

1996

# Torts: Defining the Duty Imposed on Physicians by the Doctrine of Informed Consent

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## Recommended Citation

Leier, Ranelle A. (1996) "Torts: Defining the Duty Imposed on Physicians by the Doctrine of Informed Consent," *William Mitchell Law Review*: Vol. 22: Iss. 1, Article 14.

Available at: <http://open.mitchellhamline.edu/wmlr/vol22/iss1/14>

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## TORTS: DEFINING THE DUTY IMPOSED ON PHYSICIANS BY THE DOCTRINE OF INFORMED CONSENT

*K.A.C. v. Benson*, 527 N.W. 2d 553 (Minn. 1995).

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### I. INTRODUCTION

In *K.A.C. v. Benson*,<sup>1</sup> the Minnesota Supreme Court addressed whether a physician was negligent in failing to disclose his HIV<sup>2</sup> seropositive status to patients.<sup>3</sup> The court reinstated the trial court's grant of summary judgment for the physician, Dr. Philip Benson, holding that the patient's claim could not go forward because the undisclosed risk of HIV exposure did not materialize in harm.<sup>4</sup>

The doctrine of informed consent centers upon the principle of self-determination, not paternalism.<sup>5</sup> This Case Note discusses how the *K.A.C.* court misapplied the law of informed consent and failed to

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1. 527 N.W.2d 553 (Minn. 1995).

2. *K.A.C. v. Benson*, 527 N.W.2d 553 (Minn. 1995). HIV is a retrovirus which attacks the human immune system. A person becomes HIV infected when the virus enters the blood stream and replicates itself. The HIV virus weakens the human immune system. An HIV-infected individual may not develop any symptoms of infection for years, or even decades. When these symptoms do begin to appear, the individual suffers from AIDS-related complex, or ARC. The condition turns into AIDS when the immune system becomes even weaker and infections normally fought off by the immune system appear. AIDS is fatal and presently no cure exists. Jay A. Levy, *Human Immunodeficiency Viruses and the Pathogenesis of AIDS*, 261 JAMA 2997 (1989).

3. *K.A.C.*, 527 N.W.2d at 561-62.

4. *Id.*

5. In *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914), Justice Cardozo wrote the oft-quoted phrase, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . ." See also *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960), *modified*, 354 P.2d 670 (Kan. 1960) ("[E]ach man is considered to be master of his own body and he may, if he be of sound mind, expressly prohibit the performance . . . of medical treatment.").

consider the patient's rights.<sup>6</sup> The K.A.C. decision undermines the purpose of the informed consent doctrine, which is to promote patients' decisional authority over their medical treatment.<sup>7</sup>

## II. HISTORY

### A. *Historical Development of Informed Consent*

Consent to medical treatment, and the contemporary informed consent doctrine that evolved from it, protects the patient's right of freedom from unwanted bodily invasions, whether beneficial or not.<sup>8</sup> The requirement of consent to medical treatment traces back to English common law in 1767.<sup>9</sup> Since its origination, the need for consent has been based on a person's right to determine what shall be done with his or her body.<sup>10</sup>

In *Mohr v. Williams*, the landmark case in the United States, a physician failed to obtain a patient's consent to treatment.<sup>11</sup> The patient consented to having an operation on her right ear.<sup>12</sup> However, after surgery began, the physician realized that the patient's left ear posed a greater health threat and operated on that ear instead. Even though the physician was not negligent and the operation was a success, the court held the physician liable for battery. Other jurisdictions soon followed this approach, relying on the theory of battery<sup>13</sup>

6. The scope of this Case Note does not cover whether actual exposure to the HIV virus is necessary before a compensable injury exists. For this analysis, see James C. Maroulis, *Can HIV-Negative Plaintiffs Recover Emotional Distress Damage for Their Fear of Aids?*, 62 FORDHAM L. REV. 225 (1993).

7. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1973); Jay Katz, *Informed Consent — A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137 (1977).

8. Alan Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51 (1977).

9. See *Slater v. Baker*, 95 Eng. Rep. 860 (K.B. 1767) (holding surgeon liable for damages for not obtaining the consent of his patient before operating). The court stated, "indeed it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation." *Id.* at 862. *Contra* Gerald Robertson, *Informed Consent to Medical Treatment*, 97 LAW Q. REV. 102 (1981). "The view expressed by some American commentators that the doctrine of informed consent can be traced back to the English decision in *Slater v. Baker* is at best illusory." *Id.* at 103 n.6.

10. See *Pratt v. Davis*, 79 N.E. 562 (Ill. App. Ct. 1906); *Mohr v. Williams*, 95 Minn. 261, 268-69, 104 N.W. 12, 14-15 (1905); *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (N.Y. 1914); *Rolater v. Strain*, 137 P. 96 (Okla. 1913).

11. *Mohr*, 95 Minn. at 261, 104 N.W. at 12.

12. *Id.* at 265, 104 N.W. at 13.

