view the evidence in the light most favorable to the party against whom summary judgment was granted." *STAR Ctrs., Inc. v. Faegre & Benson, L.L.P.*, 644 N.W.2d 72, 76-77 (Minn. 2002). We thus assume that N.P. Simon relayed the relevant information to Dr. Dinter and asked him to admit Ms. Warren, that Dr. Dinter opined that Ms. Warren's diabetes was the cause of her symptoms and did not require hospitalization for treatment, and that a physician exercising due care would not have rendered such an opinion.

Dr. Baldwin stated that, for all other patients, if a Fairview hospitalist declined to admit a patient she thought should be hospitalized, she would either send the patient to Fairview's emergency room or to a different hospital.

Dr. Baldwin reviewed the lab results and discussed Ms. Warren's case with N.P. Simon. She did not examine Ms. Warren. Dr. Baldwin concurred with Dr. Dinter that hospitalization was not needed and that treating Ms. Warren's diabetes would resolve her abnormal lab results.

N.P. Simon discussed this determination with Ms. Warren, prescribed medication to begin controlling the diabetes, told her to call the clinic or go to an emergency department if her symptoms got worse, and scheduled an appointment for the following Monday. The next day, Ms. Warren died due to sepsis brought on by a staph infection.

In 2016, appellant, as next of kin, filed a medical malpractice claim against Dr. Dinter and Fairview. After the close of discovery, Dr. Dinter and Fairview moved for summary judgment on the bases that (1) Dr. Dinter did not owe a duty of care to Ms. Warren, (2) there was no genuine issue of material fact as to causation, and (3) subsequent decisions by N.P. Simon and Dr. Baldwin precluded any liability on the part of Dr. Dinter or Fairview. The district court granted summary judgment on the basis that there was no duty of care, noting that "there is a fact question regarding causation."

Appellant challenges the district court's conclusion regarding duty. Respondents challenge the district court's conclusions regarding causation.

D E C I S I O N

"We review a district court's summary judgment decision de novo. In doing so, we determine whether the district court properly applied the law and whether there are genuine issues of material fact that preclude summary judgment." *Riverview Muir Doran, LLC v. JADT Dev. Grp., LLC*, 790 N.W.2d 167, 170 (Minn. 2010) (citation omitted).

> [T]here is no genuine issue of material fact for trial when the nonmoving party presents evidence which merely creates a metaphysical doubt as to a factual issue and which is not sufficiently probative with respect to an essential element of the nonmoving party's case to permit reasonable persons to draw different conclusions.

DLH, Inc. v. Russ, 566 N.W.2d 60, 71 (Minn. 1997).

Appellant argues that the district court erred in granting summary judgment for respondents based on the absence of any duty of care. "[D]uty is generally a legal question for the court to decide . . . ." *Montemayor v. Sebright Prods., Inc.*, 898 N.W.2d 623, 629 (Minn. 2017). A physician-patient relationship creates a duty of care. *Molloy v. Meier*, 660 N.W.2d 444, 450 (Minn. App. 2003), *aff'd*, 679 N.W.2d 711 (Minn. 2004). Thus, "[t]he first question we must address in a medical malpractice action is whether a physician-patient relationship existed." *Peterson v. St. Cloud Hosp.*, 460 N.W.2d 635, 638 (Minn. App. 1990).

We begin by identifying the allegedly negligent conduct. At various times appellant has identified the negligent conduct as Dr. Dinter's denial of N.P. Simon's request to admit Ms. Warren to the hospital. But at oral argument, appellant conceded that Dr. Dinter had no obligation to admit Ms. Warren, regardless of whether Ms. Warren had been correctly

diagnosed. Instead, appellant's claim is better understood as alleging that Dr. Dinter negligently made a determination and rendered advice that Ms. Warren did not require hospitalization. Such a determination and advice, however, are not actionable unless Dr. Dinter owed Ms. Warren a duty of care.

Appellant first argues that Dr. Dinter owed a duty of care to Ms. Warren because there was a physician-patient relationship between them. Dr. Dinter did not meet or examine Ms. Warren, and the record is clear that Ms. Warren never contracted directly with Dr. Dinter for medical services. Appellant argues, however, that Dr. Dinter entered into a physician-patient relationship with Ms. Warren indirectly through N.P. Simon at Essentia.

