**Case No. C9-02-1821 and C2-02-1837**

# STATE OF MINNESOTA
# IN SUPREME COURT

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Kimberly A. Molloy, et. al,

Respondents,

v.

Diane M. Meier, M.D., et al.,

Appellants.

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## *Brief of Amici Curiae The Minnesota Medical Association; Minnesota Hospital Association; Minnesota Medical Group Management Association; and the American Medical Association*

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# TABLE OF CONTENTS

**Page**

**TABLE OF AUTHORITIES** ........ ii

**INTRODUCTION AND INTEREST OF AMICI** ........ 1

- **I. Physicians Have Not Been And Should Not Now Be Held To Owe A Legal Duty To Non-Patients Based Only On A Foreseeability Of Harm Analysis.** ........ 4
  - **A. The Purpose Of Genetic Testing On A Child Is For The Benefit Of The Child; Interested Adults Should Obtain Their Own Medical Assessments.** ........ 6
  - **B. Foreseeability Is An Inappropriate Test For Physicians' Liability To Non-Patients.** ........ 8
  - **C. The Court Of Appeals Completely Ignored Requirements Of Confidentiality And Privacy Of Patient Medical Information.** ........ 10
- **II. In The Absence Of Fraudulent Concealment Or Facts Triggering The Single Act Exception, A Medical Negligence Claim Is Barred Four Years After The Date Treatment Terminates.** ........ 12

**CONCLUSION** ........ 15

# TABLE OF AUTHORITIES

**Page**

## Cases

*Grondahl v. Bullock*,
318 N.W.2d 240 242 (Minn. 1982) ........................................ 4

*Henkemeyer v. Boxall*,
465 N.W.2d 437, 439 (Minn. App. 1991) ........................................ 5

*McElwain v. Van Beek*,
447 N.W.2d 442, 445 (Minn. App. 1989) ........................................ 4, 6

*Olson v. Children's Home Society of California*,
252 Cal. Rptr. 11 (Ct. App. 1988) ........................................ 9

*Order of R.R. Telegraphers v. Ry. Express Agency, Inc.*,
321 U.S. 342, 348-49, 64 S. Ct. 582, 586 (1944) ........................................ 14

*Perl v. St. Paul Fire & Marine Ins. Co.*,
345 N.W.2d 209, 212 (Minn. 1984) ........................................ 13

## Statutes

Minn. Stat. § 144.762 ........................................ 11, 13

## Articles

Jeri E. Reutenauer, *Medical Malpractice Liability in the Era of Genetic Susceptibility Testing*, 19 QLR 539, 573 (2000) ........................................ 10

Lori B. Andrews, *Torts and the Double Helix: Malpractice Liability for Failure to Warn of Genetic Risks*, 29 Hous. L. Rev. 149, 181 (1992) ........................................ 15

A. Liang, *The Argument Against a Physician's Duty to Warn for Genetic Diseases: The Conflicts Created by Safer v. Estate of Pack*, 1 J. Health Care L. and Pol'y 437, 453 (1998) ........................................ 11

## INTRODUCTION AND INTEREST OF AMICI[1]

This amicus brief is submitted on behalf of several groups of medical professionals and hospital/health care systems:

The Minnesota Medical Association (MMA) is a voluntary, non-profit, professional association organized to support and improve the science and art of medicine and to advance community welfare, community health, and scientific education. Its membership is composed of licensed physicians, residents, and medical students from across Minnesota.

The Minnesota Hospital Association (MHA) is a statewide trade association representing Minnesota's 143 acute care hospitals and 22 health systems. MHA's objective is to provide leadership toward the advancement of health care policy and activities that promote community-based health-services delivery and an effective health care marketplace that advances universal coverage and access, consumer value, and the improvement of community health.

The Minnesota Medical Group Management Association (MMGMA) is a non-profit professional association representing executives and managers in health-service delivery organizations statewide. It provides education, advocacy, and networking opportunities to its members to enhance knowledge and develop leadership skills that improve the quality, reduce the costs, and increase the efficacy of health care.

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[1] No part of this brief was authored by counsel for a party. No person or entity, other than Amici and their counsel, made any monetary contribution to the preparation or submission of this brief.

