the trial. In *McGregor v. Gibson*, 248 F.3d 946 (10th Cir. 2001), the defendant's procedural due process rights were determined to have been violated because a competency hearing was not performed when the defendant did not consistently receive medication during the trial despite a history of mental illness, had an unusual demeanor, and his attorney consistently expressed concerns. Generally, successful substantive competency claims raise significant doubt that the defendant was competent during the course of legal proceedings.

Roberts also highlights the challenges that emerge when evaluations of competency to stand trial note a complex history or offer nuanced recommendations. Psychological and psychiatric evaluation reports often note important complexities in competency recommendations and identify elements that are needed to maintain competence or, conversely, that may destabilize and undermine competence.

Forensic mental health evaluators do not know how courts will use their observations and recommendations. Evaluators who comment on factors that affect the maintenance of competence may also have a responsibility to create a more detailed description of a defendant's mental state and abilities so that the court can make fully informed decisions. The psychologist in *Roberts* suggested that the court take into account "special concerns" to support Mr. Roberts' continued competency but did not offer specific recommendations for how to do so. Forensic mental health evaluators should be as clear as possible in the recommendations they offer in such situations.

Claim of Professional Negligence in Absence of Explicit Physician–Patient Relationship

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Physician–Patient Relationship Is Not a Necessary Requirement for a Claim of Professional Negligence

DOI:10.29158/JAAPL.3932L4-20

In *Warren v. Dinter*, 926 N.W.2d 370 (Minn. 2019), the Supreme Court of Minnesota held that a physician–patient relationship is not a necessary element for a professional negligence claim in all cases, and a professional duty may be created when it is reasonably foreseeable that the patient may rely on, and subsequently be harmed by, advice from the physician. Therefore, a malpractice claim cannot be dismissed as having no legal merit merely because there was no defined physician–patient relationship.

Facts of the Case

On August 8, 2014, Susan Warren presented to the Essentia Health Hibbing Clinic (Essentia), reporting recent smoke exposure and complaining of several symptoms including abdominal pain, fever, and chills. Sherry Simon, one of Essentia's nurse practitioners, examined Ms. Warren and concluded that she required inpatient hospitalization for treatment of an underlying infection. Because Essentia did not have its own inpatient hospital, it was standard practice for Essentia staff to call the only local hospital, Fairview, to present the cases for potential hospitalization.

When Ms. Simon called Fairview, she was connected to one of the hospitalists, Dr. Richard Dinter, and they discussed Ms. Warren's case by telephone for about ten minutes. Ms. Simon and Dr. Dinter dispute the specifics about their phone call. Ms. Simon stated she presented all laboratory results to Dr. Dinter, who reasoned that Ms. Warren's symptoms could be secondary to uncontrolled diabetes, and advised that Ms. Warren did not require hospitalization. In contrast, Dr. Dinter reported that Ms. Simon did not convey a complete picture of the patient and that he did not provide conclusive advice on the question of hospitalization.

After that phone call, Ms. Simon remained concerned that Ms. Warren required hospitalization and consulted with Dr. Jan Baldwin, a colleague at Essentia. Ms. Simon was specifically concerned about Ms. Warren's high white blood cell count, which she claimed Dr. Dinter had attributed to diabetes. Dr. Baldwin concurred that Ms. Warren's high cell count could be due to the diabetes. Ms. Simon then sent Ms. Warren home with diabetes medication and a follow-up appointment. After three days, Ms. Warren was found dead; on autopsy, the cause of death was identified as sepsis.

In 2018, Ms. Warren's son, Justin Warren, sued Dr. Dinter and Fairview for malpractice. (His lawsuit against Essentia and its employees was previously settled.) Dr. Dinter and Fairview moved for summary judgment, arguing that Dr. Dinter did not establish a physician–patient relationship with Ms. Warren and therefore did not owe a duty of care; in addition, the defendants argued that Dr. Dinter's acts or omissions were not the proximate cause of Ms. Warren's death. The court denied summary judgment on the question of proximate causation but granted it regarding the question of duty. The appellate court affirmed the district court, holding that there was no duty because there was no physician–patient relationship. Mr. Warren then appealed to the Minnesota Supreme Court, which reversed and remanded the decision.

Ruling and Reasoning

The facts proffered by Fairview and Dr. Dinter differ significantly from those presented by Ms. Simon; the court therefore based its judgment in viewing the evidence in the light most favorable to the non-moving party, i.e., Mr. Warren, as is required by summary judgment rules. In the ruling, Justice Lillehaug held that, under Minnesota law, an express physician–patient relationship is not necessary to maintain a malpractice action, and instead the question is whether a tort duty has been created by the foreseeability of harm. Justice Lillehaug opined that Dr. Dinter was analogous to a gatekeeper for the only local hospital, and thus it was reasonably foreseeable that a patient seeking admission would be affected by the hospitalist's decisions and harmed by any breach in standard of care. Therefore, it would be improper to make summary judgment for the hospitalist and his employer with regard to the element of duty of care.

The ruling did specifically address "curbside consults," clarifying that:

> Our decision today should not be misinterpreted as being about informal advice from one medical professional to another. This case is about a formal medical decision—whether a patient would have access to hospital care—made by a hospital employee pursuant to hospital protocol. We decide only that hospitalists, when they make such hospital admission decisions, have a duty to abide by the applicable standard of care [*Warren*, p 380].