13. The battery doctrine treats the consent, if flawed, as completely invalid. A patient's consent was thus vitiated when the physician failed to disclose a known risk. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS, § 18, at 112-24

and focusing on patients' rights.<sup>14</sup>

Although prior cases dealt with the concept of consent to medical treatment,<sup>15</sup> the informed consent doctrine itself was first formulated in 1957.<sup>16</sup> It placed a duty on physicians to disclose information to their patients concerning the inherent risks of proposed treatment, requiring "full disclosure of facts necessary to an informed consent."<sup>17</sup> Later cases helped to define the doctrine and established disclosure parameters.<sup>18</sup> For instance, exceptions to the disclosure requirement developed,<sup>19</sup> allowing information material<sup>20</sup> to a patient's decision to

(5th ed. 1984).

14. See *Theodore v. Ellis*, 75 So. 655, 660 (La. 1917) (holding doctor liable for failing to inform patient of the full extent of the operation and possible alternatives); *Wojciechowski v. Coryell*, 217 S.W. 638, 644 (Mo. Ct. App. 1920) (admitting testimony to show that physician did not inform patient or his family of the seriousness of his condition); *Hunter v. Burroughs*, 96 S.E. 360, 366-68 (Va. 1918) (ruling that doctor has a duty "in the exercise of ordinary care to warn a patient of the danger of possible bad consequences of using a remedy").

15. "The evolution of the obligation to communicate for the patient's benefit as well as the physician's protection has hardly involved an extraordinary restructuring of the law." *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972).

16. *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170 (Cal. Ct. App. 1957). The court advanced the following principle: "[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment." *Id.* at 180.

17. *Id.*

18. See *Natanson v. Kline*, 354 P.2d 670 (Kan. 1960) (reaffirming the duty of the physician to make a reasonable disclosure of risks, but using a negligence analysis); *Mitchell v. Robinson*, 334 S.W.2d 11, 19 (Mo. 1960), *aff'd*, 360 S.W.2d 673 (1962) (holding doctor owed patient duty to inform the patient generally of the possible serious collateral hazards of the proposed treatment).

19. Disclosure is unnecessary in an emergency, when the patient is an incompetent, or when disclosure would be harmful to the patient's psychological well-being. See *Harnish v. Children's Hosp. Medical Ctr.*, 439 N.E.2d 240, 244 (Mass. 1982); *Keogan v. Holy Family Hosp.*, 622 P.2d 1246, 1253-54 (Wash. 1980) (en banc); *Canterbury*, 464 F.2d at 789; Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 439-53 (1979).

20. Larry Gostin, *Hospitals, Health Care Professionals, and AIDS: "The Right to Know" the Health Status of Professionals and Patients*, 48 MD. L. REV. 12, 40 (1989). Material information is defined as "information which [a] physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject a recommended medical procedure." *Arato v. Avedon*, 858 P.2d 598, 607 (Cal. 1993). The scope of the required disclosure includes the risks associated with the proposed treatment, any alternatives to that treatment, and the risks associated with foregoing any treatment. *Cornfeldt v. Tongen*, 262 N.W.2d 684, 702 (Minn. 1977). Compare *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Ct. App. 1965), *aff'd*, 412 S.W.2d 299 (Tex. 1967) (requiring disclosure of one percent chance of hearing loss) with *Yeates v. Harms*, 393 P.2d 982 (Kan. 1964), *reh'g*, 401 P.2d 659 (1965) (holding no duty to disclose 1.5% chance of eye loss).

be withheld only for the patient's therapeutic benefit. In addition, negligence replaced battery as the basis for liability.<sup>21</sup>

Jurisdictions are split concerning the legal standard of physicians' duty of disclosure to patients in the informed consent doctrine.<sup>22</sup> A slight majority follows the traditional professional practice standard, which requires disclosure of information that the medical community customarily discloses to patients.<sup>23</sup> A growing number of states, however, apply a patient-based standard<sup>24</sup> that focuses on what a reasonable person in the patient's position would want to know.<sup>25</sup>

Because the informed consent doctrine determines liability under the theory of negligence,<sup>26</sup> the plaintiff must establish a causal connection between the patient's injury and the physician's breach of the duty to disclose.<sup>27</sup> Patients need not only prove that they were harmed as a result of the medical treatment, but also that had they been informed of all the relevant information they would not have consented to the procedure.<sup>28</sup> Most courts apply an objective standard to determine causation, i.e., what a reasonable person in the patient's position would have done.<sup>29</sup> Nevertheless, some jurisdictions adhere

21. Traditional battery law has a very limited disclosure obligation. Katz, *supra* note 6, at 144. An action for battery is appropriate when the treatment consists of a touching that is of a substantially different nature and character from that to which the patient consented. An action for negligent nondisclosure will lie when the patient understands the nature and character of the touching, but is not properly informed of a risk involved. *Kohoutek v. Hafner*, 383 N.W.2d 295, 299-300 (Minn. 1986).

22. Judith F. Darr, *Informed Consent: Defining Limits Through Therapeutic Parameters*, 16 WHITTIER L. REV. 187, 188 n.5 (1995).