The American Medical Association (AMA), an Illinois non-profit corporation, is a voluntary, professional association organized to promote the science and art of medicine and the betterment of public health. It is the largest association of physicians in the United States and has approximately 260,000 members. Its members practice in every area of medical specialization and in every state of the United States, including Minnesota.[2]

Amici's interests in this matter are primarily public in nature. We have no interest whatsoever in the particular dispute between these litigants. Rather, our concern is with the orderly development of Minnesota medical malpractice law.

Since the members of the MMA, MHA, MMGMA, and AMA include hospitals and health care professionals who may themselves be sued for malpractice, a decision by this Court could implicate their private interests as well. But our primary concern is that the law of medical malpractice liability in Minnesota be clear, precise, and consistent with well-recognized principles of law and policy.

Amici believe that this Court ought to have a broader perspective of the legal and policy issues raised by this case than will likely be presented by the parties. The parties

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[2] The AMA appears on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies (Litigation Center). The Litigation Center is an unincorporated coalition of the AMA and the state medical societies, developed to serve as the voice of organized medicine in the nation's courts. All fifty of the state medical societies, including MMA, and the Medical Society of the District of Columbia are Litigation Center members. The Litigation Center serves as an advocate for the medical profession by bringing cases which have broad impact and by serving as an information and advocacy clearinghouse for medical societies and related groups. The Litigation Center's purpose is to concentrate the legal resources of organized medicine in addressing the health care related issues that arise in the courts and that most significantly affect physicians around the nation.

naturally ask this Court to focus on the particular facts of this case as those facts bear on the opinion below. Amici take no position concerning how the dispute between these litigants should be resolved, nor do we intend to re-argue or re-state Appellants' arguments, as they have been articulated quite completely in their briefs. Instead, Amici seek to provide some perspective on the broader issues of law and policy that should inform this Court's decision not about who ought to win or lose this dispute, but about what the law *should* be.

In that regard, Amici urge the Court to recognize the impossible predicament that Minnesota's physicians now find themselves in as a result of the lower court's questionable decision. Unless the opinion below is reversed, Minnesota physicians will face liability to persons with whom they have had no professional relationship--in fact, to persons whom they have never met or even heard of--for failure to diagnose genetic disorders. Even more frightening, physicians may remain liable to these non-patients for many decades. Thus, if the decision below is the law in Minnesota, the scope of physicians' liability will be boundless, both in terms of extent of duty and number of years.

Physicians have always viewed their job to be the diagnosis and treatment of their patients. The duty to diagnose and treat one's patients has been just that: *a duty owed to one's patient*. Now however, physicians supposedly have been saddled with an entirely new duty to non-patients. Despite the lower court's ineffectual attempt to limit that new duty to biological parents, physicians now will owe a duty simply because potential harm to any number of third parties is deemed "foreseeable."

If this inappropriate expansion of a physician's duty is allowed to stand, physicians will be unable to figure out how to satisfy their new-found duties to third parties and avoid the decades-long-liability exposure imposed by the lower court's opinion--not to mention the time that physicians will have to devote worrying about and attempting to remedy the problems with tail liability insurance that will certainly follow this threat of unlimited liability to third parties. Needless to say, the result will be that physicians will have less time to devote to patient care, and even less time to spend learning how to test for and treat the many different genetic disorders for which medical interventions currently are or will in the near future be available. This is most certainly an undesirable outcome and is the primary reason that brings Amici before this Court.

## I. Physicians Have Not Been And Should Not Now Be Held To Owe A Legal Duty To Non-Patients Based Only On A Foreseeability Of Harm Analysis.

As set forth in Appellants' briefs, a physician-patient relationship has always been a necessary predicate for holding physicians liable for medical negligence in Minnesota.[3] *See* *Grondahl v. Bullock*, 318 N.W.2d 240 242 (Minn. 1982) (emphasizing the importance of a continuing relationship between the physician and the patient with regard to the particular illness being treated); *McElwain v. Van Beek*, 447 N.W.2d 442, 445 (Minn. App. 1989), *review denied* (Minn. Dec. 20, 1989)(family member who was injured during relative's medical exam was not entitled to maintain malpractice action against physician because there was no physician-patient relationship); *Henkemeyer v.*

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[3] The only exceptions are certain narrowly circumscribed situations involving the duty-to-warn, duty-to-control, and contagious diseases. *See generally* Appellant Meier's Brief at 22-23.

