NO. A17-0555

State of Minnesota
In Supreme Court

Justin Warren, Trustee for the Next of Kin of Susan Warren
Appellant,

vs.

Richard Dinter, M.D. and Range Health Services d/b/a Fairview Range Medical Center
Respondents.

BRIEF OF AMICUS CURIAE MINNESOTA HOSPITAL ASSOCIATION, MINNESOTA MEDICAL ASSOCIATION, AND AMERICAN MEDICAL ASSOCIATION

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INTRODUCTION AND STATEMENT OF INTEREST[1]

The Minnesota Medical Association ("MMA") is a professional association representing approximately 11,000 physicians, residents and medical students in Minnesota. The MMA seeks to promote excellence in health care, to ensure a healthy practice environment, and to preserve the professionalism of medicine through advocacy, education, information, and leadership. For more than 150 years, the MMA and its members have worked together to safeguard the quality of medical care in Minnesota as well as the future of medical professionalism.

The Minnesota Hospital Association ("MHA") represents 144 hospitals and health systems and more than 10,000 employed and affiliated physicians. The MHA assists Minnesota hospitals and health systems in carrying out their missions to provide quality health care services to their communities; improve the quality and safety of care; promote meaningful health care coverage, access and value; and coordinate development of innovative health care delivery systems. The MHA serves its members and the State of Minnesota as a trusted leader in health care policy and as a valued source for health care information and knowledge.

The American Medical Association ("AMA") is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all U.S. physicians, residents and medical students are represented in the AMA's

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[1] Pursuant to Minn. R. Civ. App. P. 129.03, the MHA, MMA, AMA and its counsel have not received or been promised any monetary or other compensation in regards to this case, and do not have a financial stake in the outcome of the case. No one affiliated with a party has participated in writing any part of this brief.

policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty area and in every state, including Minnesota. The AMA and the MMA submit this brief on their own behalves and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

The interest of these Amici is primarily a public one. A significant number of physician members from the MHA, MMA, and AMA are asked to consult or provide insight about a patient even though they have never seen the patient or established a physician-patient relationship. The issue of provider collaboration is of significant importance to these organizations and their members. The MHA, MMA, and AMA are concerned that the position advocated by Appellant and supported by *Amicus Curiae* Minnesota Association for Justice ("MAJ") would have a chilling effect on these important discussions to the detriment of patients. Not only that, but the position advanced by these parties ignores the advancements under the law with respect to nurse practitioners and other independent providers. Minnesota law no longer requires nurse practitioners to practice under the supervision and direction of physicians. With this change in the law, independent practitioners are now tasked with making their own independent treatment decisions and exercising their own medical judgment regarding their patients. To then hold physicians not involved in providing direct patient care responsible for the independent decision-making of another provider would be at odds with both the letter and the spirit of those statutory changes.

The Court of Appeals' decision recognizes both the importance of encouraging collaboration in the practice of medicine and the independent nature of nurse practitioners. The MHA, MMA, and AMA therefore seek to provide an overview of the practical implications of Appellant's position to aid this Court in analyzing and resolving these critical issues.

DISCUSSION

A medical malpractice action requires a duty of care from the physician to the plaintiff. That duty of care is premised on a finding of a physician-patient relationship. *See Peterson v. St. Cloud Hosp.*, 460 N.W.2d 635, 638 (Minn. App. 1990). Accordingly, whether a physician-patient relationship arises in the context of an informal consultation as between a physician and another independent practitioner is not just a critical component of this case—it is of the utmost significance for the practice of medicine in this State.

Minnesota courts have recognized only a few instances where a physician owes a duty of care to a non-patient plaintiff. *See Molloy v. Meier*, 679 N.W.2d 711, 717 (Minn. 2004) (collecting cases). In each of those cases, the relationship between the physician and the non-patient plaintiff was such that the plaintiff relied upon representations directly from the physician. In *Molloy*, the physician was found to have a duty to warn the biological parents of a minor patient regarding the results of genetic testing and diagnosis. 679 N.W.2d at 719. Similarly, in *Skillings v. Allen*, 143 Minn. 323, 173 N.W. 323 (1919), the Court concluded the physician had a duty to correctly advise the parents of a child with scarlet fever about the risks of contracting the disease. *Skillings*, 143 Minn. at 326, 173 N.W. at 664. In those two limited scenarios, the plaintiff was the parent of a minor patient with a disease, and the physician had

an obligation to warn the parents about that exposure. And in both of those scenarios, the plaintiff was relying directly on the physician's advice. However, there are no cases in Minnesota purporting to find the existence of a duty of care on the part of a physician offering an informal consultation to an independent medical professional treating her own patient. And there are sound policy reasons to decline Appellant's request to broaden the scope of medical malpractice law to encompass that set of circumstances in this case.

