THE PRACTITIONER'S GUIDE TO
INFORMED CONSENT

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INTRODUCTION

Despite more than a generation of superb and often provocative literature concerning it,1 informed consent remains the bete noire of the medical malpractice doctrine.2 To a large extent, the medical community has come to appreciate the stringent standards of care it must follow to avoid negligent malpractice actions once treatment has commenced.3 But the informed consent maze confronts the health care provider even before treatment is begun and may result in a claim notwithstanding otherwise

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2. One commentator has written:

The procedures for informed consent are fraught with difficulties — objective difficulties based on the complexity of the information which should be provided and the patients' intellectual and psychological abilities to comprehend the information, and subjective difficulties based upon physicians' own biases and values. And it may be generally true that patients under the current informed consent system do not understand or remember what they are told, that testing patients' understanding of the information provided is resource intensive, that patients want physicians to make decisions for them, and that physicians can persuade patients to do whatever physicians believe best in any event.

Jones, 47 Wash. & Lee L. Rev. at 427.

sound medical care.4

Historically, actions involving informed consent arose from the physician's touching or cutting a patient without the patient's approval.5 Such actions logically were considered a species of traditional battery claims which involved any unauthorized touching.6 Thus, where the patient had not consented to an invasion of his or her body, battery principles would apply.7

4. See Madsen v. Park Nicollet Medical Center, 431 N.W.2d 855 (Minn. 1988) (holding that physician's failure to insist that pregnant patient be hospitalized and to disclose risks of premature labor if she were not did not violate the doctrine of informed consent). In Madsen, the court stated:

The informed consent/nondisclosure doctrine does not involve negligence in the administration of treatment, in failure to treat, or in failure to properly diagnose. Physician liability is imposed by the rule only for failure to secure the patient's informed consent to treatment which results in harm which the patient would have avoided by declining the treatment or by choosing an alternative treatment.

Id. at 861. See Pratt v. University of Minn. Affiliated Hosps. and Clinics, 414 N.W.2d 399 (Minn. 1987) (finding that the negligent nondisclosure doctrine may apply to genetic counseling); Gates v. Jensen, 92 Wash. 2d 246, 595 P.2d 919 (1979) (holding that informed consent applies to diagnostic procedures). But see Karlsons v. Guerinot, 57 A.D.2d 73, 92, 394 N.Y.S.2d 933, 939 (1977) (holding that informed consent generally only applies to cases involving affirmative and invasive treatment).

5. See, e.g., Pratt v. Davis, 118 Ill. App. 161, 166 (1905) aff'd, 224 Ill. 30, 70 N.E. 562 (1906) (stating that "[t]he free citizen's... right to the inviolability of his person... necessarily forbids a physician... to violate... the bodily integrity of his patient... without his consent or knowledge."); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905) (holding that the physician, although given permission to operate on one ear, committed battery by operating on the other, even though the decision was medically sound). In Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914), a landmark case, Judge Cardozo established the jurisprudential principle, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." Id. at —, 105 N.E. at 93. Cardozo held "that the wrong complained of [was] not merely negligence. It [was] trespass." During the 1960s a number of courts applied the battery analysis as a remedy for injuries attributed to uninformed consent. See, e.g., Natanson v. Kline, 187 Kan. 186, 354 P.2d 670 (1960) (involving radiation therapy which resulted in injury). See also Studer, The Doctrine of Informed Consent: Protecting the Patient's Right to Make Informed Health Care Decisions, 48 MONT. L. REV. 85, 87-88 (1987); Comment, Tort — Informed Consent — Informed Consent Is Determined by Prudent Patient Rather than Reasonable Physician Standard: Largey v. Rothman, 20 RUTGERS L.J. 837 (1989) (discussing the evolution of the informed consent doctrine as protecting patient autonomy).

6. Battery is defined as "[a] harmful or offensive contact with a person, resulting from an act intended to cause the plaintiff or a third person to suffer such a contact, or apprehension that such a contact is imminent...." W. KEETON, D. DobBS, R. KEETON & D. OWEN, PROSSER & KEETON ON THE LAW OF TORTS § 9, at 39 (5th ed. 1984).

7. See Kinikin v. Heupel, 305 N.W.2d 589, 591-94 (Minn. 1981) (recognizing that breast reduction beyond patient consent constitutes battery); Bang v. Charles T. Miller Hosp., 251 Minn. 427, 88 N.W.2d 186 (1958) (stating that consent to prostate resection does not bar claim of battery where possible severance of sperm cords not disclosed). But see Karlsons, 57 A.D.2d at —, 394 N.Y.S.2d at 938-39 (1977) (holding that absent any proposed touching of the body, there was no battery where physician failed to diagnosis Down's Syndrome using amniocentesis).
Courts and commentators began to understand that actions for battery — an intentional tort — made little sense when couched in negligence terminology. By the 1970s, failure to give the patient adequate information so that he or she could make an intelligent, informed decision regarding treatment alternatives became actionable in itself. Battery principles were separated from negligent nondisclosure principles.

The doctrine which has evolved is predicated on a recognition that a patient has a right — sometimes this is acknowledged to be a constitutional guarantee — to decide what happens to his or her body. The decision can be made only after a person knows what a health care provider proposes to do, what the risks are from this treatment, and what alternatives exist.


9. The law of informed consent has developed from cases in which injured patients have claimed that a physician failed adequately to inform them before they consented to treatment. See, e.g., Canterbury, 464 F.2d 772 (discussing a physician's liability for failing to inform his patient of the risk of paralysis from a laminectomy and holding that the physician was under a duty to inform his patient of the risks and alternatives of the proposed treatment); Truman v. Thomas, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (holding physician liable for failing to inform patient of risks of refusing a pap smear); Cobbs, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514 (remanding to determine whether the physician had breached a duty to inform his patient not only of the “risks inherent in the procedure [prescribed, but also] the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment.”); Natanson, 186 Kan. at —, 350 P.2d at 1106 (1960) (stating that liability may be imposed on a physician for failing to discuss with patient the nature of the illness and proposed treatment, the risks of the proposed treatment, and the probability of success or of alternatives). See also LeBlang & King, 89 DICK. L. REV. at 6 (discussing the physician's fiduciary obligation to disclose, premised upon the right of an individual patient to exercise control over his or her own body); Shultz, 95 YALE L.J. at 219 (discussing the physician's duty to disclose information sufficient to protect the patient choice in making health care decisions).

10. The negligent nondisclosure rule was first enunciated in Cornfeldt v. Tongen, 262 N.W.2d 684 (Minn. 1977) in which the court held that when there is a particular risk inherent in a treatment or procedure the doctor may have a duty to disclose it.

11. See, e.g., Hondroulis v. Schumacher, 546 So. 2d 466, 473 (La. 1989) (holding that the constitutional right to privacy provided for a patient's right to choose whether or not to reject or obtain medical treatment). See also Comment, Hondroulis v. Schumacher: The Uniform Consent Law Revisited, 35 LOY. L. REV. 1474 (1990).

12. The rationale behind the negligent nondisclosure doctrine enunciated in Cornfeldt, is that the right to be informed of the potential consequences of treatment performed is necessary to preserve patient free choice. Cornfeldt, 262 N.W.2d at 699-700.

13. These are considered the elements of disclosure and provide the legal standard
The existence of highly specialized literature may make any re-
statement of the informed consent doctrine seem presumptuous. But
it is important for the practitioner to have available a clear statement
of the doctrine on this subject and guidelines concerning how the
duty of health care providers and the right of patients can be ef-
fected. The practitioner facing an informed consent problem comes
quickly to understand that the cases have sounded in many theories
over the years. Some courts view the physician-patient relationship
as fiduciary in nature, marked by dependency and disparity of power.14
During a medical consultation, the patient is totally depen-
dent upon the expertise of the physician and, as one author has
stated, "[A] generic fiduciary duty to disclose sometimes more effec-
tively vindicates patient interests in autonomy than do the narrower
duties that have crystallized under ordinary rules of medical
consent."15

Still other courts have employed principles of contract law in de-
fining the relationship between physician and patient.16 The treat-
ment offered by a physician and accepted by a patient is, therefore,
the result of a "bargained-for" exchange. Thus, as was stated in Gray
v. Grunnagle,17 any deviance from what the patient consented to
would be the basis for an action for breach of contract.18

The emergence of the above theories illustrates only one plane of
the complexities involved in informed consent. Beyond the theories
forming the root of the doctrine, and on a wholly separate plane, is
the hydra-like network of problems associated with defining the
standard by which informed consent claims are proved.19

by which the patient is said to be adequately informed. See P. APPELBAUM, C. LIDZ &
A. MEISEL, supra note 1, at 49.

