STATE OF MINNESOTA

IN SUPREME COURT

A17-0555

Court of Appeals

Lillehaug, J.
Dissenting, Anderson, J., Gildea, C.J.

Justin Warren,

Appellant,

vs.

Filed: April 17, 2019
Office of Appellate Courts

Richard Dinter, et al.,

Respondents.

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

William L. Davidson, Paul C. Peterson, Eric J. Steinhoff, João C. Medeiros, Lind, Jensen, Sullivan & Peterson, P.A., Minneapolis, Minnesota, for respondents.

Patrick Stoneking, J. Qortney McLeod, Jason L. DePauw, Robins Kaplan LLP, Minneapolis, Minnesota; and

Paul D. Peterson, Harper & Peterson, PLLC, Woodbury, Minnesota, for amicus curiae Minnesota Association for Justice.

Mark R. Whitmore, Christine E. Hinrichs, Bassford Remele, P.A., Minneapolis, Minnesota, for amici curiae Minnesota Hospital Association, Minnesota Medical Association, and American Medical Association.

S Y L L A B U S

1. 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.

2. Viewed in the light most favorable to the non-moving party, it was reasonably foreseeable that a patient seeking admission to a hospital would rely on a hospitalist's acts and be harmed by a breach of the standard of care, thus making summary judgment for the hospitalist and his employer on the element of duty of care improper.

Reversed and remanded.

O P I N I O N

LILLEHAUG, Justice.

In this case of first impression, we must decide whether a hospitalist's alleged decision to deny a patient admission to a hospital may constitute professional negligence. We conclude that it may.

This case arises out of an interaction between employees of two Minnesota health systems. A nurse practitioner in one system sought to have a patient admitted to the hospital of the other system. Admission was allegedly denied by a hospitalist. Three days later, the patient died.

The patient's son sued for malpractice. The district court and a divided panel of the court of appeals concluded that, as a matter of law, the hospitalist owed no duty of care to

the patient because no physician-patient relationship had been established. We reverse and remand.

FACTS

On August 8, 2014, Susan Warren, age 54, arrived at the Essentia Health clinic in Hibbing. She complained of abdominal pain, fever, chills, and other symptoms. Nurse practitioner[1] Sherry Simon ordered a series of tests to determine the nature of Warren's illness.

The test results showed that Warren had unusually high levels of white blood cells, as well as other abnormalities. These results led Simon to believe that Warren had an infection and needed to be hospitalized. Simon prepared a letter advising Warren's employer that Warren "was unable to attend work . . . due to illness and hospitalization." Simon then called Fairview Range Medical Center to seek Warren's admission to the local hospital. Simon's call was randomly assigned to Dr. Richard Dinter, who was one of three Fairview hospitalists[2] on call that day.

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[1] A nurse practitioner is one of several classes of advanced-practice registered nurses. *See* Minn. Stat. § 148.171, subds. 3, 13 (2018). "Nurse practitioner practice" includes "diagnosing [and] treating . . . acute and chronic illnesses and diseases." *Id.*, subd. 11(3) (2018).

[2] Dinter testified that a hospitalist "is a physician who provides care for patients in the setting of a hospital." The term was coined in 1996. Robert M. Wachter & Lee Goldman, *The Emerging Role of "Hospitalists" in the American Health Care System*, 335 New Eng. J. Med. 514 (1996). By 2010, 60 percent of hospitals reported that they used hospitalists. Adam C. Schaffer, et al., *Liability Impact of the Hospitalist Model of Care*, 9 J. Hosp. Med. 750, 750 (2014). "Hospitalists are central players in the inpatient or observation hospitalization decision." Soc'y of Hosp. Med., *The Hospital Observation Care Problem: Perspectives and Solutions from the Society of Hospital Medicine* 4 (2017).

Simon and Dinter were employed by different health systems. Because Essentia did not have a hospital in Hibbing, it was standard practice for Simon and other Essentia healthcare professionals to seek hospitalization of their patients at the Fairview hospital. As Simon explained, she would call the hospital, be assigned to one of the on-call hospitalists, "present the case, and [the hospitalist] would either admit or tell [Essentia staff] a different type of plan."

Simon's call to Dinter lasted approximately ten minutes. They disagree about which diagnostic information Simon shared with Dinter. Simon says that she shared both the abnormal test results and Warren's symptoms; Dinter says that Simon shared only some of the test results. Simon says that the conversation with Dinter took place after urinalysis results became available in the early afternoon; Dinter says that the conversation took place "in the late morning or noon," and that Simon did not share any urinalysis results. Simon says that she specifically requested that Warren be hospitalized; Dinter says that Simon only asked him whether Warren should be hospitalized.

Simon and Dinter disagree not only about what information Simon conveyed, but also about how Dinter responded. They agree that Dinter told Simon that the cause of Warren's abnormal test results was likely diabetes, and that Simon should get that issue under control and see Warren the following Monday. Simon says that Dinter told her that Warren did not need to be admitted to the hospital. Dinter disagrees, saying that he responded "to what end[?]" to a question as to whether Warren should be admitted. Simon says she asked whether diabetes could actually be the source of the elevated white blood-cell count, and that Dinter responded that it could. Simon says she asked this question

because it was the first time someone had told her that out-of-control diabetes could cause a high white-cell count. Dinter says Simon asked only "what about the blood sugar" and that he replied "it's probably a Type 2 diabetes."

After speaking with Dinter, Simon met with Dr. Jan Baldwin, who served as Simon's collaborating physician at Essentia.[3] Simon met with Baldwin because she still felt Warren should be hospitalized and wondered whether Baldwin might be able to help make that happen. Baldwin concurred that diabetes could be responsible for Warren's elevated white blood-cell count.

After speaking with Dinter and meeting with Baldwin, Simon met with Warren, who was still at the clinic. According to Simon, she told Warren that Simon had spoken with a hospitalist, who felt that hospital admission was not needed. Simon then discussed the diabetes diagnosis with Warren, prescribed diabetes and pain medication, scheduled a follow-up appointment, and sent her patient home. Three days later, Warren's son found her dead in her home. An autopsy concluded that the cause of death was sepsis caused by an untreated staph infection.