I. Encouraging physicians and independent medical providers to consult and collaborate with one another promotes quality patient care and should not be discouraged by the threat of litigation.

In declining to recognize a physician-patient relationship in this case, the Court of Appeals appropriately considered the need to promote and encourage informal consultations among health care providers. Physicians and other care providers often turn to the collective experiences of their colleagues in providing patient care. *See* Nancy L. Keating et al., *Factors Affecting Influential Discussions Among Physicians: A Social Analysis of a Primary Care Practice*, 22 J. GEN. INTERNAL MED. 6,794-798 (June 2007) ("[M]any physicians rate colleagues as their most valued source of information."). When 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. *See* Mary Pak et al., *Education: Hospitalists Add Value to Formal and Informal Learning Processes*, THE HOSPITALIST (Jan. 2005) ("In an inpatient setting, hospitalists are uniquely qualified to play the role of educator. They analyze and interpret a wide range of medical information to treat their patients[.]"). Patients ultimately benefit from these informal discussions and brainstorming sessions among providers by receiving improved care.

These informal discussions differ greatly from the formal, consultation process, where a treating physician orders a specialist to consult for his or her patient. In turn, that specialist visits the patient, reviews the chart, participates directly in the care plan, charts his or her assessment, plan recommendations and orders, and then bills for her services. By contrast, informal discussions among providers are naturally more limited in scope—the colleague gets information from the treating physician but does not see the patient, review the chart, or provide input on the patient care plan. The colleague's role consists of indirect suggestions and involves no actual patient care.[2] Ultimately, it is up to the provider who sees the patient, orders the labs, and reviews the results to make that final decision about diagnosis and treatment. *See* Cathy M. Perley, *Physician use of the curbside consultation to address information needs: report on a collective case study*, J. MED. LIBRARY ASS'N 2, 137-44 (Apr. 2006) (comparing formal and informal consultations and noting that "a curbside consultation does not make the consulted physician responsible for the patient in question; the responsibility for the patient remains entirely with the requesting physician"). But sharing ideas and experiences may help the treating provider sharpen his or her focus to the benefit of that patient. *See id.* (discussing the reasons why physicians seek informal consultation and why physicians agree to provide informal consultation).

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[2] This collaborative process is no different than other professions. Indeed, law firm clients benefit greatly from round table discussions with other attorneys about client interactions, trial strategy, or presenting oral arguments. Architects or engineers chat with their peers about ideas or follow recommendations in literature. But ultimately it is the primary architect, lawyer or engineer who is responsible to the client for a decision. The practice of medicine should be no different.

This case involves that same, informal consultative process, which is utilized by MHA, MMA, and AMA membership daily in connection with providing high-level and informed patient care. And accepting Appellant's argument—that a provider who offers an informal suggestion or recommendation 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.[3] *See, e.g.*, *Ford v. Applegate*, B159756, 2003 WL 22000379, at *7 (Cal. App. Aug. 25, 2003) ("The consequence of imposing liability herein would be to inhibit such free discussions and consultations, and no prudent physician would provide an opinion to a colleague without a promise of indemnification.") (citing *Rainer v. Grossman*, 31 Cal. App. 3d 539, 544 (Cal. App. 1973)).

While Minnesota courts have not addressed the policy of encouraging informal consultation and collaboration among physicians, other states have. The Court of Appeals referenced a number of authorities, each of which recognized that patient care is promoted by allowing the free and informal exchange of ideas among providers without fear of liability. Of those citations, two cases deserve particular attention.

In *Reynolds v. Decatur Memorial Hospital*, the Illinois Court of Appeals rejected an invitation to find a physician-patient relationship between a patient and a physician who was consulted over the phone about the patient's condition. 277 Ill. App. 3d 80 (1996). The patient was treated by a pediatrician, who called a colleague for thoughts and

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[3] Of course, affirmance will not and should not deny a patient his or her remedy if the patient's actual provider acts negligently. The patient can pursue claims against that provider. However, we do not believe sound law or policy should extend tort liability to those who do not provide direct patient care.

recommendations on a treatment plan. *Id.* at 82. When that treatment plan proved unsuccessful, the court declined to hold the consulting physician liable for medical malpractice, recognizing that "[a] physician's duty is limited to those situations in which a direct physician-patient relationship exists," and "[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." *Id.* Importantly, from a policy perspective, the court recognized that finding a physician-patient relationship with every provider who responds to an informal inquiry "would have a chilling effect upon practice of medicine" as "[i]t would stifle communication, education, and professional association, all to the detriment of the patient." *Id.* at 86.