23. *E.g.*, *Riedisser v. Nelson*, 534 P.2d 1052, 1054 (Ariz. 1975); *Stauffer v. Karabin*, 492 P.2d 862 (Colo. 1971).

24. *E.g.*, *Canterbury v. Spence*, 464 F.2d 772, 786-87 (D.C. Cir. 1972); *Berkey v. Anderson*, 82 Cal. Rptr. 67 (Cal. Ct. App. 1969) (adopting patient based standard). "To hold otherwise would permit the medical profession to determine its own responsibilities to the patients in a matter of considerable public interest." *Id.* at 78.

25. *E.g.*, *Cobb v. Grant*, 502 P.2d 1, 11 (Cal. 1972).

26. To establish negligence for failing to obtain informed consent, the plaintiff must prove: (1) the existence of a material risk unknown to the patient; (2) a failure to disclose that risk on the part of the physician; (3) disclosure of the risk would have led a reasonable patient to reject the proposed treatment; and (4) injury resulting from the undisclosed risk. *Cornfeldt v. Tongen*, 295 N.W.2d 638, 640 (Minn. 1980) [hereinafter *Cornfeldt II*]; *Kinikin v. Heupel*, 305 N.W.2d 589, 595 (Minn. 1981).

27. *See Canterbury*, 464 F.2d at 790. "A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it." *Id.* (footnotes omitted).

28. Sharon Nan Perley, *From Control Over One's Body to Control Over One's Body Parts: Extending the Doctrine of Informed Consent*, 67 N.Y.U. L. REV. 335, 341-42 (1992).

29. *See, e.g.*, *Macey v. James*, 427 A.2d 803, 804 (Vt. 1981); *Woolley v. Henderson*, 418 A.2d 1123, 1132 (Me. 1980); *Canterbury*, 464 F.2d at 791. The objective standard requires a patient to show that a reasonable person in the patient's position would have

to a subjective standard, which focuses on the particular patient.<sup>30</sup>

Recent court decisions involving disclosures from and *about* physicians may signal a new era in informed consent—extending the doctrine beyond its traditional boundaries.<sup>31</sup> These decisions concern the scope of informed consent and whether disclosure of physician-associated risks fall within it.<sup>32</sup> To date, several reported cases deal with a health-care provider's duty to disclose HIV seropositive status.<sup>33</sup> Additional cases focus on a physician's duty to disclose other personal characteristics, such as success rates and alcohol use.<sup>34</sup>

Different jurisdictions considering very similar claims have reached different conclusions.<sup>35</sup> Some courts hold that the informed consent doctrine encompasses disclosure of information regarding the treating physician.<sup>36</sup> Others refuse to allow claims for negligent nondisclosure of provider-associated risks, limiting the informed consent doctrine

withheld consent if the material risks would have been disclosed. *Id.*

30. *E.g.*, *Shetter v. Rochelle*, 409 P.2d 74, 83 (Ariz. Ct. App. 1965), *modified*, 411 P.2d 45 (1965); *Scott v. Bradford*, 606 P.2d 554, 559 (Okla. 1979); *Wilkinson v. Vesey*, 295 A.2d 676, 690 (R.I. 1972). *But see* Jon R. Waltz and Thomas W. Scheunernan, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 647 (1970).

31. *See Daar*, *supra* note 22, at 188.

32. *E.g.*, *Faya v. Almaraz*, 620 A.2d 327 (Md. 1993) (explaining the duty of an HIV-positive physician to disclose his status to his patients).

33. *See Scoles v. Mercy Health Corp.*, 887 F. Supp. 765 (E.D. Pa. 1994) (concluding HIV-positive surgeon posed a "direct threat" to the health of his patients); *Faya*, 620 A.2d at 333 (stating that it could not find "as a matter of law," that physician owed no duty to patients to warn them of his HIV-positive status); *Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991) (finding that under the circumstances, physician had a duty to inform his patients of risk of HIV transmission); *Brzoska v. Olsen*, 1994 WL 233866, at \*1 (Del. Super. Ct. May 2, 1994) (holding patients could not recover for "fear of AIDS" unless able to show actual exposure to HIV).

34. *See, e.g.*, *Gaston v. Hunter*, 588 P.2d 326 (Ariz. Ct. App. 1978) (finding duty to disclose novel or investigational nature of a procedure); *Hidding v. Williams*, 578 So.2d 1192 (La. Ct. App. 1991) (concerning physician's duty to disclose alcoholism); *Nisenholtz v. Mount Sinai Hosp.*, 483 N.Y.S.2d 568 (N.Y. Sup. Ct. 1984) (holding duty to provide reasonable explanation of available alternatives and potential dangers of medical procedure). *But see Kaskie v. Wright*, 589 A.2d 213 (Pa. Super. Ct. 1991) (holding no duty to disclose physician's alcoholism).

35. *Compare Kaskie*, 589 A.2d at 217 (holding physician not required to disclose matters "not specifically germane to surgical or operative treatment," including physician's alcoholism) *with Hidding*, 578 So.2d at 1198 (holding physician had duty to disclose alcoholism to surgical patient).