14. See, e.g., Canterbury, 464 F.2d at 782 (drawing on a broad concept of fiduciary
duty to impose a specific informed consent duty); Nixdorf v. Hicken, 612 P.2d 348, 354
(Utah 1980) (analyzing under fiduciary principles triggered by conflict of interest and a
disparity in possession of relevant information).


16. This theory is frequently applied to elective surgery cases. See, e.g., Depen-
ing that a patient may recover for breach of contract if doctor promised a particular
result); Sullivan v. O’Connor, 363 Mass. 579, 296 N.E.2d 183 (1973) (allowing patient to
recover for breach of contract when plastic surgery on nose did not produce results
expected). See also Powell, Consent to Operative Procedures, 21 MD. L. REV. 189, 191
(1961) (discussing the physician’s duty not to digress from what was contracted to be
done and stating that any deviance from what patient consented to would be basis for
an action for breach of contract).


18. Id. at 149, 223 A.2d at 669 (citing Powell, 21 MD. L. REV. at 191).

19. In the 1950s and 1960s, “the courts held that the degree of disclosure made to
patients was primarily a question of medical judgment. . . .” This standard of disclo-
sure, known as the “professional” standard, “closely parallels the rules of recovery in
medical negligence . . . cases generally: Physicians are held to the standard of what is
standards clash for acceptance by, and even within, the courts. In one manifestation of this conflict, under the old rule, the "professional community" standard, the physician was required to divulge to the patient only as much information as a reasonable practitioner within his community would reveal. This rule did not require consideration of the patient's subjective need for information to make his own decision regarding treatment. As one court said,

So long as the disclosure is sufficient to assure an informed consent the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.

Under the new rule, the "reasonable patient" standard, the focus is on the patient's autonomy and right to self-determination. This rule dictates that the caregiver may be liable if the patient did not

customary and usual in the profession, not only in the exercise of skill, but also in the disclosure of information to patients." P. Appelbaum, C. Litz & A. Meisel, supra note 1, at 41. In the 1970s, this standard, although still adhered to in a number of jurisdictions, was supplanted by a patient-oriented standard whose prime focus was on individual patient autonomy and self-determination in a medical decision-making context.

Today, the majority of jurisdictions follow the professional standard, with the patient standard comprising a minority. Id. at 43-47.

20. This standard was articulated in Natanson, in which the court stated that "the duty of the physician to disclose ... is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances." Natanson, 186 Kan. at —, 350 P.2d at 1106.

21. As one commentator has stated, "Despite the fact that the Natanson court declared the physician's duty to disclose to be based on the patient's right 'of thorough-going self-determination,' the court used medical practice, not patient autonomy, as the standard to define that duty." Jones, 47 Wash. & Lee L. Rev. at 390.

22. Natanson, 186 Kan. at —, 350 P.2d at 1106. Months after issuing its first opinion, the Kansas Supreme Court issued a second opinion denying motions for rehearing. In its second opinion, the court emphasized that it regarded informed consent as grounded in negligence, not battery, and that, therefore, the duty imposed upon the physician was not absolute, but rather, was a professionally-defined one. Negligence was asserted as the proper standard not only because of the plaintiff's allegations, but because the defendants had asserted assumption of the risk as a defense, which presupposed a plaintiff "equally competent with the defendant to judge concerning the risks and hazards." Natanson, 187 Kan. at —, 354 P.2d at 672.

23. With these considerations in mind, a number of courts challenged the professional standard of disclosure. See, e.g., Canterbury, 464 F.2d at 780 (stating that the better standard was one which took into consideration the patient's right to self-determination in medical decisions); Cobbs, 8 Cal. 3d at —, 502 P.2d at 10, 104 Cal. Rptr. at — (reserving judgment for the patient concerning decisions on medical treatment); Wilkinson, 110 R.I. at —, 285 A.2d at 686 (stating that the professional standard undermines patient's right to decide); Cooper v. Roberts, 220 Pa. Super. 260, —, 286 A.2d 647, 649 (1971) (holding that such standard demeans the patient's physical integrity). See also Waltz & Scheuneman, Informed Consent to Therapy, 64 NW. U.L. Rev. 628, 637 (1970) (formulating the patient-oriented standard of disclosure by describing risks considered material to the patient's decision-making).
receive material information relating to the decision to reject or accept the proposed medical treatment. The landmark decision establishing the reasonable patient standard, stressed that the cornerstone for the developing law on informed consent is the self-determination right of the patient.

The root premise is the concept, fundamental in American jurisprudence, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ." True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.

These theories of informed consent continue to evolve not just because legislatures are still grappling with the problem of which theme to adopt, but also because courts are struggling to create a

24. The standard was articulated by Waltz and Scheuneman: "A risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy." Waltz & Scheuneman, 64 Nw. U.L. Rev. at 604.


26. Id. at 780-83. Canterbury was significant for first articulating what has become known as the "prudent patient" standard, in response to criticisms of the professional standard. In that case, the patient suffered partial paralysis, incontinence, and intestinal paralysis following a myelogram, then a laminectomy. At issue was the defendant physician's duty to disclose the risk inherent in the procedures. The court stated, "The test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked." Id. at 786-87.

27. Schloendorff, 211 N.Y. at —, 105 N.E. at 93. See also Pratt, 118 Ill. App. at 166 (recognizing that a patient's rights in the private relationship with the physician are explicitly linked to the civil rights of the citizenship as "a citizen's first and greatest right").

28. Schloendorff, 211 N.Y. at —, 105 N.E. at 93.

29. Compare the approach of two state legislatures. The Iowa informed consent statute provides:

147.137. Consent in Writing
A consent in writing to any medical or surgical procedure or course of procedures in patient care which meets the requirements of this section shall create a presumption that informed consent was given. A consent in writing meets the requirements of this section if it:

1. Sets forth in general terms the nature and purpose of the procedure or procedures, together with the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures, with the probability of each such risk if reasonably determinable.

2. Acknowledges that the disclosure of that information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

3. Is signed by the patient for whom the procedure is to be performed, or if the patient for any reason lacks legal capacity to consent, is signed by a per-
consistent body of law on the subject. 30

son who has legal authority to consent on behalf of that patient in those circumstances.

**Iowa Code Ann. § 147.137 (West 1989).**

The New York informed consent statute provides:

§ 2805-d. Limitation of medical malpractice action based on lack of informed consent

1. Lack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.

2. The right of action to recover for medical malpractice based on a lack of informed consent is limited to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure which involved invasion or disruption of the integrity of the body.

3. For a cause of action therefor it must also be established that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought.

4. It shall be a defense to any action for medical malpractice based upon an alleged failure to obtain such an informed consent that:

   (a) the risk not disclosed is too commonly known to warrant disclosure; or

   (b) the patient assured the medical practitioner he would undergo the treatment, procedure or diagnosis regardless of the risk involved, or the patient assured the medical practitioner that he did not want to be informed of the matters to which he would be entitled to be informed; or

   (c) consent by or on behalf of the patient was not reasonably possible; or

   (d) the medical practitioner, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which such alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such disclosure could reasonably be expected adversely and substantially affect the patient's condition.


While standards are established by legislation for some procedures,\textsuperscript{31} accrediting agencies and individual hospitals are generating new forms to be executed by patients.\textsuperscript{32} These forms are filed as a part of the hospital admission paperwork and are a central proof whenever a claim is made that the patient did not knowingly agree to a given treatment.\textsuperscript{33}

State legislation dealing with informed consent is simply not universally adequate to the task. This may stem from a given appellate court's application of constitutional limitations on the power of the legislators to abrogate provider liability,\textsuperscript{34} or it may stem from the enactment of separate sections of a statutory scheme which are sources of sharp division in the courts.\textsuperscript{35}


33. The Joint Commission on Accreditation of Hospitals ("JCAH") standards require "evidence of appropriate informed consent" for procedures or treatments for which informed consent is required by hospital policy. \textit{Id.} at 83.

34. Such a limitation occurred in \textit{Hondroulis}, 546 So. 2d 466. There, the Louisiana Court of Appeals interpreted language in the Louisiana Constitution as a rule of law decreeing that when a patient signed a written form which tracked the language of the statute, describing broad categories of damages that may result from medical treatment, informed consent was given to encounter every particular risk involved in surgery treatment.

35. In Nebraska, for example, the state Hospital-Medical Liability Act contains two provisions relating to informed consent whose interpretation has sharply divided the supreme court over whether the professional or the patient standard controls. In Smith v. Weaver, 225 Neb. 569, 407 N.W.2d 174 (1987), the dissenting judges claimed that Nebraska should adopt a material risk standard based on a patient's need to know information, relying on Nebraska Revised Statute § 44-2820 (instead of § 44-2816 which was relied on by the majority).