In *Peterson*, this court held that a physician-patient relationship may exist when the patient's physician contracts with a third-party physician to perform services. *Id.* at 638. In that case, the patient's physician contracted with a pathologist to examine tumor-cell samples. *Id.* at 637. The pathologist examined the samples and prepared a report, which the patient alleged negligently misdiagnosed the tumor. *Id.* This court held that the pathologist had a duty to the patient, even though the patient had not personally engaged the pathologist. *Id.* at 638. We quoted a case from the Indiana Court of Appeals, which reasoned that, in determining whether a consensual physician-patient relationship exists, "'[t]he important fact . . . is not who contracted for the service but whether it was contracted for with the express or implied consent of the patient or for his benefit.'" *Id.* (quoting *Walters v Rinker*, 520 N.E.2d 465, 472 (Ind. Ct. App. 1988)).

Unlike in *Peterson*, there is no contract here. Appellant conceded at oral argument that there was no contract between Essentia and Dr. Dinter or Fairview to provide services on Ms. Warren's behalf. Dr. Dinter did not create any reports or records for use by Ms. Warren's medical providers, nor did he bill Essentia or Ms. Warren for any services.

Appellant urges that, despite the absence of a contract, it is still possible to find a physician-patient relationship between Dr. Dinter and Ms. Warren because of the "working agreement" that existed between Essentia and Fairview. Appellant argues that, because Dr. Dinter had, in the past, taken calls from Essentia employees, evaluated symptoms during those calls, and admitted patients to Fairview as a result, Dr. Dinter had consented to be responsible for Essentia's patients' care generally, and Ms. Warren's care specifically.

We are unpersuaded. No Minnesota malpractice case has held that such a past practice or working relationship is sufficient to show a physician's consent to be responsible for a patient's care or the patient's consent to be treated by that physician. Absent such precedent, it is not the role of this court to create a duty where none previously existed. *See In re Welfare of J.P.-S.*, 880 N.W.2d 868, 873 (Minn. App. 2016) (quoting *Tereault v. Palmer*, 413 N.W.2d 283, 286 (Minn. App. 1987) ("The task of extending existing law falls to the supreme court or the legislature, but it does not fall to this court."), *review denied* (Minn. Dec. 18, 1987)).

We are also unpersuaded by the dissent's suggestion that the possibility of an implied contract merits reversing summary judgment. Significantly, appellant has never argued that the "course of conduct" between Essentia and Fairview created an implied

contract, nor has he cited any cases to support finding such a contract. Moreover, the suggestion that Fairview was contractually obligated to Essentia to make admissions determinations for Essentia's patients runs counter to appellant's concession that Fairview's hospitalists could have refused to take Essentia's calls regarding possible hospitalization of Essentia's patients.

Appellant next argues that, even if there was no physician-patient relationship between Dr. Dinter and Ms. Warren, other cases permitting malpractice claims by nonpatients indicate that Dr. Dinter owed Ms. Warren a duty of care. "[A] duty to a third party who is not a patient of the [defendant] physician has been recognized in only a few Minnesota cases." *Molloy v. Meier*, 679 N.W.2d 711, 717 (Minn. 2004). Such cases have found a duty to a child's biological parents when performing genetic testing on the child, *id.* at 719, a duty to warn victims when specific threats are made against them by a treating physician's patient, *Cairl v. State*, 323 N.W.2d 20, 25 n.7, 26 (Minn. 1982), and a duty to advise parents of the danger of taking an infectious child with scarlet fever home, *Skillings v. Allen*, 143 Minn. 323, 325, 173 N.W. 663, 664 (1919).

These few cases, however, are distinguishable from the case here. In each of those cases, an existing physician-patient relationship was unquestionably present and the question before the court was whether the physician's duty of care extended beyond the patient to a nonparty to the relationship. In *Molloy*, a physician-patient relationship existed between the child that underwent genetic testing and the physician defendants. *See* 679 N.W.2d at 713-14. Similarly, in *Cairl*, the treatment facility clearly owed a duty to the patient in question. *See* 323 N.W.2d at 24 n.6. And in *Skillings*, "the child was defendant's

patient." 143 Minn. at 325, 173 N.W. at 663. Thus, all of these cases involved a clearly existing physician-patient relationship, and the issue was whether a nonparty to that relationship could recover where it was "reasonably foreseeable that the [nonparty] would be injured if the advice is negligently given." *Molloy*, 679 N.W.2d at 719. Here, there is no existing physician-patient relationship that could be extended to create a duty toward (the nonpatient) Ms. Warren. Rather, the only potential physician-patient relationship would be between Dr. Dinter and Ms. Warren, and, as discussed above, there was no physician-patient relationship between them.