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[3] At the time these events took place, Baldwin and Simon worked together under a collaborative management agreement. Minnesota law then required advanced-practice registered nurses, including nurse practitioners, to "practice within a health care system that provide[d] for . . . collaborative management." Minn. Stat. § 148.171, subds. 3, 11, 13 (2012). Collaborative management was defined as an "agreed-upon plan between an advanced practice registered nurse and one or more physicians . . . that designates the scope of collaboration necessary to manage the care of patients." *Id.*, subd. 6 (2012). The Legislature subsequently removed this requirement. Act of May 13, 2014, ch. 235, §§ 9, 42, 2014 Minn. Laws 723, 726, 743. Baldwin was not Simon's supervisor, and Simon, as a nurse practitioner, had the authority, based on her training and licensing, to provide direct care. Simon did not, however, have the ability to admit patients to the Fairview hospital.

On March 7, 2016, Warren's son sued Dinter and Fairview,[4] alleging that Dinter had been professionally negligent in the care and treatment of Warren, including advising Simon that Warren did not require hospitalization. The complaint further alleged that the negligence directly caused Warren's death, and that Fairview was liable under a theory of respondeat superior.

Dinter and Fairview moved for summary judgment, arguing that Dinter owed no duty of care to Warren because Simon had called Dinter only "for his thoughts as a hospitalist" and, therefore, he had "provided his reactions . . . as a professional courtesy" to Simon. They also argued that Dinter's acts or omissions were not the proximate cause of Warren's death.

Along with their motion for summary judgment, Dinter and Fairview filed affidavits which contained the opinions of each side's medical expert. The plaintiff's expert was Dr. Benjamin Whitten, a board-certified physician in internal medicine practicing with Abbott Northwestern General Medicine Associates with expertise as a hospitalist. Whitten opined that Dinter's actions breached the standard of care for a hospitalist. He also opined that, had Warren been hospitalized for evaluation and treatment, it was highly likely that her infection would have been diagnosed and treated, and that she would have survived with no significant disability.

The defendants' expert was Dr. Meghan Walsh, a board-certified physician in internal medicine, a practicing hospitalist at Hennepin County Medical Center, and an

[4] Before beginning this action, Warren's son sued Essentia Health for the alleged malpractice of its employees, Simon and Baldwin. That case has been settled.

associate professor at the University of Minnesota Medical School. Walsh opined that Dinter's actions were consistent with the standard of care for a hospitalist and that Warren's death was not caused by any negligence on his part. She also opined that, even if Warren had been admitted to the hospital on the day Simon called Dinter, it is unlikely and doubtful that Warren would have survived her infection.

The district court granted Dinter's and Fairview's summary-judgment motion on the issue of duty, concluding that the relationship between Simon and Dinter was "in the nature of an informal conversation between medical colleagues and did not create a doctor patient relationship" between Dinter and Warren. The district court concluded that "there [was] a fact question regarding causation," and denied summary judgment on proximate cause.

Warren's son appealed, arguing that, as a matter of law, a physician-patient relationship is not necessary for Dinter to have a duty to Warren. The court of appeals, in a divided, unpublished decision, affirmed the district court, holding that there was no duty because there was no physician-patient relationship. *Warren v. Dinter*, No. A17-0555, 2018 WL 414333, at *3, 5 (Minn. App. Jan. 16, 2018). The court of appeals did not reach the issue of proximate cause. *Id.* at *5. Judge Hooten dissented, reasoning that the district court should have denied summary judgment because, viewing the evidence in the light most favorable to the non-moving party, there was a duty because the harm was foreseeable. *Id.* at *6. We granted review.

ANALYSIS

This is an appeal from an order granting summary judgment. Such an order "is appropriate when there is no genuine issue of material fact and a party is entitled to judgment as a matter of law." *Senogles v. Carlson*, 902 N.W.2d 38, 42 (Minn. 2017). We review a grant of summary judgment de novo. *Commerce Bank v. W. Bend Mut. Ins. Co.*, 870 N.W.2d 770, 773 (Minn. 2015). "In conducting this review, 'we view the evidence in the light most favorable to the nonmoving party . . . and resolve all doubts and factual inferences against the moving parties.' " *Fenrich v. Blake School*, 920 N.W.2d 195, 201 (Minn. 2018) (quoting *Rochester City Lines Co. v. City of Rochester*, 868 N.W.2d 655, 661 (Minn. 2015)). As we have emphasized repeatedly, summary judgment is " 'inappropriate when reasonable persons might draw different conclusions from the evidence presented.' " *Montemayor v. Sebright Prods., Inc.*, 898 N.W.2d 623, 628 (Minn. 2017) (quoting *Osborne v. Twin Town Bowl, Inc.*, 749 N.W.2d 367, 371 (Minn. 2008)).

This case involves a claim of professional negligence, specifically medical malpractice. *See Kohoutek v. Hafner*, 383 N.W.2d 295, 303 (Minn. 1986); *see also Molloy v. Meier* (*Molloy II*), 679 N.W.2d 711, 717 (Minn. 2004) ("A medical malpractice action is based on principles of tort liability for negligence . . . ."). Physicians are "required to possess only the skill and learning possessed by the members of [their] profession in good standing in [their] locality and to exercise that skill and learning with due care." *Manion v. Tweedy*, 100 N.W.2d 124, 129 (Minn. 1959). As in all negligence actions, "the existence of a duty running [from the defendant] to the plaintiff is a prerequisite" to a finding of

malpractice liability. *Molloy II*, 679 N.W.2d at 717. This case turns on whether Dinter owed Warren a duty of care.

Both the district court and the court of appeals held that there was no duty based on the idea that, as a matter of law, a physician-patient relationship is a necessary predicate for a doctor to owe a duty of care. The court of appeals relied on its own precedent in *Molloy v. Meier* (*Molloy I*), 660 N.W.2d 444, 450 (Minn. App. 2003), *aff'd*, 679 N.W.2d 711 (Minn. 2004), and *Peterson v. Saint Cloud Hosp.*, 460 N.W.2d 635, 638 (Minn. App. 1990). *Warren*, 2018 WL 414333, at *2. These decisions require that we examine whether such a relationship is a necessary element of a malpractice claim.

