

OFF-LABEL USE AND THE MEDICAL NEGLIGENCE STANDARD UNDER MINNESOTA LAW

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I. INTRODUCTION

Medicare¹ is about to begin offering prescription drug benefits.² Providing drug benefits through the Medicare program is a noted achievement that may help ease the financial pressures faced by millions of older Americans. It is noteworthy that Medicare will include coverage for off-label use³ of some prescription drugs.⁴ Prescriptions for off-label use of drugs continue to climb,⁵ while concerns about the safety of off-label use

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1. Medicare is a social health insurance program that provides basic hospital coverage for Americans sixty-five years of age or older. Social Security Act, 42 U.S.C. § 1395(c) (2000). It also provides coverage for some people under age sixty-five with disabilities and for people with end-stage renal disease. *Id.*

2. On December 8, 2003, President George W. Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which amended Title XVIII of the Social Security Act. *See* 42 U.S.C. § 1395w-101. The prescription drug benefit program will become available to beneficiaries beginning in January 2006. 42 U.S.C. § 1395w-101(a)(2).

3. "Off-label use" refers to a use other than the FDA-approved uses. *See* Kaspar J. Stoffelmayr, Comment, *Products Liability and 'Off-Label' Uses of Prescription Drugs*, 63 U. CHI. L. REV. 275, 276-82 (1996).

4. *See* Medicare Program; Medicare Prescription Drug Benefit, 69 Fed. Reg. 46,632 (proposed Aug. 3, 2004) (describing the rules proposed by the Centers for Medicare & Medicaid Services (CMS) to implement the new Medicare Prescription Drug Benefit).

5. *See* Paul D. Rheingold & David B. Rheingold, *Offense or Defense? Managing*

are also on the rise.⁶ Concerns regarding off-label use include fears about untested prescribing practices⁷ and patients agreeing to a suggested course of treatment, at least in part, because the risks are not known—by the physician or the patient.⁸ Concerns also exist regarding the pharmaceutical companies' promotion of off-label use as a means to increase sales while side stepping the onerous FDA approval process.⁹ Such promotion encourages the prescription of drugs for uses that have not undergone rigorous study and may increase risk to patients.

Who decides whether a drug can be used off-label and under what circumstances? If a physician decides to prescribe a drug off-label, what legal issues, if any, should the physician be aware of?

the Off-Label Use Claim, 37 TRIAL 52, 52 (2001) (observing that there has been an increase in off-label claims by injured plaintiffs because off-label use of medical products is a growing practice); see also Veronica Henry, *Off-Label Prescribing Legal Implications*, 20 J. LEGAL MED. 365, 365 (1999) (“According to some estimates, almost half the United States population currently may be taking a medication prescribed for an unapproved reason.”).

6. See Alison Young & Chris Adams, “Off-label” Drugs Take Their Toll, KNIGHT RIDDER NEWSPAPERS, Nov. 2, 2003, at http://realcities.com/mld/kriwashington/news/special_packages/riskyrx/7146578.htm (last visited Jan. 21, 2005).

7. See James M. Beck & Elizabeth D. Azari, *FDA, Off-Label Use, and Informed Consent: Debunking Myths and Misconceptions*, 53 FOOD & DRUG L.J. 71, 72 (1998). In discussing the fen/phen controversy of the late 1990s, the authors noted:

[T]he popular media discovered that the commonly prescribed combination of fenfluramine and phentermine was an off-label use. Both drugs had been approved separately for labeling and marketing for short-term use in weight reduction, but they often had been prescribed together for not only short-term, but long-term weight-loss treatment. Millions of people used one or more of the drugs.

Id. at 71.

8. Young & Adams, *supra* note 6. “A six month Knight Ridder investigation has found that patients nationwide are being injured and killed as doctors routinely prescribe drugs in ways the FDA never certified as safe and effective.” *Id.*

9. Stoffelmayr, *supra* note 3, at 277. Manufacturers have a strong and obvious incentive to encourage off-label use since such uses increase overall sales. *Id.* at 279–80. The author explained:

[D]espite the FDA restrictions, manufacturers have been very successful at promoting off-label uses. Among the most common methods are funding research into off-label drug uses, sponsoring continuing education programs and symposia in which ostensibly independent researchers discuss off-label uses, distributing reprints of journal articles on off-label uses, and purchasing special journal supplements that feature articles about off-label uses.