*Boxall*, 465 N.W.2d 437, 439 (Minn. App. 1991), *review denied* (Minn. March 27, 1991) (holding that medical examinee was not entitled to maintain malpractice action against workers' compensation insurer's independent medical examiner because there was no physician-patient relationship).

Despite this long-standing rule, the lower court, when presented with this case (involving a pediatrician and neurologists who allegedly failed to order and accurately report to the non-custodial parent of a mentally retarded child certain genetic tests on the child), entirely abandoned the well-established and well-founded law and instead formulated a new rule which is flatly inconsistent with existing legal principles, a rule which will not only have disastrous effects on physicians but also will likely affect the availability of genetic testing to those who desire it in the future. In so doing, the court held that the pediatrician and neurologists have a duty to the biological parent for purposes of that adult's own health care planning, even *in the absence of a physician-patient relationship*. (Moreover, in this particular circumstance at least, the pediatrician would not be in a position to order tests, treatment or medical referrals for the biological parent by reason of the specialty in which she practiced, which was limited to treating children.)

In setting out this new rule the Court of Appeals relied exclusively on the notion that it was foreseeable that the patient's mother might become pregnant unless she was told her daughter had fragile X syndrome. Based solely on the notion of foreseeability, the Court of Appeals created a new rule that the child's doctor had a duty of care to the mother for purposes of her own family planning. In pronouncing this new rule of law, the Court of Appeals failed to put any limitation on the degree of biological relationship of individuals to whom this new duty is imposed. Nor did it address the prohibition imposed by state and federal law on sharing confidential medical information with non-patients. Finally, the Court glossed over the fact that, when the patient is a child, medical information by necessity is communicated to the adult caregiver simply because of the child's minority status. Instead, it transformed that traditional chain of communication for child patients into a chain of duty to the biological parent, whether or not that person is responsible to care for them.

### A. The Purpose Of Genetic Testing On A Child Is For The Benefit Of The Child; Interested Adults Should Obtain Their Own Medical Assessments.

Genetic testing of children for the parent's benefit (i.e., for making future reproductive decisions) has been criticized as medically and ethically improper. The child should not be subjected to testing for someone else's benefit--especially when such testing could just as easily be done on the parent who seeks the information. *See, e.g.*, Committee on Assessing Genetic Risks, Institute of Medicine, *Assessing Genetic Risks: Implications for Health and Social Policy* at 261 (Lori B. Andrews *et al* eds., 1994).

> In such instances, the justification is not the benefit to the newborn but the benefit to the parents for future reproductive plans. For such reasons . . . some states in the United States . . . screen newborns for Duchenne muscular dystrophy. This medical intervention has no immediate medical benefit for the newborn, and carrier screening of the parents could be obtained through other methods, even where (as in the case of Duchenne muscular dystrophy and some other conditions) they may not realize they are at risk.

*Id.*

Here, the Court of Appeals not only condones this practice but sets out legal principles to institutionalize it in Minnesota law. There is no justification for doing so, especially on the facts in this record, where Ms. Molloy knew she was a potential carrier before her last two children were conceived and nothing prohibited her from getting her own assessment.

Moreover, as a matter of well settled law, the duty is on the patient to exercise reasonable care for their own safety and health care needs. *See* CIVJIG 25.20 and authorities there cited. Specifically, a patient has a duty to act reasonably in getting care and treatment and may not recover any damages that would have been avoided by doing so. *See* CIVJIG 91.45 and authorities there cited.