I.

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.[5] But we have never held that such a relationship is necessary to maintain a malpractice action under Minnesota law. 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. Two cases—one a century old and the other much more recent—are illustrative: *Skillings v. Allen*, 173 N.W. 663 (Minn. 1919), and *Molloy II*, decided in 2004.

[5] *See, e.g.*, *Bubb v. Brusky*, 756 N.W.2d 584, 591 (Wis. Ct. App. 2008) ("Whether a suit for malpractice will lie against a particular physician depends upon whether there is a physician-patient relationship between that physician and the plaintiff."), *rev'd on other grounds*, 768 N.W.2d 903 (Wis. 2009); *see also* 1 David W. Louisell & Harold Williams, *Medical Malpractice* § 8.03(1) n.1 (2018) (outlining other cases in which courts have so ruled).

In *Skillings*, a doctor advised the parents of a girl he was treating for scarlet fever that she was no longer contagious and that they could visit her at the hospital and then take her home. 173 N.W. at 663. The doctor's advice was wrong and the parents became ill. *Id.* The district court overruled a demurrer to the complaint, and the doctor appealed. *Id.* We affirmed, concluding that, regardless of any physician-patient relationship, the doctor owed the parents a duty because his advice "exposed them to danger if they acted on the advice, and defendant was bound to know that they would be likely to follow his advice." *Id.* at 664. All people, including professionals, we reasoned, are "responsible 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 due care in [their] own conduct [they] will cause injury to that" third party. *Id.* at 663–64.

In *Molloy II*, three physicians examined a developmentally disabled child to determine the cause of her disability. 679 N.W.2d at 713–14. The child's mother believed that the cause could be genetic, and wanted to determine the likelihood of conceiving another similarly disabled child. *Id.* at 714–15. The treating physician ordered a battery of genetic testing, including for what was subsequently discovered to be the cause of the child's developmental disability: Fragile X syndrome. *Id.* at 714. But the Fragile X test was never conducted. *Id.*

When relaying the negative results of the test battery, the treating physician did not inform the mother that the Fragile-X test had not been conducted. *Id.* Two other specialists also omitted this vital information. *Id.* at 714–15. The mother later became pregnant and

gave birth to another child who had Fragile-X syndrome. *Id.* at 715. Later tests showed the same result for the mother and her first child. *Id.*

The mother brought a professional negligence claim against the doctors and their employers. *Id.* The professionals argued that the children's parents were not patients, and thus there was no duty. *Id.* We determined that "a physician's duty . . . extends beyond the patients to biological parents who foreseeably may be harmed by a breach of that duty." *Id.* at 719. Applying "the principles of negligence law set forth in *Skillings*," we concluded that "the duty arises where it is reasonably foreseeable" that injury would follow "if the advice is negligently given." *Id.*

In both cases, we focused on foreseeability of harm to a particular third party, without regard to the existence of a physician-patient relationship. *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. *Skillings*, 173 N.W. at 664 (explaining that the doctor "was bound to know that [the parents] would be likely to follow his advice."); s*ee also Molloy II*, 679 N.W.2d at 719.

We have applied the same principle to legal professionals. In *Togstad v. Vesely, Otto, Miller & Keefe*, Joan Togstad met with an attorney to discuss a potential medical malpractice claim on behalf of her husband, John. 291 N.W.2d 686, 689–90 (Minn. 1980) (per curiam). The attorney took notes and asked questions as Togstad told her story, and then said "he did not think [she] had a legal case." *Id.* at 690. Relying on this statement, the Togstads did not pursue the claim for some time. *Id.* When Joan Togstad decided to

investigate the claim again, she learned that the statute of limitations had run. *Id.* In response to a legal malpractice claim, the attorney and his firm argued that there was no attorney-client relationship between Togstad and the attorney and, therefore, that he and the firm owed her no duty of care.

We held that there *was* a duty, based on foreseeability of harm. The duty attached, we said, when legal advice was given "under circumstances which made it reasonably foreseeable to [the attorney] that Mrs. Togstad would be injured if the advice were negligently given." *Id.* at 693.

In other words, although there was not an explicit attorney-client relationship, the attorney still owed Togstad a duty "derived from the professional relationship." *Molloy II*, 679 N.W.2d at 717. It was reasonable for Togstad and her husband to rely on the attorney's professional advice and foreseeable that both would be harmed if the advice was negligent. *Id.* at 718. We relied on *Togstad*'s reasoning in *Molloy II*, and it is applicable here, as well.

The court of appeals' decisions requiring a physician-patient relationship rest on an incorrect reading of *Skillings*. In *McElwain v. Van Beek*, the court of appeals attempted to distinguish *Skillings*, saying it was "narrow in scope and *based upon the contractual relationship* between the physician and the parents who employed him to care for their daughter . . . ." 447 N.W.2d 442, 446 (Minn. App. 1989) (emphasis added), *rev. denied* (Minn. Dec. 20, 1989). This conclusion misapprehends the holding in *Skillings*, which explicitly rejected the contractual relationship test and relied instead on foreseeable reliance and harm. 173 N.W. at 664 ("[I]t is of little practical consequence whether we call [the] duty contractual or noncontractual," because the duty arises in part because "[t]he

health of the people is an economic asset" and "[t]he law recognizes its preservation as a matter of importance to the state."). Indeed, in *Molloy II*, we rejected *McElwain*'s unduly limited view of *Skillings*. We acknowledged the "claim that recent court of appeals decisions limit the application of *Skillings*," but explained that "[a]lthough the [*Skillings*] court based its holding on the lack of a doctor-patient relationship, it may have reached the same result under a foreseeability analysis." 679 N.W.2d at 717 n.5.