Id. at 280; see also Rheingold & Rheingold, *supra* note 5, at 53 (arguing “[o]ff-label use is a fiscal boon to manufacturers. . . . Fen-phen is perhaps the best example of this. Sales of two drugs that had virtually no market when prescribed under their FDA approval suddenly skyrocketed when doctors began to prescribe them together and for a long period.”).

With the increased practice of prescribing drugs for off-label use, coupled with a somewhat dated and incomplete medical negligence standard in Minnesota, the intersection of the off-label use doctrine with Minnesota's medical negligence standard is ripe for review.

This article examines the off-label use doctrine and the medical negligence standard under Minnesota law. First, the article examines what the phrase "off-label use" means.¹⁰ Next, the article explores the cases that have arisen in Minnesota which address medical malpractice claims arising, at least in part, because of off-label uses.¹¹ Finally, the article concludes with the author's observations about whether off-label use should be a cause for concern.¹² In part, the author considers whether increased off-label use presents new legal issues for physicians, patients, and attorneys.¹³

II. WHAT IS OFF-LABEL USE?

In 1962, Congress amended the Food Drug and Cosmetic Act¹⁴ (the Act) to give the FDA the power to assess the safety and effectiveness of all drugs before they could be sold in the United States.¹⁵ The Drug Amendments of 1962 constitute a comprehensive regulatory scheme that addresses the manufacturing and marketing of drugs for human use.¹⁶ Under the Act, before a drug can be marketed it must receive FDA approval.¹⁷ The FDA will not grant approval unless a drug is shown to be safe and effective.¹⁸ Moreover, prior to marketing, the FDA reviews the package literature.¹⁹ The package literature, commonly

10. See *infra* Part II. This article addresses off-label use only in the context of prescription drugs. The phrase is also used in connection with medical devices, which is a use not addressed in this article.

11. See *infra* Part III.

12. See *infra* Part IV.

13. See *id.*

14. 21 U.S.C. §§ 301–99 (2000).

15. See recitation of legislative history in 21 U.S.C. § 301 (adding sections 358–60, and amending sections 321, 331, 332, 348, 351, 353, 355, 357, 372, 374, 376, and 381 (collectively referred to as the "Drug Amendments of 1962")).

16. *Id.*

17. 21 U.S.C. § 355(a) (2000). For a description of the FDA approval process for new drugs, see David A. Kessler, *The Regulation of Investigational Drugs*, 320 NEW ENG. J. MED. 281, 281–83 (1989).

18. 21 U.S.C. § 355(d).

19. See 21 C.F.R. §§ 201.56–.57, 201.100 (2004).

referred to as the “package insert,” may only refer to the approved uses for the drug.²⁰

The complex and detailed regulatory scheme used by the FDA to assess whether, and under what circumstances, a drug can be marketed creates the public perception that drugs with FDA approval are tested and safe for all circumstances in which they are used. Yet the FDA has always tried to steer clear of interfering with the practice of medicine. Thus, the FDA openly acknowledges that “the FD&C Act does not limit the manner in which a physician may use an approved drug.”²¹ The FDA does not exercise any oversight over the practice of medicine.²²

The presence of the complex and lengthy regulatory process required to bring a new drug to market, oversight by the FDA, and the FDA’s hands-off approach to the practice of medicine gives rise to a fact that is little known to the public at large. Namely, once a drug receives FDA approval, physicians may prescribe that drug for *any* purpose, including, but not limited to, the FDA approved use.²³

Prescribing a drug for a use other than the FDA approved use is commonly referred to as “off-label”²⁴ or “unlabeled”²⁵ use. Off-label use of an FDA approved product is defined as a “specific use for which that product has not been approved.”²⁶ Off-label use can take several forms, including prescribing an approved drug to treat a disease or condition that is not indicated on the manufacturer’s label, treating the indicated disease but varying the approved dosage, or prescribing the drug to a patient population other than the intended patient population.²⁷

Off-label use is extremely common, with one study suggesting that most hospital patients receive at least one drug off-label,²⁸ and

20. The package insert must contain certain information intended to ensure safe and effective use of the drug, including information relating to the following topics: description; clinical pharmacology; indications and usage; contraindications; warnings; precautions; adverse reactions; drug abuse and dependence; over-dosage; dosage and administration; how supplied; and date of most recent revision to the labeling. 21 C.F.R. § 201.56.

21. 12 FOOD & DRUG BULL. 3, 5 (1982).

22. *Id.*

23. *Id.*

24. William L. Christopher, *Off-Label Drug Prescription: Filling the Regulatory Vacuum*, 48 FOOD & DRUG L.J. 247, 248 (1993).