Finally, Appellant argues that it was Dr. Dinter's job as a hospitalist to make admission decisions, and that this role gave rise to a duty of care when making those decisions. Dr. Dinter unquestionably took the phone call and consulted with N.P. Simon in the context of his employment as a hospitalist. However, that is a different question from whether he consented to entering into a physician-patient relationship with the unidentified patient being discussed on the phone. Although Dr. Dinter would owe a duty care to patients that he admitted to the hospital, a prerequisite of that duty is that the patient be *his patient*. Dr. Dinter may admit patients based on calls from other professionals, in which case he does enter into a physician-patient relationship, but it does not follow that those calls alone constitute consent to take on the patient.

To hold otherwise would require hospitalists who wish to avoid such relationships to refuse to take calls from other professionals to discuss potential hospitalization of those professionals' patients. Caselaw indicates that the better policy is to promote informal consultations among physicians. Although the Minnesota Supreme Court has not directly

addressed the issue, in other contexts the court has alluded to a policy favoring consultation, and other courts across the country have been explicit in recognizing it. *See Benell v. City of Virginia*, 258 Minn. 559, 562-66, 104 N.W.2d 633, 635-37 (1960) (discussing the benefits of specialist consultation, but holding such policy questions were immaterial in evaluating whether administrative resolution was arbitrary or unreasonable); *see also, e.g.*, *Oliver v. Brock*, 342 So.2d 1, 2, 4 (Ala. 1976) (holding that physician's approval of course of treatment after hearing symptoms did not create a physician-patient relationship); *Rainer v. Grossman*, 107 Cal. Rptr. 469, 472 (Cal. Ct. App. 1973) (holding that treating physician's describing symptoms and defendant physician's corresponding recommendation did not give rise to a physician-patient relationship, but rather finding liability would "stifl[e] efforts at improving medical knowledge"); *Reynolds v. Decatur Mem'l Hosp.*, 660 N.E.2d 235, 240 (Ill. App. Ct. 1996) (discussing a "chilling effect" that would occur if informal conferences gave rise to physician-patient relationships); *Irvin v. Smith*, 31 P.3d 934, 943 (Kan. 2001) ("Courts have taken these public policy concerns to heart and have routinely refused to extend liability . . . to doctors who have acted solely in the role of an informal . . . consultant. This has been true even when the doctors' involvement in giving advice to the attending physician has been very extensive."); *Sterling v. Johns Hopkins Hosp.*, 802 A.2d 440, 451 (Md. Ct. Spec. App. 2002) (noting public policy concerns of expanding liability); *Hill by Burston v. Kokosky*, 463 N.W.2d 265, 268 (Mich. Ct. App. 1990) (noting that expanding malpractice liability to "doctors with whom a treating physician has merely conferred" would "unacceptably inhibit the exchange of information"); *Scafide v. Bazzone*, 962 So.2d 585, 595 (Miss. Ct. App. 2006) (noting that

public policy favors not imposing liability for consultations where the defendant physician neither "see[s] a patient [n]or [has] any other personal knowledge"); *Ingber v. Kandler*, 513 N.Y.S.2d 11, 11 (N.Y. App. Div. 1987) (holding that an "informal opinion" where the physician neither "had any contact with the patient" nor "saw any records" did not create a physician-patient relationship).[2]

It is the role of this court to correct errors, not to change the law. *See Clark v. Connor*, 843 N.W.2d 785, 788 (Minn. App. 2014); *see also Larson v. Wasemiller*, 738 N.W.2d 300, 303 (Minn. 2007) (noting that this court should defer to the Minnesota Supreme Court's or the Minnesota Legislature's addressing of the complex policy concerns of medical-malpractice claims). Absent a policy determination by the Minnesota Supreme Court that a physician who provides noncontractual, informal consultation to another physician owes a duty to the latter physician's patient, we conclude that no physician-