Therefore, for 100 years in Minnesota, a physician has had a legal duty of care based on the foreseeability of harm. Although ours is the minority rule, it is by no means unique.[6] This rule has served Minnesota sufficiently well, and we have no compelling reason to overrule our precedent.[7]

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[6] *See Ritchie v. Krasner*, 211 P.3d 1272, 1279 (Ariz. Ct. App. 2009) ("A duty may arise even in the absence of a formal relationship."); *Plowman v. Fort Madison Cmty. Hosp.*, 896 N.W.2d 393, 401 (Iowa 2017) ("Although this contractual physician-patient relationship is sufficient to establish a duty, it is not required." (citing *J.A.H. ex rel. R.M.H. v. Wadle & Assocs., P.C.*, 589 N.W.2d 256, 260 (Iowa 1999))); *Horton v. Or. Health & Sci. Univ.*, 373 P.3d 1158, 1162 (Or. Ct. App. 2016) ("We begin with, and quickly dispose of, defendants' contention that a medical-malpractice claim must always be premised on the existence of a special status—that is, a physician-patient relationship—between the plaintiff and the defendant. We have repeatedly rejected that argument . . . ."); *Oblachinski v. Reynolds*, 706 S.E.2d 844, 846 (S.C. 2011) ("However, a doctor-patient relationship is not required in every legal action against a medical provider. Limited circumstances exist where a reasonably foreseeable third party can maintain a suit against a physician for malpractice." (citation omitted)).

[7] Under the principles of stare decisis, "[w]e are extremely reluctant to overrule our precedent," and "require[ ] a 'compelling reason' to do so." *State v. Lee*, 706 N.W.2d 491, 494 (Minn. 2005) (quoting *Oanes v. Allstate Ins. Co.*, 617 N.W.2d 401, 406 (Minn. 2000)).

II.

Against this legal backdrop, we turn next to the question of whether it was foreseeable that Dinter's decision not to admit Warren, if made negligently, would be relied on by Warren, through Simon, and cause her harm. As in *Molloy II*, 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." 679 N.W.2d at 719. "When 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.' " *Foss v. Kincade*, 766 N.W.2d 317, 322 (Minn. 2009) (quoting *Whiteford ex rel. Whiteford v. Yamaha Motor Corp., U.S.A.*, 582 N.W.2d 916, 918 (Minn. 1998)).

"Foreseeability in the context of duty is an issue that is ordinarily reviewed de novo." *Doe 169 v. Brandon*, 845 N.W.2d 174, 178 (Minn. 2014). "In close cases, the issue of foreseeability should be submitted to the jury." *Domagala v. Rolland*, 805 N.W.2d 14, 27 (Minn. 2011); *see also Fenrich*, 920 N.W.2d at 205; *Senogles*, 902 N.W.2d at 48; *Montemayor*, 898 N.W.2d at 629; *Foss*, 766 N.W.2d at 322–23; *Whiteford*, 582 N.W.2d at 918. Viewing all of the evidence in the light most favorable to Warren, as we must, we cannot conclude, as a matter of law, that it was unforeseeable to Dinter that Warren would rely on his actions and be harmed by a breach of the standard of care.

As the record shows, Simon, the nurse practitioner, was unable to admit Warren to the hospital on her own. Dinter, on the other hand, was one of Fairview's hospitalists—a physician who worked exclusively in the hospital setting and was specifically tasked with

making admission decisions. We must accept as true Simon's account that Dinter decided that Warren did not need to be admitted to the hospital. The medical experts retained by the parties appear to agree that there is a standard of care for a hospitalist in such circumstances.

Viewing the record in a light favorable to Warren, it is reasonable to conclude that Dinter knew, or should have known, that his decision whether or not to admit a prospective patient, based on his own medical judgment,[8] would be relied on by Simon and her patient. He also knew, or should have known, that a breach of the applicable standard of care could result in serious harm. Finally, there is sufficient evidence in the record—the opinion of appellant's medical expert that the applicable standard of care was, in fact, breached and caused Warren's death—to survive a summary-judgment motion. Summary judgment, therefore, should not have been granted.

Dinter and Fairview argue that the conversation between Simon and Dinter was a so-called "curbside consultation" and, therefore, cannot subject them to liability. They, amici, and the dissent all warn that making physicians liable for curbside consultations would harm patients by chilling beneficial interaction among professionals. Indeed, many states exempt third-party doctors from malpractice liability when their colleagues engage them in curbside consultations to "informally solicit one another's opinions" regarding their patients. Victor R. Cotton, *Legal Risks of "Curbside" Consults*, 106 Am. J. Cardiology 135, 135, 136 (2010); *see also, e.g.*, *Irvin v. Smith*, 31 P.3d 934, 941 (Kan.

[8] This was not a situation where admission to a hospital was denied for lack of facilities or medical staff, or for some other reason not related to a medical judgment.

2001) ("A physician who gives an 'informal opinion,' however, at the request of a treating physician, does not owe a duty to the patient because no physician-patient relationship is created.").

We have not previously addressed the legal status of curbside consultations, and we have no need to do so here. 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 preexisting 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.

According to Warren's evidence, Dinter did just that. Rather than merely offering informal observations or advice as a courtesy, Dinter exercised his power, on behalf of Fairview, to admit or not admit Warren to the only hospital in her locality. Viewing the evidence in the light most favorable to Warren, Dinter, as the gatekeeper, made the medical decision not to open the gate for Warren. Whether or not he breached the standard of care for a hospitalist when making that decision remains to be decided.

The dissent acknowledges that a physician may have a duty in the absence of a physician-patient relationship, but it tries to cabin that duty in two ways. First, the dissent asserts that Dinter could not have reasonably foreseen that, once Dinter made the medical

decision not to admit Warren, Simon would then "fail to make reasonable treatment decisions regarding her patient." Translating, the dissent is saying that, even if a doctor in the role of hospital gatekeeper breaches the standard of care and bars a patient from the only local hospital, the doctor can reasonably assume—as a matter of law, no less—that this decision will have no consequence. Why? Because other professionals will never defer to it, and will instead find a way around it.

We disagree with the dissent's position. If the dissent were correct, hospitalists would have a standard of care for hospital admissions (as the parties' experts agree they do), yet have no legal obligation to meet it. Instead, it is well-established that a physician's breach of the standard of care is not excused by another's later breach. *See, e.g.*, *Couilliard v. Charles T. Miller Hosp., Inc.*, 92 N.W.2d 96, 99 (Minn. 1958); *Benesh v. Garvais*, 20 N.W.2d 532, 533 (Minn. 1945), *overruled on other grounds*, 92 N.W.2d 96, 103 (Minn. 1958); *Goss v. Goss*, 113 N.W. 690, 692 (Minn. 1907).