25. 12 FOOD & DRUG BULL., *supra* note 21, at 5.

26. *In re Kessler*, 100 F.3d 1015, 1015 n.1 (D.C. Cir. 1997).

27. Christopher, *supra* note 24, at 248.

28. Scott Esposito, *Off-Label Prescribing of Drugs Calls FDA Role Into Question*, PITTSBURGH TRIB.-REV., Nov. 25, 2000 (citing Alex Tabarrok, *Assessing the FDA via*

that the off-label use of some popular medications constitutes more than half of all sales.²⁹ For some drugs, off-label uses account for ninety percent of all prescriptions sold for the drug.³⁰ In addition to being extremely common, the practice of off-label prescribing appears to be increasing.³¹ At least one study found that off-label prescriptions nearly doubled from 1998 to 2003.³² The rise in off-label prescription drug use will most likely continue, particularly in light of the change in Medicare law.³³

Is increased off-label use a cause for concern? Not necessarily. Whether off-label use implies increased risk depends on the circumstances. As the FDA explained, “the term ‘unapproved uses’ is, to some extent, misleading. It includes a variety of situations ranging from unstudied to thoroughly investigated drug uses.”³⁴ For those situations where off-label use has been thoroughly investigated, it is accepted practice, and may even constitute malpractice if an off-label use is not offered to patients.³⁵ In addition, off-label drug use plays a significant role in advances in drug therapy and medical care.³⁶ In other cases, even if an off-label use is not dangerous, such use may not be ethically or politically appropriate.³⁷

Because an FDA-approved drug can be prescribed for any purpose, this article examines the constraints on physician off-label prescribing practices under the Minnesota malpractice doctrine; specifically, as it has evolved in cases concerning prescription drugs.

the Anomaly of Off-Label Drug Prescribing, THE INDEP. REV., Summer 2000), at <http://www.independent.org/printer.asp?page=%2Fnewsroom%2Farticle%2Easp?ID=179> (last visited Jan. 21, 2005).

29. Knight Ridder Washington Bureau, *Unapproved Drug Uses Study*, Nov. 2003 (showing off-label prescriptions for the following drugs constituted more than half of all prescriptions: Seroquel, Risperdal, Neurontin, Topamax, Biaxin XL, Trazodone HCl, Bextra, and Avelox), at <http://161.188.204.190/krdigital/drug>.

30. Chris Adams & Alison Young, *FDA Oversight of ‘Off-Label’ Drug Use Wanes*, KNIGHT RIDDER NEWSPAPERS, Nov. 4, 2003, at http://www.realcities.com/mld/krwashington/news/special_packages/riskyrx/7152542.htm.

31. *Id.*

32. *Id.*

33. See *supra* note 4 and accompanying text.

34. 12 FOOD & DRUG BULL. 4, 5 (April 1982).

35. Stoffelmayr, *supra* note 3, at 278.

36. Henry, *supra* note 5, at 383 (noting that “[t]he regulatory process has not been able to keep pace with innovation” and “[i]n many cases, off-label prescribing is the standard of care.”).

37. Christopher, *supra* note 24, at 249.

III. THE STATE OF THE LAW IN MINNESOTA

In a medical malpractice action, the plaintiff must offer expert testimony to establish the standard of care and the defendant's departure from it.³⁸ If the case concerns allegations of improper use of prescription drugs, is the fact that a physician deviated from the package insert relevant to establishing the standard of care? The answer under Minnesota law as it currently stands is "possibly."³⁹

The Minnesota Civil Jury Instruction Guides includes a proposed jury instruction for claims of negligence by medical professionals resulting from departures from drug manufacturers' instructions.⁴⁰ The proposed jury instruction sets forth the standard for negligence, stating:

A (doctor) (dentist) is negligent if:

1. The drug manufacturer gave clear and explicit recommendations (and) (or) instructions for use of the drug, and;
2. The (doctor) (dentist) did not follow these recommendations (and) (or) instructions.

The (doctor) (dentist) is negligent unless a reasonable (doctor) (dentist) would not have followed these recommendations (and) (or) instructions under the circumstances.⁴¹

Three cases form the basis for this proposed jury instruction and each case is discussed below.⁴²

In 1970, in *Mulder v. Parke Davis & Co.*, the Minnesota Supreme Court announced its rule with regard to the circumstances under which off-label use constitutes medical negligence.⁴³ The court initially described its rule as follows: "Where the dosage is prescribed by the manufacturer, testimony of the physician's failure to adhere to its recommendation is sufficient evidence to require him to explain the reason for his deviation.