[2] The dissent points to several cases from other jurisdictions to support a contrary result. In two of those cases, however, the court ultimately reached the same result as we reach here and declined to find a physician-patient relationship. *See Irvin*, 31 P.3d at 944; *Oja v. Kin*, 581 N.W.2d 739, 744 (Mich. Ct. App. 1998). In the others, the circumstances notably differed from this case. In *Kelley v. Middle Tenn. Emergency Physicians, P.C.*, the defendant physician was "covering" for another physician in his practice who clearly had directly interacted with the patient and had an established physician-patient relationship with her. 133 S.W.3d 587, 589, 596 (Tenn. 2004). In *Cogswell by Cogswell v. Chapman*, the defendant ophthalmologist "served in the capacity of a courtesy/consulting physician at the hospital" and provided phone advice and care instructions to hospital-emergency-room personnel who lacked expertise in the area for a patient with an eye injury. 672 N.Y.S.2d 460, 460 (N.Y. App. Div. 1998). And in *Campbell v. Haber*, denial of summary judgment was affirmed because "there [was] a triable issue of fact whether the [defendant cardiologist] was 'on call'" with the hospital when an emergency-room physician consulted him by phone about a patient. 274 A.D.2d 946, 947 (N.Y. App. Div. 2000). Here, there is not a factual dispute for a jury to resolve.

patient relationship was created here, and therefore Dr. Dinter did not owe a duty of care to Ms. Warren.

The dissent suggests that *Togstad v. Vesely, Otto, Miller & Keefe*, 291 N.W.2d 686 (Minn. 1980), which was relied upon by the supreme court in *Molloy*, indicates that, even if there was no agreement on the part of Dr. Dinter to provide services, he may still be liable because he rendered medical advice in circumstances where it was reasonably foreseeable that Ms. Warren would be injured if that advice was negligently given. In *Togstad*, the plaintiff met with an attorney at the defendant law firm to discuss a potential medical-malpractice claim. *Id.* at 690. The plaintiff "told [the attorney] 'everything that happened at the hospital,' . . . . [but] brought no records with her." *Id.*

> [The attorney] took notes and asked questions during the meeting, which lasted 45 minutes to an hour. At its conclusion, . . . [the attorney] said that "he did not think we had a legal case, however, he was going to discuss this with his partner." [The plaintiff] understood that if [the attorney] changed his mind after talking to his partner, he would call her. [The plaintiff] "gave it" a few days and, since she did not hear from [the attorney], decided "that they had come to the conclusion that there wasn't a case." No fee arrangements were discussed, no medical authorizations were requested, nor was [the plaintiff] billed for the interview.

Id. The court concluded that, on those facts, "the evidence shows that a lawyer-client relationship is present here." *Id.* at 693.

Apart from arising in the distinct legal-malpractice context, *Togstad* differs from this case in two important respects. First, the formality of the "meeting" was notably different. Unlike in *Togstad*, the discussion between Dr. Dinter and N.P. Simon lasted only ten minutes, Dr. Dinter took no notes, and he did not commit to any further consideration

of the case. Second, unlike in *Togstad*, Ms. Warren never directly interacted with Dr. Dinter. Instead, N.P. Simon called Fairview and was connected with Dr. Dinter, and she alone discussed whether Ms. Warren should be admitted to Fairview. We do not see grounds in caselaw for basing the existence of a physician-patient relationship on such facts. Rather, cases where consultation has led to a professional-client relationship (either physician-patient or lawyer-client) have required that the consulted professional clearly consent to taking on responsibility for the client, *see, e.g.*, *Peterson*, 460 N.W.2d at 638, or, in the absence of such consent, required that the professional meet and provide advice to the client directly, s*ee, e.g.*, *Togstad*, 291 N.W.2d at 693. Neither of these conditions is present here.

Because the undisputed facts establish that respondents owed no duty of care to Ms. Warren, respondents were entitled to judgment as a matter of law and the district court properly granted summary judgment to respondents. Because we conclude that summary judgment is appropriate on that basis, we do not address respondents' arguments that summary judgment is also appropriate on the issue of causation and deny appellant's motion to strike arguments on that issue as moot. *See Drewitz v. Motorwerks*, 728 N.W.2d 231, 233 n.2 (Minn. 2007) (denying motion to strike portions of a brief as moot where the court did not rely on any of the materials objected to in the motion).

Affirmed; motion denied.

HOOTEN, Judge (dissenting)

I respectfully dissent from the majority's conclusion that Dr. Dinter did not owe a duty of care to Ms. Warren because there was no physician-patient relationship between them.