The Supreme Court of Kansas reached a similar result in *Irvin v. Smith*, 31 P.3d 934 (2001). The court recognized that "[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." *Irvin*, 31 P.3d at 941. In so holding, the court cited public policy: "[t]he type of telephone conversation that took place here takes place on a frequent basis in the medical profession and is vital to the treatment of patients. For courts to discourage such conversations is not to the patients' or the public's best interests." *Id.* at 943 (emphasis added). The *Irvin* Court went to great lengths to protect the ability of physicians to speak among one another and to provide perspectives and ideas without fear of liability—even in cases when the discussions are "extensive." *Id.* Indeed, "[i]mposition of liability under these circumstances would not be prophylactic but instead counter-productive by stifling efforts improved at medical knowledge." *Id.* (quotation omitted).

MHA, MMA, and AMA agree with these courts that the public policy concerns at issue in this case are significant and that obtaining input and suggestions from other providers should be encouraged. The priority of Minnesota's physicians and the membership of these Amici is to always provide the highest quality patient care. Thus, we agree that "physicians often turn to their colleagues rather than to print resources for answers" and that those inquiries should be encouraged. Perley, *supra.* And informal consultations are "an integral part of our medical culture and invaluable to the care of our patients." Victor R. Cotton, *Legal Risks of "Curbside" Consults*, 106 AM. J. CARDIOLOGY 1, 135-138 (July 2010) (abstract). Yet this important aspect of patient care is threatened by Appellant's request that this Court recognize liability for physicians providing this type of informal consult to a treating provider. 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.

II. Holding physicians who do not provide direct patient care legally responsible for the decision-making of independent medical providers is contrary to the letter and the spirit of Minnesota law.

A. Advanced Practice Registered Nurses are now independent providers under Minnesota law and are not required to have a physician authorize treatment plans or concur with diagnoses.

The position of Appellant and the MAJ also sits in direct contrast to the legislative expansion of the scope of practice for nurse practitioners in Minnesota.[4] In 2014, the legislature amended the Minnesota Nursing Practice Act to remove barriers to independent practice for advanced practice registered nurses ("APRN").[5] 2014 Minn. Laws ch. 235, §§ 1, 9. APRNs are permitted to provide "advanced assessment, diagnosing, prescribing, and ordering" as well as function "as a primary care provider, direct care provider, case manager, consultant, educator, and researcher," after 2,080 hours of collaborative practice with a nurse practitioner, clinical nurse specialist, or physician. Minn. Stat. § 148.171, subd. 13; Minn. Stat. § 148.211, subd. 1c. This statutory change removed the requirement for a collaborative management plan and written prescribing agreements between an APRN and licensed physician overseeing her care. *Cf.* Minn. Stat. § 148.171, subds. 6, 13 (2013). After the collaborative training is complete, the APRN is an independent practitioner.

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[4] Indeed, in Appellant's brief, she refers to "Nurse Simon," despite the fact that Ms. Simon is in fact a nurse practitioner. While the patient care at issue occurred before the passage of the APRN Scope of Practice Bill in 2014, these significant legislative changes are an important consideration for determining the potential liability of physicians providing informal and indirect consultations to all independent practitioners in Minnesota, including nurse practitioners.

[5] There are four categories of advanced practice registered nurses: clinical nurse specialist, certified nurse practitioner, certified nurse midwife, and certified registered nurse anesthetist. Minn. Stat. § 148.171, subd. 3.

Now, as a primary care provider, a nurse practitioner ("NP") "acts as the first point of care for comprehensive health maintenance and promotion, preventive care, and undiagnosed health concerns and who provides continuing care of varied health conditions not limited by cause, organ systems, or diagnosis." Minn. Stat. § 148.171, subd. 17a. While NPs are not permitted to practice outside their scope and experience, they are not required to have a physician or other health care professional sign off on decisions of diagnosis, treatment, or prescribing so long as the care falls within their scope of practice and population focus. *See id.*, subd. 11. And Minnesota is not alone: 18 other states allow NPs to practice independently of physicians. *See* American Association of Nurse Practitioners, *State Practice Environment*, https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment (last visited June 12, 2018).

Despite these legal advancements, the positions of both Appellant and the MAJ would continue to hold physicians and other care providers who are not directly involved in a patient's care, legally responsible for the decision-making of these independent practitioners caring for the patient. Appellant's brief makes several references to the communication between the NP and physician in this case, and each reference suggests the physician had control or authority over the NP. But under Minnesota law, that is simply not the case. Physicians lack the ability to "instruct," "advise," or "direct" a nurse practitioner;[6] and just like with physician-physician discussions, it remains the responsibility of the treating NP to

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[6] Even though the legislature had not enacted the expanded scope of practice for NPs at the time of the care at issue, the record is undisputed that Dr. Dinter was not Ms. Simon's collaborating physician, and as such, he too did not have the authority to instruct, direct, or control her treatment decisions.

diagnose and treat her patient. Thus, for the same reasons that it would be detrimental to patient care to hold providers liable for informal consultation or collaboration, public policy does not support the imposition of liability on physicians or other providers who speak with NPs about their patients absent any direct patient interaction between the physician and the patient or assumption of care on the part of the physician.