\textit{Nebraska Revised Statute} § 44-2816 states the professional community standard:

44-2816: Informed consent shall mean consent to a procedure based on information which would ordinarily be provided to the patient under like circumstances by health care providers engaged in a similar practice in the locality or in similar localities. Failure to obtain informed consent shall include failure to obtain any express or implied consent for any operation, treatment, or procedure in a case in which a reasonably prudent health care provider would have obtained an express or implied consent for such operation, treatment, or procedure under similar circumstances.
States which have seen significant changes in certain informed consent principles may find those alterations equally significantly reined in by judicial "legislation."36

Any attempt to deal intelligently with informed consent principles is made difficult not just because states have legislatively and judicially fashioned elements of the doctrine and not just because health care providers and their overseers have created complex rules and forms to deal with the myriad of problems in modern medicine. It is also true that in the 1990s there is a far greater potential for liability on the part of each of the actors in the health care system.37 Thus, it is not surprising that litigation over informed consent has burgeoned.

For these reasons, while the goal of this article may seem ambitious, it is nevertheless important that practitioners have a ready source of basic information on the law of informed consent.

THEORIES UNDERLYING INFORMED CONSENT

The earliest cases involving informed consent were dealt with under several theories of liability — intentional tort, negligence, the fiduciary nature of the doctor/patient relationship, and contract.38

Nebraska Revised Statute § 44-2820 states the reasonable patient standard:

44-2820. Before the plaintiff may recover any damages in any action based on failure to obtain informed consent, it shall be established by a preponderance of the evidence that a reasonably prudent person in the plaintiff's position would not have undergone the treatment had he or she been properly informed and that the lack of informed consent was the proximate cause of the injury and damages claimed.

In Iowa, the doctrine of informed consent has been moved inexorably by the highest court of the state from professionally-oriented to patient-oriented. See Cowman, 329 N.W.2d 422. However, the court hastened to add that the adoption of the new standard does not provide an easy burden for the patient who must still pass four rigorous tests before recovering. Id. at 426.

Under the respondeat superior doctrine, the hospital is liable for torts committed by its employees, servants and agents committed within the scope of their employment. See, e.g., Magana v. Elie, 108 Ill. App. 3d 1028, 439 N.E.2d 1319 (1982) (finding that the hospital may owe a duty to its patients to ensure that every physician using hospital facilities obtain informed consent, regardless of whether the physician is a hospital employee). But see Florentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296 (1967) (holding that a hospital does not have an affirmative obligation to monitor the content of disclosures given by nonemployed health care professionals to patients being treated within the hospital). In some cases, hospitals permit nurses to obtain signatures on consent forms or to provide information to patients. Such a practice would shift liability for disclosure to the hospital as the nurse's employer. "To avoid these consequences, many hospitals do not permit nurses to obtain consents." R. MILLER, supra note 1, at 246. A physician may legally delegate the information disclosure and documentation, but the physician remains legally responsible for the adequacy of the disclosure and validity of the consent. See, e.g., Hoffson v. Orentreich, 144 Misc. 2d 411, —, 543 N.Y.S.2d 242, 244-45 (Sup. Ct. 1989).

Under an intentional tort theory, a battery took place if the treatment the physician performed involved an unconsented touching. See, e.g., Mohr v. Williams, 95
These theories reflected a growing trend in the law toward greater recognition of a patient's right to bodily integrity and autonomy and, subsequently, the physician's obligation to disclose relevant information regarding medical treatment.39

BATTERY

A patient's right to bodily integrity and physical security was initially afforded protection under the theory of battery. In traditional tort law, a battery is "[a] harmful or offensive contact with a person, resulting from an act intended to cause the plaintiff or a third person to suffer such a contact . . ."40

In the early informed consent cases, the courts concluded that a physician who failed to obtain a patient's consent to a medical procedure involving a touching of the patient had committed the tort of battery.41 Thus, in the landmark case of *Schloendorff v. Society of New York Hospital*,42 Judge Cardozo established what has become

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39. The courts were beginning to recognize that, although consent had been given, the consent might be based on insufficient information, misinformation, or a misunderstanding and that, therefore, the patient had not made a truly informed decision regarding his or her medical treatment. It became increasingly apparent that access to complete information regarding treatment was central to a patient's right to decide the course of his or her medical care. In a leading case, *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972), the court imposed the physician's duty to disclose based on respect for the patient's right of self-determination and held that the scope of the physician's duty to disclose would be determined by the patient's need to know all "information material to the decision." Id. at 786 (emphasis added).


41. For the most part, these cases treat the presence or absence of consent as a yes/no question, without regard to the quality of the consent given. See, e.g., *Mohr*, 95 Minn. 261, 104 N.W. 12 (1905) (involving a physician who operated on patient's ear when consent had only been given for the other ear); *Pratt v. Davis*, 118 Ill. App. 161, 166 (1905) (holding that a patient had a constitutional guarantee against unconsented touching and the right to bodily integrity).

42. 211 N.Y. 125, 105 N.E. 92 (1914).
the cornerstone in the doctrine of informed consent: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." In *Schloendorff*, the patient had entered the hospital suffering from a stomach disorder and had consented to be examined under anesthesia. While the patient was anesthetized, however, the physician discovered and removed a tumor. After the operation, the patient developed gangrene in one of her arms. Alleging that the gangrene was a result of the operation, the patient sued the physician for battery.

Although the battery doctrine protected physical autonomy in patients' relations with their doctors, certain difficulties with the application of this theory were increasingly recognized. Most problematic, perhaps, was the fact that the intent element of a cause of action for battery was usually missing. Only very rarely did the facts of a particular case make it clear that the physician intended to operate over a patient's express objection to such treatment. Even less likely was the situation in which the physician actually intended harm to a patient.

Further, it could arguably be said that a patient had given a degree of consent, if only in the sense that the patient had sought medical treatment from the physician. As one court reasoned:

The law should encourage self-reliant surgeons to whom patients may safely entrust their bodies, and not men who may

43. *Id.* at —, 105 N.E. at 93.
44. *Id.*
45. One of these was the realization that a consent to treatment given without an awareness of risks, prognoses, and options resulted in an uninformed and, therefore, invalid consent. Another difficulty with the battery theory was the harsh result that a physician could be subjected to an action for battery upon a finding that consent was uninformed, even though the treatment provided had been faultless. The result was that a patient could "recover damages for inadequate disclosure alone, even if not physically injured by the physician's treatment." P. Appelbaum, C. Lidor & A. Meisel, *Informed Consent, Legal Theory and Clinical Practice* (1987). See, Schultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 225 (1985).
46. See, e.g., *Jones v. Malloy*, 226 Neb. 559, 412 N.W.2d 837 (1987). There, the court stated: "Consent may be express or implied; implied consent may be inferred from the patient's action of seeking treatment or some other act manifesting a willingness to submit to a particular course of treatment." *Id.* at 564, 412 N.W.2d at 841. In *McGuire v. Rix*, 118 Neb. 434, 225 N.W. 120 (1929), the patient had authorized the physician to reduce a foot fracture by manipulation. While the patient was anesthetized, and despite the absence of an emergency, the physician performed surgery. The court found the physician not liable for an unauthorized treatment, holding that: "[c]onsent may be implied from the circumstances." *Id.* at 437, 225 N.W. at 123. See *Jones*, 226 Neb. at 564, 412 N.W.2d at 841 (stating, "We begin with the proposition that consent to treatment will be presumed, in the absence of fraud or misrepresentation.").
be tempted to shirk from duty for fear of a law suit. The law does not insist that a surgeon shall perform every operation according to plans and specifications approved in advance by the patient, and carefully tucked away in his office-safe for courtroom purposes.\textsuperscript{47}

A further difficulty with the battery doctrine arose in determining when consent had been given. There could, for example, be a "consent," but one based on misunderstanding, misinformation, or even the nature of the treatment and its consequences to the patient.\textsuperscript{48} If a patient was given insufficient information to understand the nature of the procedure to which he consented, the courts held that the consent was void:

\textit{[i]t will be no defense for a surgeon to prove that the patient had given his consent, if the consent was not given with a true understanding of the nature of the operation to be performed, the seriousness of it, the organs of the body involved, the disease or incapacity sought to be cured, and the possible results.\textsuperscript{49}}

In recognizing the pitfalls of applying a battery analysis, the courts gradually moved toward applying a negligence theory in medical malpractice cases. From this movement, the modern doctrine of informed consent began to take shape.\textsuperscript{50}

\textsuperscript{47} Barnett v. Bachrach, 34 A.2d 626, 629 (D.C. 1943) (holding that the surgeon was justified in removing the inflamed appendix of a pregnant patient, though consent had not been given for the procedure. The court recognized that there probably would not have resulted immediate death had the surgeon wanted to get consent, but stressed that there was, nevertheless, danger to life and probably imminent danger to the patient's health, as well as possible loss of her child). \textit{But see} Tabor v. Scobee, 254 S.W.2d 474, 477 (Ky. 1951) (remanding to determine whether the surgeon was liable for removal of the patient's fallopian tubes during the performance of an appendectomy). The court in \textit{Tabor} held that, though the patient was 20 years old, she probably could not have understood the full significance of the operation and that, therefore, it was lack of her guardian's consent which gave rise to potential liability. \textit{Id.}

\textsuperscript{48} The court in \textit{Salgo} was among the first to launch an attack on mere consent, holding that "[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 \textit{intelligent consent} by the patient to the proposed treatment." \textit{Salgo} v. Leland Stanford Jr. University Bd. of Trustees, 154 Cal. App. 2d 560, --, 317 P.2d 170, 181 (1957) (emphasis added).