38. See *Todd v. Eitel Hosp.*, 306 Minn. 254, 257, 237 N.W.2d 357, 359 (1975).

39. See *infra* Part IV.

40. See MINN. DIST. JUDGES ASS'N, MINN. PRACTICE SERIES, 4A JURY INSTRUCTION GUIDES—CIVIL, CIVJIG 80.16, (4th ed. 1999).

41. *Id.*

42. The three cases are: *Reinhardt v. Colton*, 337 N.W.2d 88 (Minn. 1983); *Lhotka v. Larson*, 307 Minn. 121, 238 N.W.2d 870 (1976); *Mulder v. Parke Davis & Co.*, 288 Minn. 332, 181 N.W.2d 882 (1970).

43. 288 Minn. 332, 181 N.W.2d 882.

This is particularly true where the manufacturer's warning puts the doctor on notice of potentially lethal effects."⁴⁴

Two months later, in response to a petition for rehearing by the Minnesota State Medical Association as amicus curiae, the court expanded its rule:

Where a drug manufacturer recommends to the medical profession (1) the conditions under which its drug should be prescribed; (2) the disorders it is designed to relieve; (3) the precautionary measures which should be observed; and (4) warns of the dangers that are inherent in its use, a doctor's deviation from such recommendations is prima facie evidence of negligence if there is competent medical testimony that his patient's injury or death resulted from the doctor's failure to adhere to the recommendations.⁴⁵

The court also made clear that when such circumstances exist "it is incumbent on the doctor to disclose his reasons for departing from the procedures recommended by the manufacturer."⁴⁶ The court acknowledged that it would "ordinarily be a jury question" whether the physician justified or excused his deviation from the manufacturer guidance.⁴⁷

The Minnesota Supreme Court next addressed the issue in 1976.⁴⁸ The court in *Lhotka v. Larson* considered whether a so-called *Mulder* instruction was warranted where the plaintiff alleged that the defendant physician "knowingly deviated from the manufacturers' instructions and recommendations on the use of drugs which were administered in this case."⁴⁹ By the slimmest of margins the court disagreed and, in the process, narrowed the *Mulder* holding.⁵⁰ The court concluded that a *Mulder* instruction was not appropriate because the evidence did not establish a clear deviation from the manufacturers' instructions,⁵¹ and the drug

44. *Id.* at 339, 181 N.W.2d at 887 (citing *Magee v. Wyeth Labs. Inc.*, 29 Cal. Rptr. 322, 328 (1963)).

45. *Id.* at 339-40, 181 N.W.2d at 887.

46. *Id.* at 340, 181 N.W.2d at 887.

47. *Id.*

48. *See Lhotka v. Larson*, 307 Minn. 121, 238 N.W.2d 870 (1976).

49. *Id.* at 125, 238 N.W.2d at 873.

50. Chief Justice Sheran wrote the majority opinion, which three other justices joined. *Id.* at 121, 238 N.W.2d at 870. Four justices, Chanak, joined by Kelly, Todd, and Scott, dissented, and one justice, Otis took no part in the consideration or decision of the case. *Id.* at 133, 238 N.W.2d at 878.

51. *Id.* at 127, 238 N.W.2d at 874 (stating "[w]e hold on these facts there was

manufacturers' recommendations were not sufficiently clear and explicit to support the requested instruction.⁵² The court also noted that "[u]nderlying *Mulder* is the self-evident premise that deviation from a manufacturer's recommendations constitutes prima facie evidence of negligence *only when* the conduct complained of deviates from standards which are clear and explicit."⁵³

As the *Lhotka* dissent makes clear, however, the majority's holding rests on a thin reed.⁵⁴ At issue in the case were the drugs given to a woman in premature labor.⁵⁵ It was undisputed that the manufacturer's insert for one of the drugs explicitly stated that "fetal immaturity constitutes a relative contraindication' for administration . . . by injection."⁵⁶ The manufacturer's insert with regard to *oral* administration (which is how the drug was administered to the plaintiff) contained no explicit contraindication.⁵⁷ The dissent noted that the chemical composition, whether administered orally or by injection, was the same and, thus, the effect of the drug was essentially the same.⁵⁸

The dissent thus took the position that the jury should have been given a *Mulder* instruction, contingent upon a prior jury finding that the manufacturer's recommendations were sufficiently clear to put a reasonably prudent physician on notice that oral administration was also contraindicated.⁵⁹ The majority, however, concluded that the manufacturer's recommendations were not clear as to *oral* administration and, therefore, a *Mulder* instruction was not appropriate.⁶⁰

In 1983, the Minnesota Supreme Court further refined the circumstances in which a so-called *Mulder* instruction might be

no basis in the manufacturers' instructions for a finding that the Doctors Larson failed to observe clear and explicit recommendations with respect to [the medications at issue].").