Second, the dissent tries to limit a physician's duty to situations in which the physician and the patient have had direct personal contact. But our standard for a physician's duty is not based on personal contact; it is based on foreseeability of harm, which means the "risk to another or to others within the range of apprehension." *Molloy II*, 679 N.W.2d at 719 (quoting *Connolly v. Nicollet Hotel*, 95 N.W.2d 657, 664 (Minn. 1959) (quoting *Palsgraf v. Long Island R.R. Co.*, 162 N.E. 95, 100 (N.Y. 1928))). Thus, in *Molloy II*, we held that even a physician who had "never met with or spoke to [one of the plaintiffs,] Kimberly Molloy," *Molloy I*, 660 N.W.2d at 449, nonetheless owed her a duty. 679 N.W.2d at 719. Similarly, in *Togstad*, although the lawyer met with Joan Togstad, we

affirmed the award of damages for her injured husband, who never met with the attorney. 291 N.W.2d at 695. *See also Schendel v. Hennepin Cty. Med. Ctr.*, 484 N.W.2d 803, 808 (Minn. App. 1992), *rev. denied* (Minn. July 16, 1992) (determining that a physician-patient relationship existed, even if the consulting neurologists did not see the patient).

In this case, Warren, through Simon, sought entry through Fairview's gatekeeper, Dinter. Viewing the facts in the light most favorable to Warren, she was well within Dinter's "range of apprehension." Through Simon, Warren was advised of Dinter's decision. 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.

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.

Although our decision on the duty of an admitting hospitalist is a matter of first impression, in another respect this case is not in the least novel. The procedural posture before us is a grant of summary judgment on the issue of duty. In that respect, we have simply revisited other recent cases on the standard for summary judgment on the issue of duty. *See Fenrich*, 920 N.W.2d at 205–07; *Senogles*, 902 N.W.2d at 48; *Montemayor*, 898 N.W.2d at 633. Simply put: when duty depends on foreseeability, and the material facts regarding foreseeability are disputed, or there are differing reasonable inferences from undisputed facts (a "close call"), summary judgment on the element of duty should be

denied and the negligence claim, including the issue of foreseeability, should be tried. *See Fenrich*, 920 N.W.2d at 207. Whether Warren's son will be able to establish all of the elements of professional negligence, or whether Dinter and Fairview will prevail on one or more elements, is for the fact-finder to decide at trial.

CONCLUSION

For the foregoing reasons, we reverse the decision of the court of appeals and remand to the district court for further proceedings.

Reversed and remanded.

D I S S E N T

ANDERSON, Justice (dissenting).

At issue here is whether Dr. Richard Dinter owed Nurse Practitioner Sherry Simon's patient Susan Warren a duty of care. Because it was not reasonably foreseeable that Warren, who never met or talked to Dinter, would rely on Dinter's decision, reached in a single phone call between Dinter and Warren's actual treating professional, Simon, there is no legal duty here. I therefore respectfully dissent.

I.

The precise factual scenario Dinter faced was not as simple as the court makes it appear. I briefly recount these facts because our duty inquiry "depends heavily on the facts and circumstances of each case." *Doe 169 v. Brandon*, 845 N.W.2d 174, 179 (Minn. 2014).

Dinter was called by Simon, a nurse practitioner with whom he had no professional relationship. The "chief complaint" of Simon's patient, Warren, was "exposure to welding smoke over the course of three weeks while she was working at Walmart." During this phone call, Simon told Dinter in "some substance" about her patient, who had "three days of worsening of symptoms with fevers, chills, abdominal pain, cough, and shortness of breath." Simon's preliminary thoughts about the diagnosis centered around infection, because Warren had a high white blood cell count. But Warren also had high blood sugar and low sodium. Simon shared with Dinter that "it was a confusing case" because Warren "complained of the smoke inhalation, making the picture unclear."

Simon had called Walmart and poison control and told Dinter that exposure to welding smoke was "no longer part of the issue." Simon also told Dinter that, despite her

testimony that she told him about the patient's symptoms that led to the visit, Warren's exam "was essentially normal." Simon told Dinter that her patient did not have a fever and was in no apparent distress. Simon acknowledged she probably did not tell Dinter about some physical findings from her exam, such as Warren's abdominal bloating. Simon also admitted never communicating to Dinter that she was thinking of taking a chest x-ray. Dinter never received copies of the records or test results to which Simon referred. Simon's testimony reflects that Dinter did not have the ability to access these records on his own. There is also no indication that Dinter ever spoke to or examined Warren.

Simon told Dinter, "I believe she needs to be admitted." According to Simon, Dinter disagreed and said that "the patient did not need to be hospitalized." Dinter's view was that "it sounds like a diabetes that's out of control, treat the diabetes, and see her back in follow-up." Simon indicated that this conversation likely lasted under 10 minutes.

Simon then spoke with her "collaborating physician" Dr. Jan Baldwin. As Simon explained, Baldwin's status as her collaborating physician meant that "if I have any questions or concerns on a case, then I would go directly to her." Simon said she talked to Baldwin because, after speaking with Dinter, she was unclear about how to proceed and was also unclear as to what the "plan of care" for her patient should be. Simon testified, "I specifically asked her about the white count, and she said yes, that can be from the diabetes, get that under control and it will be okay; not in exact words, but that was the end of that conversation." This conversation also lasted 10 minutes or less.

When asked whether she concluded after speaking with Baldwin that hospitalization was unnecessary, Simon responded, "I guess, somehow . . . I mean she didn't get

admitted." Simon said that "after talking to Dr. Dinter and Dr. Baldwin, it was a conclusion that she had a chronic illness."

Following her discussions with Dr. Dinter and then Dr. Baldwin, Simon instructed Warren about diabetes. She was reassured that Warren did not have a fever, but told Warren if her symptoms worsened "to either call, come back, or go to the ER." She did not tell Warren that she suspected that Warren had an infection. Simon never considered prescribing an antibiotic. She said, "I had two physicians that changed my mind."