\textsuperscript{49} \textit{Coray}, 423 Pa. at --, 223 A.2d at 674.

\textsuperscript{50} A group of cases in the 1950s constituted the first contemporary informed consent cases. \textit{See}, e.g., \textit{Salgo}, 754 Cal. App. 2d at --, 317 P.2d at 171 (holding that a physician had a duty to disclose facts sufficient for a patient to form an \textit{intelligent consent}); Bang v. Charles T. Miller Hosp., 251 Minn. 427, --, 88 N.W.2d 186, 186 (1958) (reinforcing the physician's affirmative duty of disclosure); Hunt v. Bradshaw, 242 N.C. 517, --, 88 S.E.2d 762, 766 (1955) (stating that failure to explain the risks involved in surgery "may be considered a mistake on the part of the surgeon").
NEGLIGENCE

By the mid-1950s, the courts had shifted their focus from whether the patient gave consent to whether adequate information was given for the patient to have made an informed consent. Thus, the quantity of information provided to the patient in making decisions regarding medical treatment was given greater scrutiny and the physician's duty to disclose assumed a primary role.

One of the first cases to address the physician's duty to disclose by adopting the term "informed consent" was Salgo v. Leland Stanford Jr. University Board of Trustees. In this case, a patient who had undergone thoracic aortography suffered paralysis of the legs, a rare complication of that procedure. Although Salgo held that the physician was under a duty to disclose, the extent of that duty was unclear from the court's holding that "the physician has... discretion [to withhold alarming information from the patient] consistent, of course, with the full disclosure of facts necessary to an informed consent." The central question was what constituted "full disclosure" sufficient for the patient to make an informed consent.

In 1960, two cases were decided which attempted to provide answers to this question. In both Natanson v. Kline, and Mitchell v.
the courts held that the central information needed in making an informed consent was a disclosure of the material risks involved in a medical procedure.

In Mitchell, the patient suffered fractures of several vertebrae following insulin shock and electroshock therapy for schizophrenia. Although consent to treatment had been obtained, the plaintiff claimed the physician had breached his duty of disclosure by failing to inform him of the risks of the treatment. The court held that the physician had a duty "to inform [the patient] generally of the possible serious collateral hazards."

In Natanson, the patient, who had suffered thoracic burns from radiation therapy following a mastectomy, also claimed that the physician had breached his duty to disclose by not informing her of the dangers of the treatment. The Kansas Supreme Court's landmark decision held that the physician's duty extended beyond simply a disclosure of risks by holding that the duty required "a reasonable disclosure to the patient of the nature and probable consequences of the suggested or recommended . . . treatment, and . . . a reasonable disclosure of the dangers within his knowledge which were incident to, or possible in, the treatment he proposed to administer."

Natanson went further than Mitchell by requiring, in addition to risk information, disclosure of the ailment, the nature of the proposed treatment, the probability of success, and possible alternative treatments. These requirements are now the bedrock elements of in-
formation required in informed consent cases and statutes.65

Although Natanson was a cornerstone decision in the modern law of informed consent, and while it is read as clarifying the standards for the information which needs to be disclosed, its usefulness is blurred because of conflicting norms which can be found within the pages of the two Natanson opinions66 and because of the searing criticism to which they have been subjected.67

APPLICATION OF FIDUCIARY PRINCIPLES

Some courts have recognized an underlying conflict of interests between the physician, who may wish to withhold potentially damaging information, and the patient who claims that disclosure of such information is essential to exercising the right of self-determination. These courts have analyzed issues of disclosure under general principles of fiduciary duty and have imposed special responsibilities to regulate a relationship marked by dependency and disparity of power.68

A fiduciary analysis of the physician/patient relationship is based on the premise that the physician occupies a position of trust and is thus relied upon by the patient for information regarding his or her medical condition.69

A fiduciary duty to disclose requires that all information which might be material to the patient be revealed.70 Unlike the traditional battery or negligence-based informed consent doctrines, the fiduciary duty has no limitations based on time or stage of treatment and is

67. See Comment, Informed Consent in Medical Malpractice, 55 Calif. L. Rev. 1396, 1400-01 (1967). The Natanson court offered four different standards of disclosure: substantial disclosure, and full disclosure. Natanson, 186 Kan. at —, 350 P.2d at 1103, 1107. On rehearing reasonable disclosure and no disclosure were discussed. Natanson, 187 Kan. at —, 354 P.2d at 673. Three years later, the Kansas court ended the confusion by settling on one standard, requiring disclosure "which a reasonable medical practitioner would make under the same or similar circumstances." Williams, 191 Kan. at —, 379 P.2d at 294 (citing Natanson, 186 Kan. 393, 350 P.2d 1093).
68. See Frankel, Fiduciary Law, 71 Calif. L. Rev. 795 (1983) (emphasizing control of discretionary and unequal power as a common theme in fiduciary law).
69. See LeBlang & King, 89 Dick. L. Rev. at 6. In ensuring individual autonomy, the courts focus on bodily integrity and respect for independence of choice. Id.
70. See Nixdorf v. Hicken, 612 P.2d 345, 354 (Utah 1980) (holding the physician's duty to disclose applies to material information). Material information is defined as information that "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to . . . in deciding whether or not to undergo the proposed therapy." Waltz & Scheuneman, Informed Consent to Therapy, 64 NW. U.L. Rev. 628, 640 (1970).
triggered by a general criterion of possession of information.\textsuperscript{71}

One of the first cases to articulate a fiduciary standard of disclosure was \textit{Gates v. Jensen}.\textsuperscript{72} In that case, the Supreme Court of Washington recognized the fiduciary relationship and individual autonomy as rationales for a duty to disclose, stating: "[the] physician has a fiduciary duty to inform a patient of abnormalities in his or her body."\textsuperscript{73} In \textit{Gates}, the patient, who had gone for an eye examination, was not informed by the physician that high pressure found in both of her eyes put her in a borderline glaucoma risk classification and that this risk was increased by her myopia. Because the physician failed to disclose these facts, the patient was unable to make an informed choice about treatments which could have prevented a great part of her blindness. The court held that the physician had breached the duty of disclosure and stated:

The patient's right to know is not confined to the choice of treatment once a disease is present and has been conclusively diagnosed. Important decisions must frequently be made in many non-treatment situations in which medical care is given, including procedures leading to a diagnosis . . . These decisions must all be taken with the full knowledge and participation of the patient. The physician's duty is to tell the patient what he or she needs to know in order to make them.\textsuperscript{74}

The fiduciary duty was elaborated on by the United States Court of Appeals for the Fifth Circuit in \textit{Nardone v. Reynolds}.\textsuperscript{75} In \textit{Nardone}, a thirteen-year-old patient underwent four brain operations and various diagnostic procedures, including insertion of a ventriculoatrial shunt into his brain.\textsuperscript{76} Following this operation, the boy's difficulty with coordination, blurred vision, dyplopia, and headaches improved.