36. *E.g.*, *Behringer*, 592 A.2d at 1281. In *Behringer*, the court determined that the surgeon's HIV status constituted a material risk under the informed consent standard. *Id.* at 1279-80. The court then rejected the plaintiff's contention that the informed consent doctrine did not require the surgeon to reveal his physical condition as a risk of the surgery itself. Provider-associated risks were deemed disclosable based on a prior New Jersey case in which "the court spoke of not only an evaluation of the nature of the treatment, but of 'any attendant substantial risks'". *Id.* at 1281.

only to information regarding the proposed procedure.<sup>37</sup>

### B. *Informed Consent in Minnesota*

The Minnesota Supreme Court was the first to rule that a physician performing an operation without his patient's consent was liable in tort for battery.<sup>38</sup> To reach its decision, the supreme court emphasized the right of the patient to "be the final arbiter as to whether he will take his chances with the operation, or take his chances of living without it."<sup>39</sup> Later cases, still following the theory of battery, expanded the duty to include informing patients of possible alternatives and allowing patients to choose the course of action.<sup>40</sup>

The Minnesota Supreme Court originally recognized a cause of action for negligent nondisclosure in 1977.<sup>41</sup> For the first time in Minnesota, the court used the theory of negligence rather than battery.<sup>42</sup> The court set forth guidelines but declined to establish a definite standard for disclosure,<sup>43</sup> opting instead to outline a combination of both the professional and the patient-based standards of disclosure.<sup>44</sup> Once again the court noted the premise behind the

37. The reason for these conflicting judgments can be attributed to variations in the informed consent law of these jurisdictions and the different standards applied by them. The informed consent doctrine would support the imposition of a disclosure obligation most readily in jurisdictions which employ the patient-based standard to determine which risks must be disclosed. Mary Ann Bobinski, *Autonomy and Privacy: Protecting Patients From Their Physicians*, 55 U. PITT. L. REV. 291, 362-63 (1994).

38. *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905).

39. *Id.* at 14-15 (quoting 1 KINKEAD ON TORTS § 375 (1901)). The court also quoted *Pratt v. Davis*, 118 Ill. App. 161, 166 (1905):

Under a free government, at least, the free citizen's first and greatest right, which underlies all others—the right to the inviolability of his person; in other words, the right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent . . . to violate, without permission, the bodily integrity of his patient . . . and operat[e] upon him without his consent or knowledge.

*Id.* at 14.

40. *See, e.g., Kohoutek v. Hafner*, 383 N.W.2d 295, 299 (Minn. 1986) (stating "failure to disclose a very material aspect of the nature and character of the touching will undermine the consent, and the touching will constitute a battery"); *Bang v. Charles T. Miller Hosp.*, 251 Minn. 427, 88 N.W.2d 186 (1958) (granting new trial to determine if doctor would be liable in battery for failure to secure consent of a patient to cut spermatic cords during prostate operation).

41. *Cornfeldt v. Tongen*, 262 N.W.2d 684 (Minn. 1977).

42. *Id.* at 699.

43. *Id.* at 701. The court felt the different standards of disclosure had not been carefully briefed and thus "hesitate[d] to delineate a definitive standard, but instead advance[d] propositions whose refinement must await a later case." *Id.*

44. *Id.* at 702. "Our aim is to make a rational decision by the patient possible without imposing unreasonable requirements on the physician." *Id.* The court

doctrine of informed consent: the patient's right to knowingly and intelligently exercise control over his or her own body.<sup>45</sup>

Subsequent decisions broadened and refined the rules for disclosure.<sup>46</sup> The duty to disclose expanded to include additional risks if "a reasonable person in what the physician knows or should have known to be the patient's position would likely attach significance to that risk . . . ."<sup>47</sup> In other words, physicians now also need to disclose certain risks if they are or should be aware that the patient attaches particular significance to them.<sup>48</sup> This is true even if the risks are "not generally considered by the medical profession serious enough to require a discussion with the patient . . . ."<sup>49</sup>

### III. THE K.A.C. DECISION

#### A. *The Facts*

Dr. Philip Benson, tested positive for HIV on September 12, 1990. After testing positive, Dr. Benson performed two gynecological examinations on plaintiff T.M.W.<sup>50</sup> He did not disclose his HIV status to T.M.W. during either visit. Although he wore gloves during the invasive procedures,<sup>51</sup> Dr. Benson had running sores on his hands and arms.<sup>52</sup> T.M.W. inquired about these skin lesions but received evasive or disingenuous answers.<sup>53</sup>

In a letter dated June 17, 1991, Dr. Benson, in cooperation with the Minnesota Board of Medical Examiners, informed T.M.W. and 335

advanced two rules to define the scope of risks subject to disclosure. Physicians had a duty to disclose: (1) risk of death or serious bodily harm; and (2) risks that would be disclosed by a practitioner of good standing in like circumstances. *Id.* (citing *Cobb v. Grant*, 502 P.2d 1 (Cal. 1972)).