In this case, it is undisputed Ms. Molloy knew she might be a carrier for some inheritable condition resulting in mental retardation. She knew that not only because her daughter Sameera was mentally retarded but also because her brother was, too. She also knew that even if she was a carrier, not every pregnancy would result in a mentally retarded child because not all of her children were mentally retarded. It could not be more clear that the question of Ms. Molloy possibly being a carrier was known to her. Under the law, it was her duty to get her own medical assessment of her carrier status. She did not do that. Instead, she got pregnant before even waiting for the results of Sameera’s testing. After that, still without consulting a treating physician about her own carrier status, she got pregnant again and delivered Michael. In this case, the Court of Appeals has erroneously shifted Ms. Molloy’s own legal duties to the doctors treating her daughter. That is simply not the law of this state. Nor is it the way genetic testing ought to be carried out.[4]

### B. Foreseeability Is An Inappropriate Test For Physicians' Liability To Non-Patients.

To illustrate how aberrational the opinion below is, consider its holding that the doctor involved in genetic testing of the child has a duty to the *biological* parent. The court did not address whether the duty extends to adoptive parents or to blood relatives such as adult siblings of the patient--nor whether telling only one biological parent is adequate. Nor did it address the duty when a biological parent has no involvement with the child.

Since it is foreseeable that biological relatives other than the parents could also be harmed, under the court's analysis the duty would extend to others, indeed, to *all* of the patient's current and future blood relatives. What if the patient's aunt, uncle, grandparent, or even cousin has custody of the patient? And what about a patient's adult sibling? These people are all blood relatives, thus it is foreseeable that any of them might potentially be at risk. If foreseeability is the only test, then the physician has a duty to these people as well. Extending the duty to all such people would undoubtedly be disastrous for the medical community; however, the lower court's holding does nothing to protect against such an extension of the duty and in fact invites it.

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[4] If Sameera had been tested for fragile X and was negative, that would not have determined of Ms. Molloy's carrier status. Only her own genetic assessment by her own physician could answer that question.

Moreover, where the biological parents do *not* have custody, or are simply estranged or uninvolved in the patient's life, would physicians still have a duty to these people? If so, how are physicians to handle patient-physician confidentiality and privacy of patient's medical information, basic tenets of the physician-patient relationship?

These questions become even more complex in the context of adoption. If physicians owe a duty to biological parents, must they also track down parents who have given their children up for adoption?[5] Such a duty is both impractical and unreasonable.

Another important consideration is whether physicians, in attempting to satisfy some ill-defined duty to notify blood relatives of genetic risks, are exposing themselves to liability for providing such notification. Imagine a situation in which a physician seeks out a blood relative (perhaps a biological parent who is not involved with the patient) to inform them that they may have a genetic disorder. What if they did not wish to be the recipient of such information? What if that knowledge causes them emotional distress? (*See* p. 11, *infra*) Will they then have a claim against the doctor, who was simply trying

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[5] *See Olson v. Children's Home Society of California*, 252 Cal. Rptr. 11 (Ct. App. 1988). Children's Home Society of California ("CHS") arranged for the adoption of Barbara Olson's son. *Id.* at 12. Thirteen years later she gave birth to another child who died of the genetically transmitted disease, combined severe immune deficiency ("CSID"). Mrs. Olson contacted CHS to inquire about the health of the son she had put up for adoption and was informed that the boy also had CSID, but was alive. *See id.* Mrs. Olson and her husband filed suit against CHS for the wrongful death of their son, intentional infliction of emotional distress, and fraud. *See id.* Plaintiffs alleged that CHS had a duty to warn them that their child had a genetic disease and if they had been so warned, they would have either not conceived the child or received medical treatment to save his life. *See id.* The court of appeals rejected plaintiffs' argument that there was a special relationship between Mrs. Olson and CHS that imposed a duty on CHS to notify her of the 50% risk of having another affected male child. *Id.* at 13.

to satisfy a duty created by the Minnesota judiciary? Surely the opinion below has unfairly placed physicians in an untenable situation.

Amici are deeply concerned about broadening the duty of health care professionals in this manner. As Judge Willis wisely recognized, the court's holding has serious implications for the medical profession and the people of Minnesota. *See* opinion below at 22-23.[6] Physicians cannot and should not be expected to prevent harm from befalling one who is not under their care and for whose well-being they are not responsible. The obligation to prevent any foreseeable harm to non-patients is a heavy, uncertain, and in some instances, an impossible burden, with which physicians should not be saddled.