Although the majority emphasizes a lack of a contractual relationship between Ms. Warren and Dr. Dinter, Minnesota courts have historically looked beyond the existence of a contract in determining whether a doctor owed an individual a duty of care. In *Skillings v. Allen*, the defendant-physician treated the plaintiff's daughter who was suffering from scarlet fever. 143 Minn. 323, 324, 173 N.W. 663, 663 (1919). The physician negligently advised the plaintiff's wife that it would be safe for her and plaintiff to visit their child, and then allowed them to visit the child. *Id.* After visiting their daughter and becoming infected with scarlet fever themselves, both plaintiff and wife sued the physician for negligence. *Id.*, 143 Minn. at 325, 173 N.W. at 663. The physician argued that the plaintiff lacked a cause of action because there was no contractual relationship between the plaintiff and the physician. *Id.* The Minnesota Supreme Court disagreed, concluding that regardless of whether the duty is contractual or noncontractual, the physician owed a duty to the plaintiff and wife for the advice he gave them. *Id.*, 143 Minn. at 326, 173 N.W. at 664.

The majority attempts to distinguish the *Skillings* line of cases by stating the cases are limited to exceptional, third-party circumstances in which a physician-patient relationship already exists in some form and that they concern issues regarding whether a third-party may bring suit for injuries related to the existing physician-patient relationship. *See id.*, 143 Minn. 323, 173 N.W. 663; *Molloy v. Meier*, 679 N.W.2d 711 (Minn. 2004);

Lundgren v. Fultz, 354 N.W.2d 25 (Minn. 1984). But, "Generally speaking, one is responsible for the direct consequences of his negligent acts whenever he is placed in such a position with regard to another that it is obvious that if he does not use due care in his own conduct he will cause injury to that person." *Id.*, 143 Minn. at 325, 173 N.W. at 663–64 (citation omitted). Due to the typical practice of having a Fairview hospitalist, not an Essentia nurse practitioner, decide whether to admit a patient, Dr. Dinter, as one of Fairview's hospitalists, was in the obvious position to exercise due care in admission decisions because his negligent failure to do so could foreseeably lead to a person suffering future injuries. In advising the nurse practitioner that Ms. Warren did not need to be admitted and that a follow-up visit three days later would be sufficient, Dr. Dinter became bound to this advice and, were the advice given negligently, a cause of action could exist. *See id.*, 143 Minn. at 326, 173 N.W. at 664; *see also Molloy*, 679 N.W.2d at 719 (applying negligence principles set forth in *Skillings* to conclude that "the duty arises where it is reasonably foreseeable that the parents would be injured if the advice is negligently given").

Though appellant may have conceded that there was no formal contract between Essentia and Fairview or Dr. Dinter, "[a] signed agreement is not required for a formation of a contract." *Powell v. MVE Holdings, Inc.*, 626 N.W.2d 451, 462 (Minn. App. 2001), *review denied* (Minn. July 24, 2001). An implied contract may be inferred from the course of conduct of the parties. *Gryc v. Lewis*, 410 N.W.2d 888, 891 (Minn. App. 1987); *see also Gorham v. Benson Optical*, 539 N.W.2d 798, 800 (Minn. App. 1995) ("A party may manifest acceptance of an agreement by written or spoken words, or by conduct and

actions."). In light of the "typical practice" between Essentia employees and Fairview hospitalists in making admission decisions, I believe that this consistent course of conduct between Essentia and Fairview creates a factual issue that is material to whether a contractual relationship existed.[3] *See Bergstedt, Wahlberg, Berquist Assocs., Inc. v. Rothchild*, 302 Minn. 476, 479–80, 225 N.W.2d 261, 263 (1975) ("Whether a contract is to be implied in fact is usually a question to be determined by the trier of fact as an inference of facts to be drawn from the conduct and statements of the parties." (citation omitted)). On this basis alone, I would conclude that we should reverse the district court's grant of summary judgment.

