Any Advice which is Directive, Conclusive and is Likely to be Followed is Liable for Professional Negligence

A recent judgement of the Supreme Court in the state of Minnesota in the United States may have changed practice in the US. It has widened the scope under which a physician who has no patient-physician relationship might be sued for negligence.

On April 17, 2019, in **Warren v. Dinter,** the Court held that *"a physician-patient relationship is not a necessary element of a claim for professional negligence. A physician owes a duty of care to a third party when the physician acts in a professional capacity and* ***it is reasonably foreseeable that the third party will rely on the physician's acts and be harmed by a breach of the standard of care****."*

In this judgement, the Minnesota Supreme Court overturned the lower court rulings, stating in part that *"…To be sure, most medical malpractice cases involve an express physician-patient relationship. And a physician-patient relationship is a necessary element of malpractice claims in many states. But* ***we have never held that such a relationship is necessary to maintain a malpractice action under Minnesota law****…"*

The Court applied a foreseeability standard in their ruling… *"To the contrary:* ***when there is no express physician-patient relationship, we have turned to the traditional inquiry of whether a tort duty has been created by foreseeability of harm****…"*

The Facts

The patient, aged 54 years, sought medical care for abdominal pain, fever and chills, among other symptoms. She was evaluated by a nurse practitioner (NP). The test results showed very high white blood cell count, based on which the NP suspected that the patient had an infection and needed hospitalization. The NP placed a call to the local hospital to discuss admission with the admitting hospitalist. During this conversation, which lasted approximately 10 minutes and during which the admitting hospitalist was unable to view the patient's medical record, the decision was made by the hospitalist to not admit the patient. Her symptoms were attributed to her diabetes and outpatient follow-up was recommended. Three days later, the patient was found dead in her home. An autopsy concluded that the cause of death was sepsis caused by an untreated staph infection.

The patient's son brought a medical malpractice action against both the NP and the hospitalist. The trial court granted summary judgement to the defendants, and the Minnesota Court of Appeals affirmed the decision, holding there was no duty of care owed by the hospitalist because there was no physician-patient relationship. The hospitalist had only spoken to the NP by phone and had not seen the patient.

The following points were highlighted in the judgement:

- The NP did not have admitting privileges, and it was the hospitalist's sole duty to make decisions around patient admission.
- The hospitalist knew or should have known that the decision to admit or not would have been relied upon by the NP and her patient. The Court cited Skillings v. Allen (1919) and Molloy II (2004) and stated that *"Skillings and Molloy II teach us that* ***a duty arises between a physician and an identified third party when the physician provides medical advice and it is foreseeable that the third party will rely on that advice****."*
- The hospitalist knew or should have known that breach of the standard of care could result in harm. *"…It is a reasonable inference that Dinter must have known, or should have known, that a negligent decision not to admit Warren could harm her."*
- The Court referred to the hospitalist in this case as the "gatekeeper," distinguishing him from a "curbside consult" in that the hospitalist was the individual with the sole authority to make a decision around hospital admission. *"…Viewed in the light most favorable to Warren,* ***this interaction was neither a curbside consultation nor what Dinter and Fairview characterized as a 'professional courtesy'.*** *Simon did not know Dinter and, as the dissent notes, they had no pre-existing professional relationship. Unlike a curbside consultation, Simon did not contact Dinter to pick a colleague's brain about a diagnosis.*

In fact, she had already memorialized her own diagnosis in a letter to Warren's employer. Instead, Simon called Dinter pursuant to Fairview's protocol for hospital admissions. Consistent with that protocol, Fairview randomly assigned her to Dinter so that Fairview, through its gatekeeper, could make a medical decision on whether to accept and admit a new patient…"

Although this judgement was delivered by a US Court, this judgement highlights the fact that any advice which is directive, conclusive and/or confirms the decision and is likely to be followed is liable for professional negligence.

The Supreme Court of India too has held that telephonic consultations should be avoided as a routine.

In judgement in the matter of **Martin F. D'Souza vs. Mohd Ishfaq** (3541 of 2002) dated 17.02.2009 in the Supreme Court of India, the Bench of Justice Markandey Katju and GS Singhvi cited rules laid down by the Supreme Court in the Jacob Mathews case about precautions which doctor/hospitals/nursing homes should take to protect themselves from frivolous complaints of medical negligence.

They said, ***"No prescription should ordinarily be given without actual examination. The tendency to give prescription over the telephone, except in an acute emergency, should be avoided (54(b)."***

If needed, consultations on phone can be given, provided there is an established relationship between the doctor and the patient, i.e., the concerned patient is under the treatment of a doctor, and the doctor is aware of the nuances of the case. And most importantly, the doctor is fully cognizant of the attendant risks, both medical and medicolegal.

■■■■

In COVID Patients, a 50% Prevalence of Panic Disorder was Observed in a Study

In a study published in the *Asian Pacific Journal of Tropical Medicine*, it was shown that the measures taken for the containment of the COVID virus have led to the disruption of the physical and mental well-being of individuals. The study conducted by Amrita hospitals revealed a high prevalence of panic disorder with a cut-off score of eight on the Panic Disorder Severity Scale.

The study enrolled 109 COVID patients who were admitted to the hospital. Dr KP Lakshmi, Psychiatry and Behavior Medicine, stated that panic disorder was diagnosed in 54.3% of married patients, followed by 32% of unmarried and all widowed or widowed patients. She also added that the findings of the study showed that the prevalence of panic disorder was higher in patients with known physical illnesses and psychiatric illnesses. Similarly, the prevalence of panic disorder was lower in patients with recent alcohol use; however, it was increased in smokers. She explained that the decrease in panic disorder in patients with recent alcohol use was due to alcohol acting as a central nervous system depressant, while, on the other hand, she explained that tobacco is a central nervous system stimulant. Hence, the increased prevalence of panic disorders among smokers.

(*Source: https://www.daijiworld.com/news/newsDisplay?newsID=1008685*)

After COVID Infection, Patients Suffer from At Least 1 Out of 3 COVID Symptoms

A study published in the *JAMA Network* showed that 6.2% of 1.2 million people experienced at least one of the three long COVID symptoms, namely persistent fatigue with bodily pain or mood swings, cognitive problems or ongoing respiratory problems after 3 months of acute infection onset. In the meta-analysis study, 54 studies were taken for analysis, out of which 44 were published studies and 10 were collaborating cohort trials.

The study revealed that 15.1% of the patients continued to experience long COVID symptoms for more than 12 months. The study also revealed that the risk of long-term COVID was greater in female patients in comparison to their male counterparts. Similarly, the risk of long COVID symptoms was also found to be greatest in those who needed hospitalization for the initial SARS-CoV-2 infection, particularly among those needing intensive care unit care. The findings of the study revealed that one of the three self-reported long COVID symptom clusters included 3.7% for ongoing respiratory problems, 3.2% for persistent fatigue with bodily pain or mood swings and 2.2% for cognitive problems after adjusting for health status before COVID.

(*Source: https://www.daijiworld.com/news/newsDisplay?newsID=1008847*)