### C. The Court Of Appeals Completely Ignored Requirements Of Confidentiality And Privacy Of Patient Medical Information.

The Court of Appeals did not consider the fact that, in disclosing genetic information to third parties, physicians may be exposing themselves to liability for breach of physician-patient confidentiality. Physicians are required to uphold a duty of confidentiality to their patients under both state and federal law. In creating a duty to

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[6] In his concurring opinion, Judge Willis notes that "Short term 'tail' liability-insurance coverage after an event such as retirement will no longer be sufficient to protect the interests of a physician who was in any way involved in genetic testing." He further notes that ". . . the fact that any [decades-old claim] based on failed genetic diagnoses could be made will cause medical professionals, acting in their rational self-interests, to avoid to the greatest degree possible medical practice likely to involve genetic testing. That clearly is not in the public interest." *See also* Jeri E. Reutenauer, *Medical Malpractice Liability in the Era of Genetic Susceptibility Testing*, 19 QLR 539, 573 (2000)(". . .fear of lawsuits will force physicians either to overuse genetic diagnostics to defend against malpractice suits or to avoid genetic testing altogether by adopting a practice of blanket referrals. Such physician uncertainty can lead to what has come to be known as 'defensive medicine.'").

disclose to third parties based on foreseeability, the opinion below creates unresolvable conflicts for physicians.

Genetic information, like all medical information, is protected by the legal and ethical principle of confidentiality that exists within a patient-physician relationship. Physicians may not disclose genetic information without the patient's permission. The reasons for requiring strict adherence to this duty of confidentiality in the context of genetics are obvious. Disclosure of genetic test results has been found to lead to insurance and employment discrimination, abandonment, physical violence, emotional abuse and suicide. *See* A. Liang, *The Argument Against a Physician's Duty to Warn for Genetic Diseases: The Conflicts Created by Safer v. Estate of Pack*, 1 J. Health Care L. and Pol'y 437, 453 (1998). Moreover, American Medical Association policy dictates that genetic information be kept confidential and should not be disclosed to third-parties without the explicit informed consent of the tested individual. American Medical Association, Patient Privacy and Confidentiality, H.-315.983(7)(8) (2002). As noted by Appellants, when the patient is a minor, private health information must be disclosed to the authorized caregiver only for purposes of caring for the child, not for the adult's own personal benefits. *See generally* Appellant Backus's Br. at 14-16.

The legislature has emphasized this state's interest in protecting confidentiality of medical information even when third parties have a definite need to know. Minn. Stat. § 144.762 prohibits the release of a patient's HIV and hepatitis B status to emergency medical personnel after a significant blood exposure unless the patient consents or the matter is brought before the court and the court issues a specific order requiring disclosure. HIV and hepatitis B are life-threatening diseases requiring prompt treatment to avoid or postpone death or serious bodily harm. It is certainly not up to the courts to override such a clear and strong policy of this state favoring confidentiality and set out a new disclosure rule in this case where no one is at risk of death or serious bodily harm and the information allegedly needed for family planning is available elsewhere.

The Court of Appeals may have had the notion that disclosure to the biological parent is required anyway in this case simply because the patient is a minor. While it is true that the patient here is a minor and that disclosure needed to be made to the authorized adult responsible for her care, that person was not the plaintiff. According to the record, the person responsible for the patient's care was her father. While it is acknowledged that the father was entitled to information about the patient's condition and any test results, that is only because he, as her father, stood in her place. *See generally* Appellant Backus's Br. at 14-16. The Court of Appeals nonchalantly transformed this recognized manner of communication into something entirely different--an entirely new legal duty never before recognized in this state with endless, negative implications.

## II. In The Absence Of Fraudulent Concealment Or Facts Triggering The Single Act Exception, A Medical Negligence Claim Is Barred Four Years After The Date Treatment Terminates.

Amici agree with the law and arguments proffered by Appellants concerning the statute of limitations issue and do not wish to burden this Court with repetitive text. Amici join Appellants in urging this Court to reject the lower court's holding in this case.