When the physicians later performed a pantopaque ventriculogram,\textsuperscript{77} some of the dye entered the shunt tube, rendering it non-functional. The patient's condition worsened and the child later became comatose, totally blind, and suffered irreversible brain damage. The physicians failed to disclose to the patient or his parents

\textsuperscript{71} See Schultz, 95 \textsc{Yale L.J.} at 261.
\textsuperscript{72} 92 Wash. 2d 246, —, 595 P.2d 919, 922 (1979).
\textsuperscript{73} \textit{Id.} at —, 595 P.2d at 922.
\textsuperscript{74} \textit{Id.} at —, 595 P.2d at 922-23.
\textsuperscript{75} 538 F.2d 1131 (5th Cir. 1976).
\textsuperscript{76} A ventriculoatrial shunt was installed to replace another tube designed to permit the flow of spinal fluid between the ventricles of the brain into the right side of the patient's head. \textit{Id.} at 1134.
\textsuperscript{77} A pantopaque ventriculogram is a diagnostic procedure in which dye is introduced into the ventricles of the brain. \textit{Id.}
that the pantopaque ventriculogram had been performed and that it was the possible cause of the boy's deterioration. The court in Nardone held that the doctor/patient relationship was fiduciary in nature and that, therefore, the physician was under a duty to disclose any adverse conditions: "[The fiduciary, confidential relationship of physician-patient] imposes on the physician a duty to disclose... known facts." Although the Nardone and Gates courts based the physician's duty to disclose on the fiduciary nature of the physician/patient relationship, the Nardone court went further by holding that this duty did not expire when the physician/patient relationship ended, nor was a direct relationship needed between the physician and patient. The duty to disclose was based in part on the nature of the relationship and in part on the physician's knowledge of the patient's condition.

In addition to requiring disclosure of adverse information regarding a patient's condition or treatment, in recent years the physician has been required to disclose test results, as well as their availability and end value.

One case which was significant for defining the scope of the physician's duty in this area was Truman v. Thomas. In Truman, a patient died of cervical cancer after failing to undergo a pap smear. The California Supreme Court found that a physician may breach his duty of care by failing to inform a patient of the potentially fatal consequences of allowing cervical cancer to develop undetected by a diagnostic test. The court held that the physician's duty to disclose was

78. Id. at 1135.
79. Id. at 1136. The disclosure obligation of a physician has also been extended to a spouse or next of kin. See, e.g., Wohlgemuth v. Meyer, 139 Cal. App. 2d 326, 293 P.2d 816, 820 (1956) (noting that "In the event of the death of the patient while under the care of the doctor and the hospital, the spouse has a right to know the cause of death"). See also Emmett v. Eastern Dispensary & Casualty Hosp., 396 F.2d 931, 935 (D.C. Cir. 1967) (holding that the hospital had a duty to disclose to deceased patient's son the contents of the decedent's medical records).
80. The requirement to disclose test results is an established legal responsibility. See Annotation, Delay in Telling Patient Outcome of Test, 49 A.L.R.3d 501, 504 (1973). This duty has been applied by courts in holding that a reasonable attempt be made to notify a patient of any abnormalities revealed by a test. See, e.g., Keene v. Methodist Hosp., 324 F. Supp. 233, 234-35 (N.D. Ind. 1971) (finding hospital liable for failing to communicate results of X-rays which indicated skull fracture); Phillips v. Good Samaritan Hosp., 65 Ohio App. 2d 112,-, 416 N.E.2d 646, 647-48 (1979) (finding radiologist liable for failing to disclose that X-ray revealed fracture).
81. 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (holding that a physician was required to disclose all relevant information to allow the patient, in regard to diagnostic tests, to make an informed decision whether to submit to or refuse such tests which could detect illnesses leading to death or serious complication). But see, Truman, 27 Cal. 3d at 298-302, 611 P.2d at 909-10, 165 Cal. Rptr. at 315-17 (Clark, J., dissenting) (stating that this comprehensive disclosure placed an undue burden upon the physician).
necessary so that patients might make intelligent and informed decisions about their own bodies.\textsuperscript{82}

The fiduciary principles have even been extended to the hospital-patient relationship in some cases,\textsuperscript{83} while others have absolved hospitals of liability.\textsuperscript{84} A focus of this latter analysis may be whether the physician providing care is an employee of the hospital, or whether he or she is an independent contractor.

**Analysis Under Contract Principles**

Some courts have analyzed the physician’s duty to protect a patient’s interest in medical choice under theories of contract. These courts emphasize the definiteness of the doctor’s promise and the need to vindicate patient expectations.\textsuperscript{85} Under this analysis, the patient is seen as having contracted for maximum disclosure and choice and “where no explicit term is agreed to, patient control of decision-making should be the term implied into the contract.”\textsuperscript{86} Thus, the doctor’s failure to give material information deprives the patient of his or her expectation.

Other courts applying contract principles view the patient’s consent as a contract for a specific procedure to be performed. Therefore, the surgeon may not digress from what was contracted to be done. Any deviation from what the patient consented to would be the basis for an action for breach of contract.\textsuperscript{87}

\textsuperscript{82} Id. at 292-93, 611 P.2d at 905, 165 Cal. Rptr. at 312.

\textsuperscript{83} See, e.g., Magana v. Elie, 108 Ill. App.3d 1028, ---, 439 N.E.2d 1319, 1322 (1982) (holding that it was a factual issue whether the hospital should have required physicians to inform patients of the risks of proposed procedures, in order to conform with its duty to act reasonably in light of apparent risks to its patients).

\textsuperscript{84} See Pickle v. Curns, 106 Ill. App. 3d 734, ---, 435 N.E.2d 877, 881 (1982) (stating, “We do not recognize the existence of a duty on the part of the hospital’s administration to insure that each of its staff physicians will always perform his duty of due care to his patient.”); Pauscher v. Iowa Methodist Medical Center, 408 N.W.2d 355, 357, 362 (Iowa 1987) (holding that the hospital did not have a duty to inform patient with urinary tract problem that intravenous pyelogram resulted in 1/100,000 chance of death); Fiorentino v. Wenger, 19 N.Y.2d 407, 411, 227 N.E.2d 296, 297, 280 N.Y.S.2d 373, 375 (1967) (reversing a verdict against a private proprietary hospital that plaintiff’s son had been subjected to an unusual, dangerous operation by a private surgeon without informed consent. The court held that the physician was an “independent contractor,” and refused to enlarge the liability of the hospital to include ensuring that its physician had obtained informed consent).


\textsuperscript{86} Shultz, 95 YALE L.J. at 282.

\textsuperscript{87} See Powell, Consent to Operative Procedures, 21 Md. L. Rev. 189, 191 (1961). Damages for breach of contract were awarded in Sullivan v. O’Connor, 363 Mass. 579, 296 N.E.2d 183 (1973) (allowing patient to recover under breach of contract for unsatisfactory plastic surgery on nose); Guilmet, 385 Mich. 57, 188 N.W.2d 601 (allowing pa-
While some courts apply a contract analysis, many are skeptical about applying these principles, holding that medical science is too uncertain and the physical and psychological makeup of individual patients too varied for doctors to promise specific results.88

The courts adopting a contract analysis are careful to distinguish between an optimistic or encouraging statement made by the physician and a firm promise. These courts will also require clear proof that a promise was made.89

STANDARDS OF DISCLOSURE

THE PROFESSIONAL COMMUNITY STANDARD

Although Natanson v. Kline90 did much to clarify modern informed consent doctrine, establishing the type of information to be disclosed was only the tip of the iceberg. Two questions still remained: how much information was the physician required to disclose and by what standard should this requirement be measured?91

88. Although the court in Sullivan held that the doctor had breached the contract, the court went on to state:

Considering the uncertainties of medical science and the variations in the physical and psychological conditions of individual patients, doctors can seldom in good faith promise specific results. Therefore it is unlikely that physicians of even average integrity will in fact make such promises. Statements of opinion by the physician with some optimistic coloring are a different thing .... But patients may transform such statements into firm promises in their own minds ....

Id. at —, 296 N.E.2d at 186.

89. Following the Michigan Supreme Court's judgment for damages for breach of contract in Guilmet (in which, according to the patient's testimony, the surgeon had said before the operation, "After this operation, you can throw your pillbox away," "No, there is no danger at all in this operation," and "Once you have an operation, it takes care of all your troubles." Guilment, at —, 188 N.W.2d at 603-04.) the Michigan legislature in 1974 enacted a statute providing that an "agreement, promise, contract, or warranty of cure relating to medical care or treatment" is void unless evidenced by a signed writing. Mich. Comp. Laws Ann. § 566-132(g) (West Supp. 1990).