52. *Id.* at 125, 238 N.W.2d at 873-74.

53. *Id.* at 128 n.14, 238 N.W.2d at 875 n.14 (emphasis added).

54. *See id.* at 131-33, 238 N.W.2d at 877-78.

55. *See id.* at 123, 238 N.W.2d at 872 (noting that physician prescribed the oral administration of three grains of Seconal, a brand of sodium secobarbital used as a sedative to ease apprehension).

56. *Id.* at 131, 238 N.W.2d at 877 (quoting from the plaintiffs' Exhibit K).

57. *Id.*

58. *Id.* at 132, 238 N.W.2d at 877. The only difference in terms of effects was that "the drug would metabolize more slowly when administered orally." *Id.*

59. *Id.*

60. *Id.* at 126, 238 N.W.2d at 874.

warranted in the medical malpractice case *Reinhardt v. Colton*.⁶¹ In *Reinhardt*, the court considered whether the trial court properly directed a verdict for the defendants in connection with the plaintiff's claim of negligent treatment.⁶² In considering that issue, the Minnesota Supreme Court addressed two issues concerning *Mulder*.

First, the court observed that a *Mulder* instruction is appropriate only "if there is competent medical testimony that [the] patient's injury or death resulted from the doctor's failure to adhere to the recommendations."⁶³ Thus, in *Reinhardt*, although the plaintiff introduced evidence that the physician did not conduct a direct platelet count as recommended in the package insert, but rather only estimated blood platelets, the plaintiff failed to introduce evidence that the physician's failure to take a direct platelet count was the direct cause of the plaintiff's injuries.⁶⁴

Second, the court in *Reinhardt* questioned, but did not resolve, the issue of whether the type of off-label use was relevant to the analysis of whether a *Mulder* instruction is appropriate.⁶⁵ The *Reinhardt* court observed that in *Mulder* it

described the type of "package insert" which can serve as a standard of care in this context as one which recommends: "(1) the conditions under which its drug should be prescribed; (2) the disorders it is designed to relieve; (3) the precautionary measures which should be observed; and [which] (4) warns of the dangers which are inherent in its use."⁶⁶

The court then noted that unlike the off-label use in *Mulder*,

61. 337 N.W.2d 88 (Minn. 1983).

62. *Id.* at 92-93.

63. *Id.* at 95 (quoting *Mulder v. Parke Davis & Co.*, 288 Minn. 332, 340, 181 N.W.2d 882, 877 (1970)).

64. *Id.*

65. *Id.* at 95 n.4. The court explained:

The Food and Drug Administration did not approve the use of [the drug at issue] for rheumatoid arthritis until late 1978, and the package inserts admitted as evidence at trial and applicable to the treatment period (February 1977 to August 1977) do not list rheumatoid arthritis as an approved indication. An issue therefore arises regarding whether the package inserts introduced at trial can serve as a standard of care under the criteria established in *Mulder*. However, . . . we need not address this issue.

Id.

66. *Id.* (quoting *Mulder*, 288 Minn. at 339, 181 N.W.2d at 877).

the off-label use at issue in *Reinhardt* was not a change in the recommended dosage.⁶⁷ Instead, the physician defendant in *Reinhardt* had prescribed a drug to treat an indication for which the drug was not approved.⁶⁸ As a result, the package inserts that were used as evidence at trial made no mention of the plaintiff's ailment (the second factor identified in *Mulder*), thus raising the question of whether the package inserts were relevant.⁶⁹ The court acknowledged that its holding on the evidentiary issue concerning causation eliminated the need to substantively address this second issue and so did not affirmatively resolve it.⁷⁰ The *Reinhardt* decision certainly leaves open the question of whether off-label use to treat a different ailment even comes under the scope of *Mulder*.⁷¹

IV. CONCLUSION

In light of the dramatic increase in off-label use, where are physicians and patients left with respect to off-label use? Despite the fact that Minnesota case law addressing issues of medical negligence in the context of off-label use is somewhat well-entrenched,⁷² should physicians be concerned about a possible increase in exposure for off-label use? Should patients be worried? The answer to both physician and patient fears is "probably not."