In its decision below, the Court of Appeals acknowledged that its holding may effectively open the door to genetic diagnosis claims without time limit, that a claim could be made years or even decades after the failed diagnosis. *See* opinion below at 18. At the same time, the opinion states that "it is the province of the legislature, not this court, to enact a statute of repose or to take other action to limit the risk to physicians if that is the desired outcome." *Id.* However, the legislature *has* enacted a statute of limitations limiting the duration of physicians' potential liability to four years. The Court of Appeals need only have applied that statute to medical malpractice cases consistent with Minnesota precedent and good policy to effect the intended protection.

If the defendant physicians in this case are held to owe a duty to a non-patient, then the breach of that duty *ipso facto* must have caused presumed harm, which is actionable and thus starts the running of the statute of limitations. Cf. *Perl v. St. Paul Fire & Marine Ins. Co.*, 345 N.W.2d 209, 212 (Minn. 1984) (allowance of nominal damages to address breach of an absolute right is really a fiction to satisfy legal maxim that every right has a remedy). *See also* Appellant Meier's Br. at 38. Hence, the statute of limitations in this case should be deemed to begin running when the defendant physicians failed to diagnose Kimberly Molloy's daughter with fragile X, not years down the road when she became pregnant with another child.

The lower court's holding in effect erases all time limits that might bar a claim. If its holding on the statute of limitations issue is to stand, Kimberly Molloy could not only sue her daughter's pediatrician for failing to diagnose her with a genetic disorder (even though that failure occurred more than four years before she brought suit), she could also sue her brother's physician for failing to diagnose him (and to warn her), no matter how long ago the failure to diagnose and warn occurred.

The termination of treatment rule ensures there is a definite end or cutoff of the period within which a physician's liability may arise. Such an end point or cutoff for liability is necessary both for determining the appropriate malpractice insurance coverage to obtain, and for allowing health care professionals to have peace of mind. It is also required to ensure the orderly administration of justice by eliminating stale claims. *Order of R.R. Telegraphers v. Ry. Express Agency, Inc.*, 321 U.S. 342, 348-49, 64 S. Ct. 582, 586 (1944). However, the decision below effectively eliminates that cutoff by holding that a cause of action in a medical negligence case can survive decades after termination of treatment.

With all due respect, the decision below not only is contrary to well-settled Minnesota law, but also will harm Minnesota's medical profession by greatly increasing the potential liability of all health care professionals. With increased potential for liability comes increasing numbers of lawsuits and skyrocketing medical malpractice insurance rates, problems which in many states have already begun to drive physicians and other health care professionals away from health care practice. *See* D. Eisenberg and M. Sieger, *The Doctor Won't See You Now*, Time Magazine, June 9, 2003 at 46-60.

Amici are concerned that the decision below will lead to similar problems for the medical community in Minnesota. This outcome is not only bad for the medical profession, but will likely adversely impact the health and well being of health care consumers throughout Minnesota by decreasing availability and quality and increasing the overall costs of medical treatment. To paraphrase Judge Willis' concurring opinion below, unless the liability of Minnesota's physicians is limited, "it is difficult to see where the next generation of geneticists willing to practice in Minnesota will come from." *See* opinion below at 23.

## CONCLUSION

The pitfalls of the Court of Appeals' decision were not well considered. Genetic testing and genetic counseling is relatively new and growing rapidly.[7] The court need not and should not pronounce far reaching legal principles in this case when the area of science and medicine is developing at such a rapid rate. *See* A. Liang, *The Argument Against A Physician's Duty To Warn For Genetic Diseases; The Conflicts Created by Safer v. Estate of Pack, I J. HealthCare L. &* Policy 437, 453 (1998). The decision here should be limited to this case and should hold that Appellants had no legal duty to Ms. Molloy because there was no physician patient relationship. Finally, if the statute of limitations needs to be addressed at all, it should bar this claim under the longstanding termination of treatment rule.

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[7] "The explosion of genetic information and genetic services that will become available as work progresses on the Human Genome Project may tax the disclosure capacities of health care professionals." Lori B. Andrews, *Torts and the Double Helix: Malpractice Liability for Failure to Warn of Genetic Risks*, 29 Hous. L. Rev. 149, 181 (1992).

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