Appellant's position is also untenable in light of the expanding nature of NPs as primary care providers both in Minnesota and nationally. The need and role for NPs as primary care providers has increased as a result of the declining number of family practice physicians in this country. *See* American College of Physicians, The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care: A Report from the American College of Physicians (Jan. 30, 2006) ("The demand for primary care is increasing, while at the same time there has been a dramatic decline in the number of graduating medical students entering primary care."). This is particularly true in rural areas, where a significant number of Minnesotans turn to NPs for their primary care. *See* Minnesota Department of Health, RHAC Brief: Nurse Practitioners in Rural Minnesota—Results of an Employer Survey (Aug. 2015) ("NPs represent a significant portion of the primary care workforce in the rural clinics and hospitals surveyed. On average, NPs represented nearly one third (27-29 percent) of primary care provider staff in each rural facility."). Holding physicians or any other independent provider legally responsible for the independent clinical decisions made by NPs after an informal consultation would lead to isolation—providers would be unwilling to offer impressions or insights into patient care for fear of liability. And in areas

without easy access to primary care physicians or even other specialists, the resulting impact on patient care in many areas in this State would be devastating.

The Minnesota Legislature has determined that APRNs have the training and experience to render independent decisions about patient diagnosis and treatment. The MHA, MMA, and AMA membership believe that patient care is better served by encouraging these types of discussions as between physicians and NPs for the benefit of patient care. But holding physicians liable for the decision-making of independent practitioners is antithetical to that policy, and contrary to the language of Minnesota law. It also would negatively impact the important and necessary informal discussions that occur between those taking care of a patient and those who provide informal suggestions to the patient's care provider.

B. Physicians who offer informal suggestions to non-independent providers should not be held liable for the decision-making of that provider or her collaborating physician.

The legislature only recently amended the law with respect to APRNs—at the time of the events giving rise to this claim, APRNs still operated with a collaboration agreement. However, imposing liability on physicians who receive random questions from practitioners who cannot practice independently raises the same concerns as imposing liability for informal discussions between physicians and those who can practice independently. In Minnesota, there are still other providers authorized to practice only pursuant to a collaboration agreement with physicians, such as physician's assistants ("PA"). Thus, even though the legislature has made this change with respect to APRNs, any decision from this Court that addresses non-independent providers continues to have significant ramifications for providers in Minnesota.

Currently, PAs are permitted to practice "only with physician supervision" and only pursuant to a delegation agreement between the PA and a physician. Minn. Stat. § 147A.09, subd. 1. Such delegation agreements outline the PA's scope of practice and authorize specific patient services that may be performed by the PA. Minn. Stat. § 147A.20. Critically, "[o]rders of the physician assistants shall be considered the orders of their supervising physicians in all practice-related activities, including, but not limited to, the ordering of diagnostic, therapeutic, and other medical services." Minn. Stat. § 147A.09, subd. 2. This type of delegation agreement is similar to the collaboration agreement required by the NP in this underlying case.

The MHA, MMA, and AMA believe that holding non-collaborating physicians or other providers responsible for the decisions of non-independent providers also runs counter to public policy. First, the law does not completely assign liability for any malpractice to the collaborating/delegating physician—non-independent providers are and should be held responsible for their own, independent decision making with respect to patient care. That is true now for PAs, and it was true for NPs before the legislative change.

Second, physicians should not be responsible or held liable for the actions of these non-independent providers. Collaborating or delegating physicians enter into such agreements with non-independent providers after careful consideration, and they can craft agreements to suit the skills and comfort level of the two parties. Other physicians who are not part of this agreement should not be held responsible for directing, instructing, or otherwise overseeing the practice of these non-independent providers when they did not enter into an appropriate agreement. However, appellant's argument in this case would have that effect. And a decision from this Court imposing liability on other physicians who offer

informal impressions to a non-independent provider and never see the patient is contrary to the same public policy considerations outlined earlier in this brief. Indeed, adopting Appellant's argument would cause physicians—including specialists—to refer PAs back to his or her delegating physician instead of having a discussion about possible avenues for patient treatment and care. Patients would continue to be negatively impacted by a decision imposing liability on non-delegating physicians who offer suggestions or insight to PA or other non-independent provider.

The law should encourage collaboration, discussion and input between providers and not impose civil liability on those who make informal suggestions or offer ideas to those who are actually providing the direct patient care. This is true whether the individual providing the direct patient care is able to practice independently or not.

CONCLUSION

For the foregoing reasons, the MHA, MMA, and AMA respectfully submit that the Court should affirm the decision and analysis of the Court of Appeals on this important issue.

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CERTIFICATE OF COMPLIANCE

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