Dissent

In his dissent, Justice Anderson argued that it was not foreseeable to Dr. Dinter that Ms. Simon, and subsequently her patient, would rely on his medical opinion for the course of treatment, and that therefore no legal duty was created. The primary medical treater in the case (Ms. Simon) deferred to a colleague (Dr. Dinter) with less comprehensive knowledge of the patient. Justice Anderson noted that, unlike all the cases cited as precedent for foreseeability of harm in the majority opinion, Dr. Dinter had neither firsthand knowledge of the patient nor full access to the medical record, and that, therefore, Dr. Dinter was not bound to know that Ms. Simon would apply his opinion to the course of treatment and "fail to make reasonable treatment decisions regarding her patient, including infection-related testing of her patient or electing to move her patient to emergency care" (*Warren*, p 382).

Furthermore, Justice Anderson noted that the availability of other viable options may have diminished Dr. Dinter's view of his advice as determinative. Dr. Baldwin had testified that sending a patient for an emergency room evaluation was always an option, which Dr. Baldwin herself had previously exercised in situations where a hospitalist had advised against a patient's admission. In that he was not the only gatekeeper to the hospital, Dr. Dinter may not have foreseen that the patient would rely on his advice.

Discussion

Although this case has yet to be retried after remand to the district court, the Minnesota Supreme Court's ruling has provoked thought and concern on the part of several local and national medical associations. This case has challenged the notion that an explicit patient relationship is required to create a duty of care; a notion that many medical professionals have long held. In doing so, the ruling has highlighted the need for clearly delineating responsibility in contemporary treatment roles, extensively documenting conversations with other providers regarding complex medical cases, and demonstrating caution when exercising a gatekeeper role.

Increasingly complex treatment modalities, combined with tiered responsibility and greater sub-specialization among medical professionals, has altered the nature of patient care. The doctor–patient dyad has transformed into a complex set of relationships among patients and their various providers. As treatment becomes apportioned among providers, clinicians may be asked to opine about patients from whom they are farther removed, including those they may never directly examine. In the absence of a bright-line standard delineating responsibility and, hence, liability, providers may

become reluctant to discuss and collaborate in settings where their role is not clearly defined.

This sentiment was reflected in the *amicus* brief from the Minnesota Hospital Association, the Minnesota Medical Association, and the American Medical Association, who noted the importance of defining provider liability. The brief states that all independent practitioners are "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 [the statute]" (Brief of *amicus curiae* Minnesota Hospital Association, Minnesota Medical Association, and American Medical Association, as *Amici Curiae* supporting respondents, p 2, available at: https://www.mnmed.org/getattachment/advocacy/protecting-the-medical-legal-environment/MMA-in-the-Courts/Warren-Dinter-Amicus.pdf.aspx?lang=en-US, accessed February 8, 2020).

This ruling addresses practical concerns for providers and institutions operating within complex care models. In situations where providers are asked to opine on a patient without personally examining the patient, providers should clarify the nature and potential impact of the advice with whomever is consulting them. This clarification should be explicitly documented to mitigate liability and to address differences in professional judgment between providers. Finally, by highlighting the potential impact of providers in a gatekeeper position, the ruling emphasizes that even greater care may be required when there is no direct physician–patient contact.

Civil Detainees' Rights to In-Custody Care

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Failure to Provide Discharge Planning Violates Civil Detainees' Rights to In-Custody Care

DOI:10.29158/JAAPL.3932L5-20

In *Charles v. Orange County*, 925 F.3d 73 (2d Cir. 2019), the plaintiffs appealed a Southern District of New York decision to dismiss all claims against the Orange County detention facility that alleged constitutional violations for failing to provide discharge planning for the plaintiffs upon release. The Second Circuit Court of Appeals ruled that the plaintiffs had stated a plausible claim for relief under the Fourteenth Amendment for deliberate indifference to their serious medical needs.

Facts of the Case

The unrelated Plaintiffs Michelet Charles and Carol Small are lawful, permanent U.S. residents who had serious mental illness. Both were arrested by the Immigration and Customs Enforcement Agency (ICE) and held as civil immigration detainees in a detention facility in Orange County, New York.

Mr. Charles, a 55-year-old man, was arrested in July 2014 and detained for about a year. He had schizoaffective disorder and a history of hallucinations, delusions, and mood instability when not taking his medications. He was seen by a psychiatrist at Orange County's Detention Facility once every three weeks. His health care insurance expired while he was in custody and could not be renewed.

On July 22, 2015, Mr. Charles was brought to New York City for an immigration court proceeding. The court ordered that Mr. Charles be released from custody. Mr. Charles was released directly from the court with only his identification. The detention center provided him with no records about his treatment while confined, no list or supply of his current medications, no list of outside referrals, nor any plan for care after release. When Mr. Charles returned to the detention facility to obtain his medications, he was told he could not be given medications after release. The ICE deportation officer did not respond to inquiries from Mr. Charles's immigration attorney. Without access to his psychotropic medication and counseling, Mr. Charles quickly decompensated, showing signs of disorganization, paranoia, and mania. On August 4, 2015, his family called 911 and he was admitted to an inpatient psychiatric unit. He was discharged after two months.

Ms. Small, a 45-year-old woman, was detained in May 2015. A month later she began experiencing