91. In the 1950s and 1960s, the courts held that the degree of disclosure made to patients was a question of medical judgment and adopted a "professional standard": "The duty of the physician to disclose . . . is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances." Natanson at —, 350 P.2d at 1106. However, problems inherent in the professional standard eventually became apparent: (1) there was no uniform custom in the medical profession to disclose information to patients, (2) where some custom exists, the quantity of information to be disclosed may be too little for the patient to make an informed decision, and (3) under the professional standard, the patient's obligation to obtain expert witnesses may present difficulties. It was because of these difficulties and a new respect for patient choice in medical decision-making that the courts started to adopt patient-oriented standards. As the court stated in Canterbury v. Spence, 464 F.2d 772
The Natanson court, and its articulation of a "reasonable physician" standard, provided a starting point for addressing the issue of what constituted adequacy of disclosure:

The duty of the physician to disclose . . . is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. . . . [It is] primarily a question of medical judgment. So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.92

What is required then is not total disclosure but reasonable disclosure.93

The professional community standard espoused the view that the physician, being highly trained and experienced in complex medical matters, was in a position to know what was best for the patient.94 This theory reflected the high esteem in which physicians were generally held and was consistent with the way that other medical malpractice questions were decided.95

Because the physician's duty of disclosure was defined by the standard of the medical community, a patient claiming a breach of the duty was required to produce expert medical testimony as to

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93. According to Natanson, reasonable disclosure requires the doctor to use simple language in explaining the necessary information to the patient. Reasonable disclosure does not mean that the patient must be informed of all the risks of the procedure, but only of those within the knowledge of the physician. See Natanson, 186 Kan. at —, 350 P.2d at 1106. As one author states: "The courts have trotted out the tired and weary old creature of tort law, the reasonable man, and asked him to stand guard around the citadel of negligence, lest the walls come crumbling down completely." Meisel, The Expansion of Liability For Medical Accidents: From Negligence to Strict Liability By Way of Informed Consent, 56 Neb. L. Rev. 51, 88 (1977).

94. This view reflects the paternalistic attitude that "doctor knows best." As one commentator observed, the wide-spread acceptance of the professional standard of disclosure "reveals the enormous deference paid by courts to the medical community's definition of its responsibilities, and the relatively low value they have placed upon the autonomy of the patient." Riskin, Informed Consent: Looking for the Action, 1975 U. Ill. L. F. 580, 586. See also Katz, Informed Consent — A Fairy Tale?, 39 U. Pitt. L. Rev. 137, 140 (1977) (stating that medical law in the United States is "institutionalized paternalism").

what the standard practice would be in such a case and how the physician had deviated from such practice.96

The fulfillment of this requirement often precluded a finding of liability not only because of the difficulty in obtaining expert testimony, and breaking through the medical community's so-called "conspiracy of silence,"97 but also because there was no real community standard of disclosure. Establishing community custom through expert testimony is perfectly acceptable where such custom exists.98 However, because a physician supposedly considers his patient's emotional, mental, and physical condition in deciding whether to disclose,99 and because each patient is mentally and emotionally unique, there can be no single established custom concerning disclosure; if there is one, it is so general that it is of little value.100 Requiring the plaintiff to present expert testimony that a standard does exist and was breached may well impose an insuperable burden.101

96. The requirement for expert testimony was suggested in the first Natanson opinion, but was expressly stated in the court's later opinion denying the motion for rehearing, in which the court held that expert testimony was required to establish whether the disclosures made were "in accordance with those which a reasonable medical practitioner would make in the same or similar circumstances." Natanson v. Kline, 187 Kan. 186, —, 354 P.2d 670, 673 (1960).

97. In Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957), the court criticized the physician-oriented standard of disclosure because of the burden it placed on plaintiffs to overcome a conspiracy of silence among members of the medical professions. Id. at —, 317 P.2d at 175. See also Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw. U.L. Rev. 628, 637 (1970).

98. As the court stated in Canterbury, it was not certain whether there was "any discernible custom reflecting a professional concensus [sic] on communication of option and risk information to patients..." Canterbury, 464 F.2d at 783. Subsequently, in Wilkinson v. Vesey, 110 R.I. 606, —, 295 A.2d 676 (1972), the court held the view that since disclosure in a particular case depends substantially upon the facts of that case — facts not known to the medical profession generally — there can be no professional standard of disclosure. Id. at —, 295 A.2d at 676. See also Scaris v. St. Paul Fire & Marine Ins. Co., 68 Wis. 2d 1, 227 N.W.2d 647 (1974) (recognizing that disclosure is not a matter of medical custom and that the applicable standard is within the province of a jury).

99. The need to consider a patient's psychological and emotional well-being was considered by the Canterbury court. The court explained that an exception to disclosure existed when disclosure of risks would be detrimental to the patient, as when disclosure would cause the patient to become ill or so emotionally distraught as to preclude making a rational decision, complicating treatment, or inducing psychological damage to the patient. The court stated that the central question the doctor must ask is, would disclosure of the risks threaten the patient's well-being? Canterbury, 464 F.2d at 789.

100. See Recent Case, 75 Harv. L. Rev. 1445, 1447 (1962). See also Waltz & Schueneman, 64 Nw. U.L. Rev. at 636-37 (stating that "it has been questioned whether there in fact exists any discernable professional standard").

101. The plaintiff's primary difficulty in obtaining an expert witness was the unwillingness of physicians to testify against other physicians. In large part, this "conspiracy of silence" is fostered by the attitude of the medical profession toward malpractice actions. See Committee on Medicolegal Problems, Professional Liability and the Physician, 183 J. A.M.A. 695, 703 (1963).
By the early 1970s, the courts and legislatures recognized that the professional community standard of disclosure was inconsistent with patients' rights to make their own health care decisions. A new standard evolved which required physicians to disclose all of the information that a reasonably prudent patient would consider material to the decision whether to accept treatment.102

THE REASONABLE PATIENT STANDARD

The reasonable patient standard focused on the informational needs of an average, reasonable patient, rather than on professionally-established norms.103 This standard required the doctor to disclose all material risks incident to the proposed therapy in order to secure an informed consent.104

The United States Court of Appeals for the District of Columbia Circuit was the first to articulate a patient-oriented standard of disclosure in Canterbury v. Spence,105 a 1972 landmark case. In that case, the patient sought damages for injuries sustained as a result of a negligently performed laminectomy and claimed that the physician had not disclosed the risks of serious disability inherent in the operation. The court held that the physician's duty to disclose stemmed from three considerations: First, every human being has a right to

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102. The reasonably prudent patient standard required that disclosure and causation be measured by the standard of the reasonably prudent person, not the particular patient, although facts about a particular patient-plaintiff were relevant. In the influential article by Waltz and Schueneman, 64 NW. U.L. REV. at 644-45, the authors suggested that to impose a subjective standard would be too burdensome on physicians and too uncertain for jurors. In adopting the patient-oriented standard, most courts framed their rules in terms of "the patient's need to know;" only two courts explicitly adopted a subjective standard: the North Carolina Supreme Court in McPherson v. Ellis, 305 N.C. 266, 287 S.E.2d 892 (1982); and the Oklahoma Supreme Court in Scott v. Bradford, 606 P.2d 554 (Okla. 1979). See J. AREEN, P. KING, S. GOLDBERG & A. CAPRON, LAW, SCIENCE AND MEDICINE 385 n.5 (1984).

103. The patient-oriented standard was framed in terms of information material to the decision-making process of the reasonable man with the underlying rationale being that the informed consent doctrine was designed to permit the patient to exercise choice concerning his or her own medical treatment and the risks to which they were willing to subject themselves. See P. APPELBAUM, C. LIDZ & A. MEISEL, INFORMED CONSENT, LEGAL THEORY AND CLINICAL PRACTICE 44 (1987); Meisel, 56 Neb. L. Rev. 51 (1977).

104. Material risks were defined by Waltz and Scheuneman: "A risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy." Waltz & Scheuneman, 64 NW. U.L. REV. at 640.

determine his or her own course of medical treatment. Second, real consent requires the informed exercise of choice, which in turn requires an opportunity to evaluate the options available and the risks associated with each. Third, the average patient has little understanding of medicine, and can only turn to a physician for advice.106

The Canterbury court went further by holding that protection of a patient's right of self-determination demanded a standard set by law, rather than by the medical community:

[The test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked.]

... [a] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.107

Adequate disclosure under a reasonable patient standard required the physician to discuss the nature of the proposed treatment, whether it was necessary or merely elective, the risks, and the available alternatives and their risks and benefits.108 Thus, the reasonable patient standard included more information than a professional community standard, but did not require the doctor to tell the patient all information about risks, benefits, alternatives, diagnosis, and the nature of the treatment. To do so would require the patient first to

106. Canterbury, 464 F.2d at 780.


108. In Truman v. Thomas, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) the scope of disclosure was extended to include the material risks of not consenting to a recommended test. There, the Supreme Court of California held that a physician may breach his duty of care to his patient by failing "to inform her of the potentially fatal consequences of allowing cervical cancer to develop undetected by a pap smear." Id. at 290, 611 P.2d at 905, 165 Cal. Rptr. at 311. The court quoted from its prior decision in Cabbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) in which it had stated that a patient should be informed not only of the "risks inherent in the procedure [prescribed, but also] the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment." Id. at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.
undergo complete medical training himself.  