The majority also emphasizes our position as an error-correcting court and that it is not our role to expand the law. I agree that "[t]his court, as an error correcting court, is without authority to change the law." *Lake George Park, LLC v. IBM Mid-Am. Emps. Fed. Credit Union*, 576 N.W.2d 463, 466 (Minn. App. 1998), *review denied* (Minn. June 17, 1998). However, based on the supreme court's ruling in *Skillings*, a conclusion that Dr. Dinter owed Ms. Warren a duty of care would not be an extension of the current law but rather is consistent with longstanding tort principles regarding the existence of a duty of care. As the supreme court stated in *Molloy*, "[T]he risk reasonably to be perceived defines the duty to be obeyed, and risk imports relation; it is risk to another or to others within the

[3] The majority suggests that, because Fairview's hospitalists "could have" refused Essentia's calls, a contractual relationship could not have existed between Fairview and Essentia. But, what Fairview hospitalists "could have" done and what the typical practice was between Essentia and Fairview, if anything, illustrates the factual issues present regarding the extent of their relationship.

range of apprehension." 679 N.W.2d at 719–20 (quotation omitted). It is not a contract that necessarily governs the existence of physician-patient relationship and the duty of care, it is the presence of foreseeable risk. *See generally Lundgren*, 354 N.W.2d at 28 ("What a man may reasonably anticipate is important, and may be decisive, in determining whether an act is negligent." (quotation omitted)).

Minnesota courts have applied these principles in the context of other professional relationships. *See Togstad v. Vesely, Otto, Miller & Keefe*, 291 N.W.2d 686, 693 (Minn. 1980). For instance, Minnesota courts have developed different methods for determining the presence of a professional relationship in legal malpractice cases, including an express or implied contract theory and a tort theory. *See TJD Dissolution Corp. v. Savoie Supply Co., Inc.*, 460 N.W.2d 59, 62 (Minn. App. 1990). In *Togstad*, the supreme court concluded that the analyses under the tort or contract theories can be quite similar because an attorney-client relationship exists "under circumstances which made it reasonably foreseeable to [the attorney] that [the client] would be injured if the advice were negligently given." *Togstad*, 291 N.W.2d at 693. The majority attempts to distance this case from *Togstad* by stating that the meeting between Dr. Dinter and the nurse practitioner was less formal than the meeting in *Togstad*. But in determining the presence of malpractice in a professional relationship, the formality or length of a meeting is irrelevant if an attorney or physician gives negligent advice to a client or patient and it is reasonably foreseeable that the client or patient may be injured by relying on this advice. *See Veit v. Anderson*, 428 N.W.2d 429, 432 (Minn. App. 1988) ("An attorney-client relationship exists under the 'tort theory' even in the absence of an express contract '*whenever* a person seeks and receives legal advice

from a lawyer under circumstances in which a reasonable person would rely on the advice.'" (emphasis added) (quotation omitted)).

I also take issue with the majority's holding that there cannot be a physician-patient relationship because Dr. Dinter took part in an indirect consultation with another medical professional in which he discussed the possible admission of a patient. The nurse practitioner informed Dr. Dinter about Ms. Warren's possible hospitalization, disclosing private information regarding her symptoms, specific lab results, and general medical history. The fact that Dr. Dinter did not personally consult with Ms. Warren does not necessarily preclude the existence of a physician-patient relationship. *See Peterson v. St. Cloud Hosp.*, 460 N.W.2d 636, 638 (Minn. App. 1990) (stating that physician-patient relationship may be present even when pathologist has "no direct contact" with patient). This court in *Peterson* stated that "[a] consensual relationship between a physician and a patient may exist where others have contracted with the physician on the patient's behalf." *Id.* (quoting *Walters v. Rinker*, 520 N.E.2d 468, 472 (Ind. Ct. App. 1988)). Here, there is a material issue of fact as to whether an implied consensual relationship existed between Ms. Warren and Dr. Dinter based on the agreed-upon admission procedure between Essentia employees (the nurse practitioner) and the Fairview hospitalists (Dr. Dinter) to make treatment-related decisions, such as hospital admission, on the behalf of Ms. Warren.

In addition, other jurisdictions have applied these legal principles in assessing whether there is an implied physician-patient relationship. *See Irvin v. Smith*, 31 P.3d 934, 941 (Kan. 2001) ("A physician's indirect contact with a patient . . . does not preclude the finding of a physician-patient relationship. A physician-patient relationship may be found