45. *Id.* at 701. "Our society is morally and legally committed to the principle of self-determination, a corollary of which is the right of every adult of sound mind to determine what shall be done with his own body." *Id.*

46. *E.g., Kinikin*, 305 N.W.2d at 589; *Cornfeldt v. Tongen*, 295 N.W.2d 638 (Minn. 1980).

47. *Cornfeldt II*, 295 N.W.2d at 640.

48. *Kininik*, 305 N.W.2d at 595. "A [patient's] peculiar or unfounded fear . . . might, if anything, require [the physician] to devote more time discussing its probability with [the patient] . . . ." *Id.*

49. Appendix to Appellant K.A.C.'s Brief at A-40.

50. *K.A.C. v. Benson*, 527 N.W.2d 553, 556 (Minn. 1995). From 1980 until June 1991, the Palen Clinic employed Dr. Philip Benson as a family practitioner. *Id.*

51. *Id.*

52. Respondent's Brief at 2. The type of bodily fluid exuding from Dr. Benson's sores has been shown to be capable of carrying the HIV virus. See Richard N. Danila et al., *A Look-Back Investigation of Patients of an HIV-Infected Physician*, 325 NEW ENG. J. MED. 1406, 1407 (1991).

53. *K.A.C. v. Benson*, Nos. C6-93-1209, C5-93-1306, C4-93-1328, 1993 WL 515825, at \*6 (Minn. Ct. App. Dec. 14, 1993).



other patients that he was HIV seropositive and advised them to have an HIV test performed.<sup>54</sup> None of the former patients, including T.M.W., tested positive for the HIV antibody.<sup>55</sup>

Over fifty former patients of Dr. Benson, including T.M.W., sued for negligent nondisclosure.<sup>56</sup> The district court, in its first order, stated that “[p]laintiffs clearly had a right to know that Dr. Benson was afflicted with the AIDS virus and that this posed a risk, however minimal, to them.”<sup>57</sup> It also concluded that whether damages resulted from Dr. Benson’s nondisclosure was a jury question.<sup>58</sup> In its second order, however, the district court ruled that the plaintiffs must allege actual exposure to, or direct contact with, Dr. Benson’s bodily fluids.<sup>59</sup> Concluding that the patients had not made the required showing, the district court granted defendant’s motion for summary judgment.<sup>60</sup>

The court of appeals reversed and remanded the case, holding that the plaintiffs had made a sufficient showing to withstand summary judgment.<sup>61</sup> It noted that “the standard of care in the medical community requires physicians performing invasive procedures to inform their patients of their HIV-infected status.”<sup>62</sup> The Minnesota Supreme Court reversed the court of appeals and reinstated the trial

54. K.A.C., 527 N.W.2d at 557. The letter read:

I am sending you this letter because there is a very minimal possibility that you were exposed to the AIDS virus through body fluids from this rash during certain medical procedures. . . . I did not realize that there may have been any risk to you because I was wearing gloves . . . even with gloves, an extremely minimal risk still existed. . . . the likelihood that you have been infected with the AIDS virus from this type of exposure is *extremely low*.

*Id.*

55. *Id.* Blood tests for the detection for HIV are extremely accurate. When used in conjunction, the ELISA (Enzyme-Linked Immunosorbent Assay) and Western Blot tests are more than 99.9 % accurate. *Faya v. Almarez*, 620 A.2d 327, 333 n.4 (Md. 1993). Ninety-five percent of HIV-infected individuals test positive within 6 months of the date of viral transmission. *Id.* at 332.

56. K.A.C., 527 N.W.2d at 555. T.M.W. also alleged negligent infliction of emotional distress, intentional infliction of emotional distress, battery, and violation of the Consumer Fraud Act. *Id.* at 556. All patients except T.M.W. settled with Dr. Benson and the Palen Clinic. *Id.* at 555-56.

57. Appendix to Respondent’s Brief at A-96.

58. *Id.* at A-244.

59. Dist. Ct. Order & Mem. (Second Order) at 18 (March 15, 1993).

60. *Id.*

61. K.A.C., 1993 WL 515825, at \*1. The court of appeals relied on two cases decided after the trial court’s second order, *Faya v. Almarez*, 620 A.2d 327 (Md. 1993) and *Kerins v. Hartley*, 21 Cal. Rptr. 2d 621 (Cal. Ct. App. 1993), *vacated*, 868 P.2d 906 (Cal.), *rev’d on reh’g*, 33 Cal. Rptr. 2d 172 (Cal. Ct. App. 1994).