"[T]he patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required . . . ."  

Under this standard of disclosure, the physician is faced with the difficult tasks of deciding which risks are necessary for disclosure and informing a patient of only those risks needed to give an intelligent consent. If a physician discloses risks to an excessive degree, he faces the possibility of frightening the patient away from a potentially beneficial treatment. Alternatively, he can do what he thinks is best for the patient without disclosing the risk, in which case he is then liable for resulting injury. Although some patients would prefer to entrust themselves to their doctor's best judgment,
not all patients may feel that way, and the wise physician would likely proceed on the assumption that a patient would want to know all material risks, unless, in response to an offer of disclosure, he declines and defers to his physician's judgment.

EXCEPTIONS TO DISCLOSURE

"Over the years, courts have come to recognize that there are a number of situations in which physicians are permitted to render treatment without patients' informed consent." For instance, "the law does not require that informed consent be obtained when doing so would seriously jeopardize the well-being of a patient, that is, when health values take precedence over the value of individual choice." Exceptions to the requirements for informed consent — therapeutic privilege, waiver, and emergency — are discussed in the following section.

THERAPEUTIC PRIVILEGE

Under certain circumstances, a patient's consent to treatment will still be considered valid when less than full disclosure has occurred if full disclosure would have had a deleterious effect upon the patient's emotional condition. Under these circumstances, the physician is said to have a "therapeutic privilege" to withhold information from the patient. The concept was best stated in Canyon v.

not to be told anything about their condition or procedures for treating it. Courts have acknowledged that a patient may elect "to know nothing and instead to rely completely upon the physician," even to the point of being "free to unwittingly act in the dark ...." Henderson v. Milobycki, 595 F.2d 654, 656 n.8 (D.C. Cir. 1978) (quoting Canyon, 464 F.2d at 784). See also Putensen, 12 Cal. App. 3d at 1069, 91 Cal. Rptr. at 323 (involving a patient who told physician she preferred not to know about proposed operation); J. Areen, P. King, S. Goldberg & A. Capron, supra note 102, at 459 n.1.


117. See P. Appelbaum, C. Lidz & A. Meisel, supra note 115, at 72-78. Several good discussions of the privilege exist. See Waltz & Scheuneman, INFORMED CONSENT TO THERAPY, 64 NW. U.L. REV. 628, at 641-43; LeBlang & King, TIGHT LIABILITY FOR NON-DISCLOSURE: THE PHYSICIAN'S LEGAL OBLIGATIONS TO DISCLOSE PATIENT ILLNESS AND INJURY, 89 DICK. L. REV. 1, 46-47 (1984). An interesting fact concerning exercise of the therapeutic privilege was revealed by the PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS (1982), reprinted in J. Areen, P. King, S. Goldberg & A. Capron, LAW, SCIENCE AND MEDICINE 287 (1984). In the Commission's survey, it was reported that, despite reports of patients who committed suicide, suffered heart attacks, or plunged into prolonged depression upon being told "bad news," there was little proof that this frequently happened. When physicians were questioned about their
The second exception [to the requirement of disclosure] obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. Where it is so, the cases have generally held that the physician is armed with a privilege to keep the information from the patient, and we think it clear that portents of that type may justify the physician in action he deems medically warranted. The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to patients' well-being.\textsuperscript{119}

Recognition of a therapeutic privilege to withhold information from a patient presented the potential for undermining the patient's right to self-determination and rational decision-making — the very values that the informed consent doctrine sought to preserve. Thus, the \textit{Canterbury} court cautioned:

The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs.\textsuperscript{120}

While the discussion of the privilege in \textit{Canterbury} is framed primarily in terms of relieving physicians of the duty to disclose risk information,\textsuperscript{121} there is the implication that a physician is still obligated to disclose other relevant information about purpose, benefits, or alternatives, unless such disclosure would substantially interfere with a patient's decision-making capacity. Thus, the careful circumscription of the privilege articulated by the \textit{Canterbury} court would still require disclosure of all relevant information, within limits.

Other courts have given the therapeutic privilege doctrine a

\begin{itemize}
  \item \textsuperscript{119} \textit{id.} at 789.
  \item \textsuperscript{120} \textit{id.}
  \item \textsuperscript{121} In \textit{Canterbury} the privilege was said to operate only "where the patient's reaction to risk information, as reasonabl[y] foreseen by the physician, is menacing." \textit{id.}
\end{itemize}
broad definition. In *Nishi v. Hartwell*, for example, the physician was given substantial latitude in withholding information as the court emphasized the value of patients' health, almost to the exclusion of the right to choose:

the doctrine [of informed consent] recognizes that the primary duty of a physician is to do what is best for his patient . . . a physician may withhold disclosure of information regarding any untoward consequences of a treatment where full disclosure will be detrimental to the patient's total care and best interest.

The *Nishi* court's interpretation of the privilege, carried to its extreme, embodied the paternalistic notion of "doctor knows best," permitting the substitution of the physician's judgment for the patient's.

Despite the fact that therapeutic privilege may be given a broad interpretation, there is some evidence that courts may, nevertheless, closely scrutinize a physician's invocation of the privilege as a defense. Therefore, in those courts applying a patient-based standard for disclosure, a physician would be well advised not to rely upon a defense of therapeutic privilege unless the fact that disclosure of information would have harmed a patient is well documented.

This conclusion is reached by recognizing that it is too easy to claim, after the fact, that a patient was distraught.

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123. In recognizing that the privilege might "devour the disclosure rule itself," the *Canterbury* court cautioned against the privilege being framed so broadly:

The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude . . . runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.

*Canterbury*, 464 F.2d at 789.


125. *But see* Smith, *Therapeutic Privilege To Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness*, 19 TENN. L. REV. 349, 351 (1946) (stating that the existence of a therapeutic privilege to withhold information from a patient presumes an affirmative obligation of disclosure).


127. A hospital legal manual suggests:

To document a patient's high susceptibility to anxiety, confirmation of the doctor's observation by another medical person and/or a relative or close friend of the patient should be sought and entered on the patient's treatment record. If called upon to defend withholding of information in a legal action, the provider must prove not only the factual element of the patient's sensitivity but also that other practitioners would have done the same under the circumstances involved.


128. *Id.*
 Whether therapeutic privilege is given a narrow reading, preserving patient autonomy, or a broad reading, providing maximum physician decision-making, as it is currently conceived, the privilege overlooks the possibility that if patients were asked to make a prospective determination, they might waive their right to disclosure.

WAIVER

Waiver shifts the responsibility for halting harmful disclosure to patients, keeping them, not their physicians, in control of their right of self-determination.\textsuperscript{129} Because the patient remains the decision-maker, a waiver, if properly given, is in keeping with the values sought to be promoted by informed consent.\textsuperscript{130} In the case of informed consent, patients decide about treatment; in the case of waiver, some patients may recognize their own inability to deal with stress-provoking information and request that they do not want information, or that they would prefer that someone else decide, or both.\textsuperscript{131}

Because a waiver is defined as a "voluntary and intentional relinquishment of a known right,"\textsuperscript{132}

[in order for patients to waive their right to render informed consent, they must know that they have that right. [Thus, the patient] must know that (1) physicians have a duty to disclose information to them about treatment, (2) they have a legal right to make decisions about treatment, (3) physicians cannot render treatment without their consent, and (4) the right of decision includes a right to consent to or refuse treatment.\textsuperscript{133}

Therefore, if a patient expresses a desire not to participate in the decision-making process, a conditional obligation ought to arise for the physician to inform patients of their right to waive.\textsuperscript{134} “When patients demonstrate a desire to relinquish their rights, physicians should be obligated to ascertain whether they know that they are relinquishing a right, not merely a grace bestowed on them by

\textsuperscript{129} P. Appebaum, C. Lidz & A. Meisel, supra note 115, at 69-72.
\textsuperscript{130} See Meisel, The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking, 1979 Wis. L. Rev. 413, 453-460. The author stated that the impact of the waiver exception is that if a waiver is properly obtained “[t]he patient remains the ultimate decisionmaker, but the content of his decision is shifted from the decisional level to the metadecisional level — from the equivalent of ‘I want this treatment (or that treatment or no treatment)’ to ‘I don’t want any information about the treatment.’” Id. at 459.
\textsuperscript{131} See supra note 115 and accompanying text.
\textsuperscript{133} P. Appebaum, C. Lidz & A. Meisel, supra note 115, at 70.
\textsuperscript{134} Id.
physicians.”