II.

We review the district court's grant of summary judgment to determine whether there are genuine issues of material fact and whether the district court erred in its application of the law. *Langston v. Wilson McShane Corp.*, 828 N.W.2d 109, 113 (Minn. 2013). We "examine the evidence in the light most favorable to the party against whom judgment was granted." *Doe 76C v. Archdiocese of Saint Paul & Minneapolis*, 817 N.W.2d 150, 163 (Minn. 2012). "To defeat a summary judgment motion, the nonmoving party must come forward with specific facts showing that there are genuine issues for trial." *Whiteford ex rel. Whiteford v. Yamaha Motor Corp., U.S.A.*, 582 N.W.2d 916, 917 (Minn. 1998).

As a general rule, a person does not owe a duty of care to a third person absent a special relationship or circumstances under which the defendant's conduct creates a foreseeable risk of injury to a foreseeable plaintiff. *See Doe 169*, 845 N.W.2d at 177–78; *see also H.B. ex rel. Clark v. Whittemore*, 552 N.W.2d 705, 708 (Minn. 1996). We are

concerned here only with the second category, whether Dinter's conduct created a foreseeable risk of injury to a foreseeable plaintiff.

Under Minnesota law, "when a person acts in some manner that creates a foreseeable risk of injury to another, the actor is charged with an affirmative duty to exercise reasonable care to prevent his conduct from harming others." *Domagala v. Rolland*, 805 N.W.2d 14, 26 (Minn. 2011). To determine foreseeability, "we look to the defendant's conduct and ask whether it was objectively reasonable to expect the specific danger causing the plaintiff's injury." *Id.* at 27. " 'The 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 range of apprehension.' " *Connolly v. Nicollet Hotel*, 95 N.W.2d 657, 664 (Minn. 1959) (quoting *Palsgraf v. Long Island R.R.*, 162 N.E. 99, 100 (N.Y. 1928)).

The court concludes that Dinter's duty and a foreseeable risk of injury to Warren can be established by reason of his one-time, limited discussion with another medical professional: Simon. Factually, the court's analysis is not complicated. Because Simon was unable to admit her patient to Fairview Range Medical Center without Dinter's affirmative decision, the court concludes that Dinter should have foreseen that his decision would be relied on by Simon and her patient, and this decision could harm Simon's patient if made carelessly.[1]

[1] The court frames the reliance comment from the standpoint of both Simon and Warren. The relevance of *Simon's* reliance on Dinter's input on the admission question is unclear. Simon has not asserted a claim against Dinter and therefore does not allege that Dinter owed her a duty. The only question here is whether it is reasonably foreseeable that *Warren*—who apparently never met or talked to Dinter—would rely on Dinter's input on the admission question.

In my view, no duty existed here. Dinter could not have reasonably foreseen based on this single conversation that Simon, who *did* owe a duty to Warren, would fail to make reasonable treatment decisions regarding her patient, including further infection-related testing of her patient or electing to move her patient to emergency care. Even viewing the evidence in the light most favorable to Warren, the record contains no evidence from which we can infer that it was reasonably foreseeable *to Dinter* that Simon's single phone call and limited disclosure of information regarding her patient would be determinative in *preventing* further care for Warren, including hospitalization, if that is what the professional who was actually treating Warren—Simon—deemed necessary for her patient. Concluding that Dinter owed a duty to Warren under these facts stretches foreseeability too far. *See Foss v. Kincade*, 766 N.W.2d 317, 322 (Minn. 2009) (declining to assess foreseeability based on "any conceivable possibility").

Baldwin's deposition testimony is consistent with the conclusion that it is objectively unreasonable to pin on Dinter the foreseeability of harm to Warren. Baldwin testified that a hospitalist disagreeing with a request for admission "doesn't happen very often," but when it does, a medical professional will select another path to hospitalization. The one time it happened to her, Baldwin "had the patient go to the emergency room at Fairview Range." She had the emergency room observe the patient until "more evidence was acquired" that would confirm the need for hospitalization. Baldwin indicated that sending a patient to the emergency department to be evaluated is always an option. Baldwin's testimony does not support the view that a medical professional such as Simon yields control over her patient to the hospitalist, should defer to the hospitalist's views on

how to treat the patient, or should conclude that hospital admission is no longer a treatment option. Yet, apparently, this is what Simon concluded.

In addition, Simon, like Baldwin, did not respond as if the hospitalist's advice was determinative. The record shows that Simon did not rely on Dinter's advice alone. Simon, uncertain about the care plan, sought advice from Baldwin, knowing that Baldwin might disagree with Dinter. Simon testified, "My understanding of the politics—or maybe politics isn't the right word—was that all admissions at that point went through the hospitalists." But Simon's "thought process" was that if she had a "second opinion and then if [Warren] needed to be admitted that possibly Dr. Baldwin could help orchestrate that through the hospitalists." So, even if Simon relied in part on Dinter to jettison her own independent duty to her patient, she did not rely on Dinter alone. In other words, Dinter's hospitalization decision was neither determinative nor the final answer. As Simon testified, "I had *two* physicians that changed my mind." (Emphasis added.)

We should take Baldwin by her example and Simon at her word. The testimony of Baldwin and Simon shows, generally, that it is not reasonably foreseeable that Warren would rely on Simon's remote, brief telephone consultation with Dinter to establish a duty owed by Dinter to Warren. On these facts, it is objectively *unreasonable* to assign a duty to Dinter as a matter of law. *See Foss*, 766 N.W.2d at 322 ("A harm which is not objectively reasonable to expect is too remote to create liability."); *see also Doe 169*, 845 N.W.2d at 179 (concluding that the link between the defendant's approval of a volunteer's credentials and the victim's injuries from sexual abuse committed by the

volunteer "is too attenuated" to "create a foreseeable risk of injury" when the defendant did not employ, control, or supervise the volunteer).

Even if we set aside the testimony of the participants, the structure of hospitalist consultations does not support a duty determination. For example, why one medical professional—the professional with the first-hand, direct knowledge of the patient's condition—would rely on the opinion of a "randomly assigned" physician to make a treatment decision is difficult to ascertain. And that reliance is even less persuasive where the "randomly assigned" physician has neither talked to nor examined that professional's patient, has not seen the patient's medical records, and the case, like here, is "confusing."