62. K.A.C., 1993 WL 515825, at \*7.

court's decision.<sup>63</sup>

### B. *The Court's Analysis*

The Minnesota Supreme Court held that T.M.W.'s claim of negligent nondisclosure must fail because "the undisclosed, minuscule 'risk' of HIV exposure did not materialize in harm."<sup>64</sup> After outlining the disclosure requirements in Minnesota, the court expressly declined to determine whether physicians have a duty to disclose their HIV status to patients.<sup>65</sup> Because T.M.W. tested negative for HIV, the court concluded that no compensable injury had resulted and dismissed the negligent nondisclosure claim.<sup>66</sup>

In his dissent, Justice Page suggested that the majority misapplied the law.<sup>67</sup> He argued that three jury questions remained: (1) "whether [Dr.] Benson should have known T.M.W. attached particular significance to the risk of disease transmission from his open and weeping wounds, . . . (2) whether a reasonable person, in her position, would have shared her fear" and (3) "whether the undisclosed risk of transmission materialized in harm."<sup>68</sup>

Addressing the first issue, Justice Page, stated that a jury could find that a reasonable person would refuse treatment if the risk was disclosed.<sup>69</sup> With regard to the second, he argued that emotional distress caused by a physician's failure to disclose a risk is a compensable injury.<sup>70</sup>

## IV. ANALYSIS OF THE K.A.C. DECISION

The Minnesota Supreme Court failed to apply the doctrine of informed consent in holding that the undisclosed risk of HIV exposure must result in transmission of the HIV virus before a patient's claim will survive summary judgment.<sup>71</sup> It avoided determining whether the informed consent doctrine requires disclosure of provider-associated

63. *K.A.C.*, 527 N.W.2d at 553.

64. *Id.* at 561-62.

65. *Id.*

66. *Id.*

67. *Id.* at 562-64 (Page, J., dissenting).

68. *Id.* at 563-64.

69. *Id.* at 564.

70. *Id.* at 564. Justice Page noted:

The harm avoided by such disclosure is emotional distress on the part of the patient—either because the physician explains away the cause of worry, or because the patient does not consent to the treatment. Here, emotional distress is precisely the harm T.M.W. claims she suffered because of Benson's nondisclosure.

*Id.*

71. *K.A.C.*, 527 N.W.2d at 561-62.

risks or whether the doctrine is limited only to those risks related to proposed treatment.<sup>72</sup> The court dodged its opportunity to clarify this unsettled area of law. Arguably, Minnesota's informed consent law is broad enough to encompass provider-associated risks, including a physician's HIV-positive status.<sup>73</sup>

In Minnesota, a physician's duty of disclosure is not limited to those risks that the medical profession deems significant. Rather, physicians must supply any information that reasonable, prudent patients would regard as material to the health-care decision facing them.<sup>74</sup> It is for the patient to assess the benefits of a proposed medical procedure and to determine for herself whether to undergo it.<sup>75</sup> The decision is the patient's, however unwise the physician believes that decision to be.<sup>76</sup> "Although the probability of an adverse result may seem slight to the physician . . . he cannot withhold information if it is relevant to [a] patient's ability to make an informed consent."<sup>77</sup> Patients have a right to determine what is done to their bodies, particularly when the unavoidable consequence of HIV transmission is death.<sup>78</sup>

Under the doctrine of informed consent, a physician must disclose all information material<sup>79</sup> to a patient's decision concerning a particular medical treatment.<sup>80</sup> It also requires disclosure of information unrelated to the proposed treatment but which could impact the

72. *Id.*

73. This Case Note does not analyze whether T.M.W. was "actually exposed" to the AIDS virus or whether actual exposure is required before a compensable injury results.

74. *E.g.*, *Kinikin v. Heupel*, 305 N.W.2d 589, 593 (Minn. 1981); *Conrfeldt v. Tongen*, 295 N.W.2d at 638, 640 (Minn. 1980). A duty to disclose may be established by a showing that a "reasonable person in what the physician knows or should have known to be the patient's position would likely attach significance to that risk or alternative" in deciding whether to consent to treatment. *Id.*

75. *E.g.*, *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972). *See also* Majorie Macguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 220 (1985). "[T]he more intense and personal the consequences of a choice and the less direct or significant the impact of that choice upon others, the more compelling the claim to autonomy in the making of a given decision." *Id.*

76. *Wilkinson v. Vesey*, 295 A.2d 676, 687-88 (R.I. 1972) (emphasizing that patient's right to make decision in light of own value judgment is very essence of freedom of choice).

77. *Hales v. Pittman*, 576 P.2d 493, 497 (Ariz. 1978).

78. *See Gostin*, *supra* note 20, at 37. "If the adverse consequences would be intolerable for the reasonable, prudent patient, that patient's entitled to make the decision . . ." *Id.*

79. *E.g.*, *Truman v. Thomas*, 611 P.2d 902, 905 (Cal. 1980) "Material information is that which the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject the recommended medical procedure." *Id.*

80. *E.g.*, *Nan Perley*, *supra* note 28, at 338; *Schultz*, *supra* note 75, at 221-23.

patient's decision.<sup>81</sup> A physician's HIV status is highly material to a patient's decision to be treated by that physician and thus should be disclosed.<sup>82</sup> The law recognizes that it is up to the individual, rather than the physician, to weigh all the risks and make an informed decision.<sup>83</sup>

Dr. Benson's HIV seropositive status constituted a material risk to his patients. Although the probability of transmitting the HIV virus from health-care provider to patient is usually extremely low,<sup>84</sup> under these particular circumstances it was likely greater.<sup>85</sup> The gravity of the harm, inevitably death, coupled with the ability to completely eliminate the risk makes this risk material.<sup>86</sup>

81. *E.g.*, *Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1281 (N.J. Super. Ct. Law Div. 1991). In *Behringer* the plaintiffs argued that the informed consent doctrine did not require a surgeon's physical condition to be disclosed as a risk of the surgery. The court stated that "[t]he informed consent cases are not so narrow as to support that argument." *Id.*

82. *See* Marcia Angell, *A Dual Approach to the AIDS Epidemic*, 324 NEW ENG. J. MED. 1499, 1500 (1991) (favoring disclosure).