where a physician is contacted by someone on behalf of the patient. Indeed, an implied physician-patient relationship may be found where the physician gives advice to a patient by communicating the advice through another health care professional." (internal citations omitted)); *Oja v. Kin*, 581 N.W.2d 739, 743 (Mich. Ct. App. 1998) (explaining that "merely listening to another physician's description of a patient's problem and offering a professional opinion regarding the proper course of treatment is not enough" to create a physician-patient relationship but a physician who "receives a description of a patient's condition and then essentially directs the course of that patient's treatment, has consented to a physician-patient relationship."); *Cogswell v. Chapman*, 249 A.D.2d 865, 866 (N.Y. App. Div. 1998) (stating that "a doctor-patient relationship can be established by a telephone call when such a call 'affirmatively advis[es] a prospective patient as to a course of treatment' and it is foreseeable that the patient would rely on the advice" (internal citation omitted)); *Kelley v. Middle Tenn. Emergency Physicians, P.C.*, 133 S.W.3d 587, 596 (Tenn. 2004) (holding that implied physician-patient relationship exists if physician affirmatively undertakes to diagnose and/or treat person or affirmatively participates in diagnosis and/or treatment).

While these cases may be factually distinguishable from the instant case, they are consistent regarding the applicable law in the determination of whether there is an implied physician-patient relationship. In applying these legal principles to the facts in this case, and viewing the evidence in the light most favorable to appellant, there is evidence supporting a determination that Dr. Dinter consented to the physician-patient relationship because he "receive[d] a description of [Ms. Warren's] condition" when the nurse

practitioner described her symptoms and "essentially direct[ed] the course of [her] treatment" by instructing the nurse practitioner to treat Ms. Warren's diabetes and to have her back for a follow-up visit. *See Oja*, 581 N.W.2d at 743. And, an implied physician-patient relationship was present because the nurse practitioner contacted Dr. Dinter on Ms. Warren's behalf, and through the nurse practitioner, Dr. Dinter gave Ms. Warren medical advice by stating that her diabetes was out of control but that she did not need to be hospitalized. *See Irvin*, 31 P.3d at 941.

In applying these legal principles, *Campbell v. Haber*, 274 A.D.2d 946 (N.Y. App. Div. 2000), affirmed the denial of a summary judgment brought by a cardiologist under facts very similar to those in the instant case. In *Campbell*, the plaintiff arrived at the emergency room with chest pains. *Id.* at 946. After obtaining test results that suggested that the plaintiff may be suffering from heart muscle damage, the emergency room physician contacted a cardiologist by phone. *Id.* The physician informed the cardiologist of the plaintiff's symptoms and test results, but the cardiologist opined that neither the plaintiff's symptoms nor test results were consistent with a cardiac event. *Id.* Based on his discussion with the cardiologist, the physician discharged the plaintiff. *Id.* The plaintiff sued the cardiologist and the cardiologist moved for summary judgment for lack of a physician-patient relationship. *Id.* The *Campbell* court, in affirming the trial court's denial of summary judgment, explained that "[w]hether the [cardiologist's] giving of advice furnishes a sufficient basis upon which to conclude that an implied physician-patient relationship had arisen is ordinarily a question of fact for the jury." *Id.* at 947 (quotation

omitted). The court further concluded that the evidence regarding the cardiologist's level of involvement in the plaintiff's treatment created a fact issue. *Id.*

The majority next highlights the policy argument that favors promoting informal consultations amongst physicians. I agree that our caselaw should not be construed in a manner that creates a chilling effect on physicians. But there is a difference between physicians being fearful of consulting with other medical professionals and physicians creating a hospital-admission process that effectively insulates them from potential liability. And permitting this complete insulation from liability may actually counteract the majority's goal of encouraging collaboration.[4]

While the existence of a contract or a formal consultation with a patient presents clear indicators of a physician-patient relationship, we must not overlook that a fundamental principle regarding the duty of care in a negligence case is that "risk imports relation." *See Molloy*, 679 N.W.2d at 719–20 (quotation omitted). Viewing the evidence in the light most favorable to appellant, and in accordance with classic legal principles regarding the existence of a duty in negligence cases, I would conclude that there is a material issue of fact as to whether a physician-patient relationship existed between Ms. Warren and Dr. Dinter, and whether Dr. Dinter therefore owed a duty of care to Ms. Warren. Accordingly, I would reverse the district court's grant of summary judgment and

[4] If this were the result, a system like the one developed between Essentia and Fairview, which implicitly discourages hospital admission, may ultimately lead patients to seek medical attention elsewhere, such as emergency room departments where patients must receive an appropriate medical screening and necessary stabilizing treatment. *See* Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd (2012).

remand the case for a jury determination of whether an implied physician-patient relationship existed under the facts of this case.