There are no disputed facts or differing *reasonable* inferences to be drawn from the facts that support the court's conclusion that a patient who has never met the hospitalist, let alone requested treatment by that hospitalist, would reasonably rely on the hospitalist's consultation with the patient's treating professional. Thus, summary judgment for Dinter should be affirmed. *Whiteford*, 582 N.W.2d at 919 (explaining, based on the undisputed facts, that "the danger . . . was too remote to impose a duty on [the defendant] and was not one which [the defendant] was required to anticipate or protect against").[2]

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[2] The court translates my dissent as stating, "even if a doctor in the role of hospital gatekeeper *breaches the standard of care* and bars a patient from the only local hospital, the doctor can reasonably assume—as a matter of law, no less—that this decision will have no consequence." (Emphasis added.) I agree that if Dinter breached the applicable standard of care for hospitalists, his negligence should have consequences. But the court neglects to specify what standard of care Dinter breached.

By "the standard of care," the court may mean the standard offered by Warren's expert, who opined that physicians must "accept and understand that they *assume responsibility* for the patient's welfare by virtue of agreeing to engage in a substantive

III.

By concluding that a duty exists in these circumstances, the court introduces confusion into the law governing tort claims based on professional relationships. The court acknowledges that although Simon worked in a healthcare system that provided for "collaborative management," *see* Minn. Stat. § 148.171, subds. 3, 6, 11, 13 (2012), Simon's collaborating physician was not her supervisor, and Simon had her own "authority, based on [her] training and licensing, to provide . . . direct care" to patients. These points are difficult to reconcile with the court's conclusion that Dinter should have foreseen that his discussion with Simon about her patient's condition—a discussion far less formal than the collaborative relationship between Simon and Baldwin—would be relied on by Simon, and derivatively, by her patient.

The fact that Dinter interacted with another medical professional, who then interacted with the party asserting that a duty was owed, is the critical distinction from the

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conversation with another caregiver." (Emphasis added.) But this is conclusory. Whether Dinter assumed responsibility for Simon's patient by speaking with Simon depends on whether Dinter owed Simon's patient a duty, which is the threshold question before us. *Doe 169*, 845 N.W.2d at 177 ("The existence of a duty of care is a threshold question because a defendant cannot breach a nonexistent duty."). The court cannot circle back to a standard of care that states Dinter "assume[d] responsibility" for Simon's patient, to conclude that Dinter owed Simon's patient a duty. To do so assumes what is in dispute.

For the reasons I discuss in my dissent, we should decline to recognize a duty here, and hold that professionals do not "assume responsibility for" the clients of other professionals merely by "agreeing to engage in a substantive conversation." *Cf. Minneapolis Emps. Ret. Fund v. Allison-Williams Co.*, 519 N.W.2d 176, 182 (Minn. 1994) ("Duty in negligence cases may be defined as an obligation, *to which the law will give recognition and effect*, to conform to a particular standard of conduct toward another." (emphasis added)).

cases cited by the court. None of our previous decisions on which the court relies imposed a duty on a professional in the absence of an actual interaction between that professional and the party that claimed the duty was owed. For example, in *Skillings v. Allen*, a doctor was "employed by" the parents of a minor child "to treat" the child. 173 N.W. 663, 663 (Minn. 1919). In the course of that treatment, the parents asked the doctor questions relevant to their risk of infection from the child's illness. *Id*. We concluded that the doctor, in responding to the parents' specific inquiry, owed the parents a duty because he "exposed them to danger if they acted on the advice, and [he] was *bound to know* that they would be likely to follow his advice." *Id.* at 664 (emphasis added).

I agree that the contractual or non-contractual nature of the relationship between the doctor and the parents in *Skillings* was irrelevant. But what was relevant, in fact critical, to our decision were the actual interactions of the parents with the doctor and the actual reliance by the parents on the doctor's advice "in visiting their child while sick at the hospital and in taking her from the hospital to her home." *Id*. at 663. Here, in contrast, Dinter never met with or spoke to Warren about a recommended course of treatment. True, he declined to admit her to the Fairview hospital based on the information Simon provided, but the actual decision to end consideration of hospitalization for Warren was made by Simon, not Dinter. Unlike the doctor in *Skillings*, Dinter had no reason to know—and certainly was not "bound to know"—that Simon, a medical professional, would conclude an alternate path towards hospitalization such as the emergency room was not needed for her patient. He had no reason to know that Simon would rely on the conversation to

abandon her own course of treatment and, for example, decline to order a chest x-ray for her patient.

Our holding in *Togstad v. Vesely, Otto, Miller & Keefe*, 291 N.W.2d 686 (Minn. 1980) (per curiam), is to the same effect. There, we noted that the plaintiff "went to [the lawyer] for legal advice, was told there wasn't a case, and relied upon this advice in failing to pursue the claim . . . ." *Id.* at 693. Here again, the presence of a contractual relationship between the client and lawyer was irrelevant. *Id.* But here again, what was relevant to our decision was that the client "sought and received legal advice from [the lawyer] under circumstances which made it reasonably foreseeable that [the client] would be injured if the advice were negligently given." *Id.*; *see also Molloy v. Meier*, 679 N.W.2d 711, 717 (Minn. 2004) (explaining that "[o]ur decision in *Togstad* derived from the professional relationship" between the client and the lawyer).[3]

In *Molloy*, we held that three doctors owed a duty to the biological parents of the doctors' patient—a child—to convey genetic information to those parents about the child's inherited disorder. 679 N.W.2d at 719. As in the two previous cases, the plaintiff in *Molloy*

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[3] Notably, in *Togstad* it was not the client's *lawyer* relying on another lawyer's advice about a potential medical malpractice action; the client's wife relied directly on the lawyer's advice, which triggered the duty for that lawyer to act with care. *See* 291 N.W.2d at 690. In both *Skillings* and *Togstad*, professionals directly advised non-professionals, and reliance was foreseeable. Here, Dinter, a medical professional, advised Simon, another medical professional, who did not treat the advice as determinative but rather conferred with Baldwin, who further advised Simon, who then advised Warren. The foreseeability of harm here, which I agree is the proper standard, differs significantly from the circumstances in *Togstad* and the other cases cited by the court. "If the connection between the danger and the defendant's own conduct is too remote, there is no duty." *Doe 169*, 845 N.W.2d at 178. If the circumstances here are not too remote to assign duty, then "remote" has little meaning.