83. *See* *Canterbury v. Spence*, 464 F.2d 772, 780 ((D.C. Cir. 1972). "True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeable the options available and the risks attendant upon each." *Id.* "Few if any choices are more private and intimate than those that concern the use made of one's body, and thus society should not permit one's bodily integrity to be threatened by another unless one has knowingly and voluntarily consented to (i.e., willed) the intrusion." Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 924 (1994).

84. The Center for Disease Control estimates the probability of HIV transmission from an infected surgeon to a patient to be between one in 40,000 and one in 400,000. Norman Daniels, *HIV-Infected Professionals, Patient Rights and the 'Swiching Dilemma'*, 267 JAMA 1368, 1369 (1992).

85. The New England Journal of Medicine published a case study, documenting the incidents giving rise to the K.A.C. litigation. The authors stated:

According to standard infection-control policies, the physician we have described should not have had direct contact with patients during the time of his severe hand dermatitis. This incident underscores the need to reinforce standard infection-control policies in clinical settings.

The lack of HIV transmission in the patients we studied is encouraging, given the severity of the physician's dermatitis and the presence of serous fluids potentially containing HIV.

Danila et al., *supra* note 52, at 1409.

86. In *Canterbury*, a one percent risk of paralysis from a laminectomy was considered material. 464 F.2d at 794. In *Hidding v. Williams*, which also involved a laminectomy, a one in 200,000 risk of loss of bowel and bladder control was found to be material. 578 So.2d 1192, 1195 (La. Ct. App. 1991). In *Doe v. Johnston*, 476 N.W.2d 28, 31 (Iowa 1991), which involved a provider's failure to inform a patient of the risk of contracting AIDS from a blood transfusion, the Iowa Supreme Court held that the issue of materiality of a risk was a jury question.

The Supreme Court of Texas defined "materiality" to include "how the condition manifests itself; the perman[en]cy of the condition caused by the risk; the known cures for the condition; the seriousness of the condition; and the overall effect of the

The risk of HIV transmission is unique compared to other general risks of a medical procedure because the patient can readily avoid the risk by seeking treatment elsewhere, from an uninfected physician.<sup>87</sup> If a patient can receive virtually the same services from another equally qualified physician without any risk of acquiring the lethal virus, the patient who chooses the non-infected physician is acting reasonably.<sup>88</sup> While no patients are guaranteed a risk-free, health-care environment, surely they are entitled to the elimination of any and all risks within their physician's control. These risks are to be distinguished from risks inherent to a particular procedure, which patients cannot eliminate regardless of where they go for treatment or who performs the procedure. Physicians should not deprive patients of their right to make an informed decision.

Given the deadly nature of AIDS, physicians are not only ethically obligated as professionals, but also legally obligated under the doctrine of informed consent, to disclose their HIV-positive status.<sup>89</sup> Insisting that patients only consider the underlying probabilities of death when they assess risks is strongly paternalistic.<sup>90</sup> Even though the risk is slight, transmission is fatal.<sup>91</sup> Above all, patients can avoid the risk entirely by choosing another physician.

To prevail on a claim of negligent nondisclosure, a patient must also prove proximate cause.<sup>92</sup> In Minnesota, causation is based on an

condition on the body." *Barclay v. Campbell*, 704 S.W.2d 8, 10 (Tex. 1986). With respect to HIV, the condition manifests itself by infection, the infection is permanent, no cures exist, and the effect is fatal.

87. See A. Samuel Oddi, *Reverse Informed Consent: The Unreasonably Dangerous Patient*, 46 VAND. L. REV. 1417, 1430 (1993).

88. *Id.*

89. *E.g.*, *Faya v. Almaraz*, 620 A.2d 327 (Md. 1993). The court stated, "a physician who knows that he or she has an infectious disease, which if contracted by the patient would pose a significant risk to that patient, should not engage in any activity that creates a risk of transmission of that disease to the patient." *Id.* at 334 (quoting *Current Opinions, Code of Medical Ethics*, AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (1992)).

90. *Daniels*, *supra* note 85, at 1370.