Under Minnesota law as it currently stands, a physician is held to the standard of care outlined in the manufacturer's insert only when the packaging insert is explicit, the physician clearly deviated from the manufacturer's recommendations or instructions, and the physician's deviation caused harm to the patient.⁷³ It is an open question whether *Mulder* is applicable only in dosage cases or whether it would also apply in cases involving prescriptions for indications not addressed in the manufacturer's insert, which is a common form of off-label use, or for use in patient populations other than those recommended by the manufacturer. The suggestion in *Reinhardt* is that a *Mulder* instruction could be

67. Compare *Reinhardt*, 337 N.W.2d at 95 n.4, with *Mulder*, 288 Minn. at 335, 181 N.W.2d at 885.

68. *Reinhardt*, 337 N.W.2d at 95 n.4.

69. *Id.*

70. *Id.*

71. *Id.*

72. The three cases controlling medical negligence in Minnesota in the context of off-label prescription drug use were decided in 1983, 1976, and 1970.

73. *Reinhardt*, 337 N.W.2d at 95.

inappropriate in cases involving off-label use for a different indication.⁷⁴

As a result, the pronouncement in *Mulder*, which has been rejected by some courts,⁷⁵ has been tempered by the subsequent decisions into a rule that holds physicians to a reasonable standard.⁷⁶ The remaining legal questions are (1) whether *Mulder* applies to situations where a physician prescribes a drug to a patient outside of the manufacturer-defined patient populations, and (2) whether *Mulder* applies to situations where a physician prescribes a drug to treat a condition not referenced in the package insert.

The Minnesota Supreme Court has yet to decide a case that directly answers these questions. Until the Minnesota Supreme Court hears a case directly on point, it is unclear where the law stands. By voicing concerns about the evidentiary value of the package insert, the *Reinhardt* court hinted that it might resolve the question about off-label use for treatment of an indication not mentioned on the package insert by concluding that the insert does not establish a standard of care in this type of case. The court has provided no similar suggestion for off-label use in populations other than the manufacturer-defined patient group. Attorneys are likely to make arguments for and against extending *Mulder* in both types of off-label use cases.

It is unclear whether Minnesota will encounter a significant legal change as a result of increased off-label use. Nevertheless, until the Minnesota Supreme Court addresses the law, or the state legislature initiates a change, the areas of uncharted waters for physicians are instances of off-label use for treatment of an indication other than those listed on the package insert, and

74. *Id.* at 95 n.4.

75. See *Ramon v. Farr*, 770 P.2d 131, 135 (Utah 1989). The *Ramon* court noted that there is a split among authorities. *Id.* at 134 (stating “[w]e recognize that the courts appear to be split on whether the recommendations contained in a package insert are prima facie evidence of the standard of care.”). The *Ramon* court expressly declined to follow *Mulder*, observing that only “a few other states” have followed *Mulder*, and the Minnesota courts “have since retreated somewhat from the *Mulder* standard.” *Id.* (citing *Lhotka v. Larson*, 307 Minn. 121, 131–32, 238 N.W.2d 870, 877 (1976)). The *Ramon* court adopted a rule that a manufacturer’s recommendations are “some evidence that the finder of fact may consider along with expert testimony on the standard of care.” *Id.* at 135 (citing *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 180 (Cal. Ct. App. 1957)).

76. *Reinhardt*, 337 N.W.2d at 95.

prescriptions given to patients outside the manufacturer-defined patient populations. Today, Minnesota medical negligence law, although well-established, remains incomplete.

Should patients be concerned about the rise in the use of off-label prescriptions coupled with a *Mulder* holding that has been softened over the years? No. Physicians' actions are, and will likely continue to be, judged against a reasonable standard of care that serves to constrain physicians from straying beyond the bounds of reasonableness. In addition, patients have and continue to use tools at their disposal (both malpractice actions and complaints to the Board of Medical Practice⁷⁷) to constrain prescribing practices. Patients also have the right to know the risks involved in recommended courses of treatment⁷⁸ and should exercise that right by asking questions about the medications they are being given.

77. See *Kollmorgen v. State Bd. of Med. Exam'rs*, 416 N.W.2d 485 (Minn. Ct. App. 1988) (upholding a disciplinary order of the State Board of Medical Examiners resulting from an over-prescription of medication that deviated from the manufacturer's recommendation).

78. See MINN. STAT. § 144.651, subd. 9 (2004) (Patient's Bill of Rights). "Patients and residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose." *Id.*