(one of the parents) "asked [the doctor] to conduct genetic tests on [the child] to determine whether [the child] had inherited any abnormalities from [the parent]." *Id*. at 714. Following testing, the doctor informed the parent that "test results were 'normal.' " *Id*. The parent then asked one of the other doctors who evaluated the child "about [the parent's] chances of conceiving another child with [the same genetic] defect," and that doctor told the parent that the possibility was "extremely remote." *Id*. Based on these facts and others, we considered "whether a physician owes a duty to inform a child's family about the genetic implications of a child's genetic disorder." *Id*. at 717. We concluded that the doctors owed "a duty of care regarding genetic testing and diagnosis, and the resulting medical advice, not only to [the child] but also to her parents." *Id*. at 719. In reaching this conclusion, we relied on the "evidence in the record," including evidence that two of the doctors "met face-to-face with" the plaintiff and "were aware of her specific need for accurate genetic information." *Id*. at 720.[4] Our decision to find that a duty exists was "informed by the practical reality of the field of genetic testing and counseling," which, we recognized, "does not affect only the patient." *Id*. at 719. We concluded that it was foreseeable that families would rely on the diagnosis of a genetic disorder, particularly "parents who have consulted the physicians concerning the patient's condition." *Id*. We

[4] The court is correct that in *Molloy*, one doctor "did not meet face-to-face" with the plaintiff, but he was the child's treating physician. 679 N.W.2d. at 715, 720. This doctor also "conceded that a physician should share the genetic implications of positive genetic test results with the parents of a child diagnosed with an inheritable disorder." *Id.* at 715. The same cannot be said here. Dinter was not Warren's treating physician, and he has not conceded that he should give his advice to the patients of other medical professionals seeking patient admission to the hospital. Further, it is unclear whether, or how, Dinter could contact Warren; he had never met Warren and reviewed none of her medical records.

specifically declined to extend our holding beyond the minor patient's biological parents. *Id*. at 720.

Dinter's involvement in Warren's patient care looks nothing like the circumstances in these cases. Indeed, it is difficult to conclude that Dinter provided *any* patient care. He never treated the patient, never saw the patient, and never reviewed a single medical record. This is not to suggest that Dinter's admission decision was either correct or ill-informed. Rather, these undisputed facts demonstrate that there is only one reasonable inference that can be drawn: unlike the cases cited by the court, in which the plaintiff had a direct relationship with the professional, the only relationship here was between two medical professionals. True, Warren was the subject of the communications between those professionals, but Warren did not, as did the plaintiffs in *Molloy*, *Skillings*, and *Togstad*, seek out Dinter's professional opinion. In the absence of any interaction or communication between Dinter and Warren, none of these cases supports the expansive duty the court imposes here.

IV.

Skillings, *Togstad*, and *Molloy* show that reliance by persons who seek out the advice of professionals may be reasonably foreseeable even in the absence of an express contractual relationship between those persons. These cases do not, however, address reliance by professionals on the advice of other professionals, the circumstances that prevail here, and for good reason.

As the court of appeals observed, the most immediate result of the court's expansive holding is that hospitalists who wish to avoid liability must "refuse to take calls from other

professionals to discuss potential hospitalization of those professionals' patients." *Warren v. Dinter*, No. A17-0555, 2018 WL 414333, at *4 (Minn. App. Jan. 16, 2018). This new rule 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.

Today's expansion of duty also has a broader impact. The informal conversation that occurred between Simon and Dinter is not unique to the medical profession. Lawyers, accountants, architects, engineers, and other professionals often engage in similar conversations with their colleagues—brief conversations, by telephone, on complicated topics, without formal transfer of paperwork, and without follow-up, that serve as a reasonable means of evaluating professional decisions and judgment calls. Often, the subject of these conversations—the client, the patient, or the customer—is unaware of the exchange. And, just like in this case, the professional that seeks the input of colleagues will take that input into consideration in making final decisions, such as Simon did here in turning to Baldwin and in deciding to discharge Warren without further consideration of hospitalization.

But if these kinds of conversations create a duty, and thus potential liability, then no prudent professional will share insight, ideas, and recommendations with a colleague "without a promise of indemnification," *Ford v. Applegate*, No. B159756, 2003 WL 22000379, at *7 (Cal. Ct. App. Aug. 25, 2003), as amici persuasively argue. *See also Pham v. Black*, 820 S.E.2d 209, 212 (Ga. Ct. App. 2018) (concluding that no physician-patient relationship existed where the hospitalist's "sole involvement with the decedent was consulting with his treating doctors regarding whether he should be admitted . . . and

ultimately refusing to admit him."). Perversely, the best advice—advice that will be foreseeably relied on—is deterred the most. In other words, as a result of today's expansion of duty, professionals must think twice about giving advice, especially if it is advice worth following.

In the past, we have avoided imposing a legal duty where it would deter actors from taking measures that advance public health, safety, and welfare. *See, e.g.*, *Funchess v. Cecil Newman Corp.*, 632 N.W.2d 666, 675 (Minn. 2001) (declining to impose a duty on a landlord related to security measures because it "would tend to discourage landlords from instituting security measures for fear of being held liable for the actions of a criminal"); *L&H Airco, Inc. v. Rapistan Corp.*, 446 N.W.2d 372, 379 (Minn. 1989) (concluding that an attorney does not owe a duty to a client's adversary because to find that duty would undermine essential elements fundamental to the attorney-client relationship). That same principle should guide us here.

V.

Because the undisputed facts do not support a reasonable inference that Dinter's conduct posed foreseeable harm to Warren, and we have never previously held that a duty exists under similar circumstances, I respectfully dissent.

GILDEA, Chief Justice (dissenting).

I join in the dissent of Justice Anderson.