91. *Canterbury v. Spence*, 464 F.2d at 772, 788 (D.C. Cir. 1972). "A very small chance of death or serious disablement may well be significant; a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady may summons discussion with the patient." *Id.*

92. To establish proximate cause, the plaintiffs must show that had the risk been disclosed, they would not have consented to the proposed treatment. The Minnesota civil jury instruction regarding informed consent states:

1. The physician knew or should have known of the risk involved in surgery or other treatment, or alternatives to such surgery or treatment;

2. The risk or alternative treatment was significant enough that the physician should have told his or her patient of it. A risk or alternative treatment is significant if the physician knew or should have known that it would be regarded as significant by a reasonable person in the

objective standard: that of a reasonable person.<sup>93</sup> Some physicians and health-care professionals may argue that a "reasonable" person would not refuse treatment if informed of the risk because of the low probability of transmission. However, more than eighty percent of patients want to know the HIV status of their physicians.<sup>94</sup> Further, if informed that their physician was HIV-positive, most people would choose another provider.<sup>95</sup> Arguably, these particular preferences of a majority of Americans are not unreasonable.

Some commentators argue that physician-associated risks lie outside the doctrine of informed consent or that the risks are too small to be material.<sup>96</sup> They contend that given the low risk of transmission, the physician's right of privacy, and the possible adverse effect on the health-care system, physicians should not be required to inform their patients as long as proper precautions are taken to prevent transmission.<sup>97</sup> While disclosure would have an obvious adverse impact on the physician, concern for the provider's rights must not overshadow the rights of "the most critical participant—the patient."<sup>98</sup> Difficulties created by public reaction to AIDS cannot deprive the patient of making the ultimate decision where the risk is so significant.<sup>99</sup>

patient's position when deciding to accept or reject surgery or other treatment;

3. The physician failed to disclose the risk or alternative treatment to the patient;

4. A reasonable patient in the patient's position would not have consented to the treatment or operation if the risk or an alternative treatment had been known; and

5. [That] the undisclosed risk resulted in harm from the treatment or operation which was performed (the injury sustained by the plaintiff would have been avoided by the undisclosed alternative treatment).

MINN. CIV. JIG 427.1 (1992). See also *Kinikin v. Heupel*, 305 N.W.2d 589, 593 (Minn. 1980); *Cornfeldt v. Tongen*, 262 N.W.2d at 684, 689 (Minn. 1977).

93. E.g., *Cornfeldt*, 262 N.W.2d at 701.

94. A 1991 *Newsweek* poll found that 90% of Americans wanted to know their physician's HIV status. Jane Gross, *Many Doctors Infected with AIDS Don't Follow New U.S. Guidelines*, N.Y. TIMES, August 18, 1991, at A20.

95. Sandra L. Mitchell, *Employment Issues Facing HIV-Infected Health Care Workers*, 3 J. PHARMACY & L. 5, 27 n.41 (1994) (stating that more than 50% of those surveyed would change doctors upon learning of their doctor's HIV-positive status).

96. E.g., Daniels, *supra* note 84, at 1369; Darrell Fun, *HIV-Infected Healers: Do Patients Have a Right to Know?* 21 BRIEF 6 (Summer 1992).

97. See Daniels, *supra* note 84, at 1371 (concluding that there should be no duty to disclose). See also Bobinski, *supra* note 37, at 304-06 (arguing that broad disclosure requirements are not supportable); Chai R. Feldblum, *A Response to Gostin "The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety"*, 19 LAW MED. & HEALTH CARE 134 (1991) (stating that the risk is not material, and further, that provider-associated risks lie outside the informed consent doctrine).

98. *Behringer v. Medical Ctr. at Princeton*, 592 A.2d 1251, 1278 (N.J. Super. Ct. Law Div. 1991).

99. *Id.* at 1280.

Courts require physicians to disclose all information that a reasonable patient would find relevant to make an informed decision on whether to undergo a medical procedure.<sup>100</sup> "As the severity of potential harm becomes greater the need to disclose improbable risks grows."<sup>101</sup> While the risk may be low, it does exist.<sup>102</sup> More importantly, the risk can be eliminated completely by choosing another physician who is not infected with HIV. "Where the ultimate harm is death, even the presence of a low risk of transmission justifies the adoption of a policy which precludes invasive procedures when there is 'any' risk of transmission."<sup>103</sup>

## V. CONCLUSION

Risks relevant to a patient's decision to undergo a medical procedure usually have been confined to risks related to the proposed treatment rather than to those associated with the treating physician.<sup>104</sup> However, because the purpose of the doctrine of informed consent is to place the health-care decision with the patient,<sup>105</sup> physician-associated risks are just as relevant, if not more so, as those related to the treatment itself. The risk of HIV exposure can be completely avoided by choosing an uninfected physician. A physician's HIV status constitutes a material risk to the patient and thus should be included with the informed consent doctrine.

This Case Note does not call for an industry-wide standard requiring disclosure of all HIV-infected health care providers under all circumstances. Instead, it argues for disclosure when a physician proposes an invasive procedure and a risk of transmission exists. Patients have the right to be informed of the risk and to decide whether they are willing to accept it.

*Ranelle A. Leier*

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100. *Id.* at 1282.

101. *Id.*

102. *Id.*

103. *Id.*

104. *See, e.g.,* Bobinski, *supra* note 37, at 343-45.

105. Gostin, *supra* note 20, at 33-34.