EMERGENCY

A physician may give emergency medical treatment without a patient’s consent if the patient suffers an injury requiring immediate treatment and is incapacitated and unable to give an informed consent. The rationale underlying this rule is that since reasonable persons would consent to treatment in an emergency if they were able to do so, it is presumed that any particular patient would consent under the same circumstances.

Courts will also excuse inadequate disclosure when the risk is either known to the patient or is so obvious that knowledge can be presumed — for example, the risk of infection from surgery. Furthermore, physicians are usually not required to discuss risks inherent in common procedures when it is widely known that such risks rarely materialize, or when the physician does not know of the risk and could not have been aware of it in the exercise of ordinary care.

One of the difficulties inherent in the emergency doctrine lies in defining what the law considers to be an emergency and under what circumstances medical treatment may be rendered without consent. The widely accepted view is that an operation may be com-

135. Id. at 71.
136. See, e.g., Grosjean v. Spencer, 258 Iowa 685, —, 140 N.W.2d 139, 145 (1966); Bang v. Charles T. Miller Hosp., 251 Minn. 427, 88 N.W.2d 186, 190 (1958); Cunningham v. Yankton Clinic, P.A., 262 N.W.2d 508, 511 (S.D. 1978); Trogun v. Fruchtman, 58 Wis. 2d 596, —, 207 N.W.2d 297, 309-10 (1973). See also Brennan v. Parsonnet, 83 N.J.L. 20, 24-25, 93 A. 948, 950 (1912) (holding that a surgeon may operate or extend an operation without express consent if the condition of the patient presents an imminent danger to his life, limb, or health); King v. Carney, 85 Okla. 62, 204 P. 270, 272 (1922) (placing discretion in the surgeon in order to more adequately perform his duties for the benefit of the patient). See Powell, Consent to Operative Procedures, 21 MD. L. REV. 189, 193 (1961).


140. At the one extreme, an emergency has been found to exist when there was an immediate threat to life or limb. Cunningham, 262 N.W.2d at 511. At the other extreme, an emergency was found to exist merely when “suffering or pain [would] be alleviated” by treatment. Sullivan v. Montgomery, 155 Misc. 448, —, 279 N.Y.S. 375, 577 (City Ct. 1935).
menced or extended without first gaining express consent if conditions are such that they endanger the life or health of the patient.\textsuperscript{141} This view was first articulated in \textit{Mohr v. Williams}:\textsuperscript{142}

If a person should be injured to the extent of rendering him unconscious, and his injuries were of such a nature as to require prompt surgical attention, a physician called to attend him would be justified in applying such medical or surgical treatment as might reasonably be necessary for the preservation of his life or limb . . . .\textsuperscript{143}

Accordingly, the surgeon in \textit{Mohr}, who had been given consent to operate on the patient’s right ear, was found unjustified in operating on the patient’s left ear after discovering a serious, but not emergent, condition to exist in that ear.\textsuperscript{144}

**MODIFIED CONSENT AND THE EXTENSION DOCTRINE**

“As a general rule, a patient’s consent is limited to those procedures contemplated when consent is given.”\textsuperscript{145} However, there are times during the performance of the contemplated procedure, when the physician discovers a condition for which additional procedures are needed. At these times, the consent form executed by the patient is given a broader reading, holding that the patient has consented to the use of all reasonable steps to remedy the condition, although the method employed may differ from that anticipated.\textsuperscript{146} The theory that the physician may have broad latitude in choosing a particular approach and procedure is known as the extension doctrine and is based on the presumption that “no reasonable person would object if in a position to make a decision.”\textsuperscript{147}

\textsuperscript{141} See \textit{King}, 85 Okla. 62, 204 P. 270 (holding that a surgeon was justified in an emergency in removing ovaries and fallopian tubes of patient during an operation to cure a laceration of her womb). \textit{But see} Chambers v. Nottbaum, 96 So. 2d 716, 721 (Fla. Dist. Ct. App. 1957) (finding that no emergency existed in doctor’s administration of anesthetic to patient during appendectomy).

\textsuperscript{142} 95 Minn. 261, 104 N.W. 12 (1905).

\textsuperscript{143} \textit{ld.} at --, 104 N.W. at 15.

\textsuperscript{144} \textit{ld.}


\textsuperscript{146} See McGuire v. Rix, 118 Neb. 434, 225 N.W. 120, 123 (1929) (holding that consent to reduction of the patient’s fracture implied consent to an operation if manual methods failed). \textit{See} Rothe v. Hull, 352 Mo. 926, 930, 180 S.W.2d 7 (1944). \textit{But see} Catamer v. Hunter, 27 Ariz. App. 780, --, 558 P.2d 975, 979-80 (1976) (rejecting the physician’s claim that insertion of a hip prosthesis was a “lesser included” operation subsumed under patient’s authorization to hip replacement); Wells v. Van Nort, 100 Ohio St. 101, 125 N.E. 910 (1919) (holding the surgeon liable for removal of the patient’s ovaries and fallopian tubes when the patient had only given express consent for an appendectomy).

\textsuperscript{147} \textit{W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER & KEETON ON THE LAW OF TORTS} § 18, at 117-18 (5th ed. 1984).
Another exception to the requirement of consent occurs when circumstances make it unfeasible to consult with the patient or someone who can give consent on the patient's behalf, at the time that surgery must be performed. Such was the case in *Kennedy v. Parrott*.\(^{148}\) There, during the course of an appendectomy, the surgeon justifiably punctured some cysts which he discovered on the patient's ovaries, although he had no express authorization to do so. When this procedure later caused phlebitis requiring remedial surgery, the plaintiff sued, charging negligence and assault and battery arising from a lack of consent. The court concluded that there was no medical negligence and that there had been an implied consent to an extension of the operation beyond that originally contemplated and authorized. The court stated:

In such case the consent — in the absence of proof to the contrary — will be construed as general in nature and the surgeon may extend the operation to remedy any abnormal or diseased condition in the area of the original incision whenever he, in the exercise of his sound professional judgment, determines that correct surgical procedure dictates and requires such an extension of the operation originally contemplated. This rule applies when the patient is at the time incapable of giving consent, and no one with authority to consent for him is immediately available.

In short, where an internal operation is indicated, a surgeon may lawfully perform, and *it is his duty to perform*, such operation as good surgery demands, even when it means an extension of the operation further than was originally contemplated, and for so doing he is not to be held in damages for an unauthorized operation.\(^{149}\)

Thus, where there is a sound medical justification for extending the authorized surgery, a surgeon may lawfully perform an operation as good surgery demands and will not be held liable for an unauthorized operation.

**STANDARD METHODS FOR OBTAINING CONSENT**

The health care provider's quest for a single perfect solution to the informed consent puzzle is almost certainly doomed to failure.\(^{150}\)

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\(^{148}\) *243 N.C. 355, 90 S.E.2d 754* (1956). In contrast to *Kennedy*, the court in *Lloyd v. Kull*, *329 F.2d* 168 (7th Cir. 1964), found the physician liable for damages for unauthorized removal of an insignificant mole from a female patient's upper inside thigh while she was undergoing surgery for repair of a vesicovaginal fistula. *Id.* at 170. Whereas there was sound medical justification for extending the authorized surgery in *Kennedy*, no reason was found to exist in *Lloyd*.

\(^{149}\) *Kennedy*, *243 N.C.* at —, *90 S.E.2d* at 759 (emphasis added) (citations omitted).

\(^{150}\) See generally Jones, Autonomy and Informed Consent in Medical Decision-
There is, simply put, no single method by which a provider can be certain that he or she has anticipated every source of claim arising from the treatment of a human being.¹⁵¹

No form, no statute, no pamphlet¹⁵² alone can convey the information essential to patients generally and extract consent based on possession of material information relating to risks attendant upon the medical treatment.

And while there is simply no substitute for the interpersonal dialogue between a caring physician and an alert patient, even dialogue can fail as a route to informed consent.¹⁵³ This statement is rooted in the notion that the caring provider is also a wholly honest one as well and does not take into consideration the legal problems arising from a fraudulent misrepresentation to the patient¹⁵⁴ or a conceal-

¹⁵¹ Jones, 47 WASH. & LEE L. REV. at 408. Despite the physician's adequate disclosure of information and the patient's comprehension of that information, scenarios may still arise in which patients allege they were misinformed, their comprehension of the information was not adequately tested, the manner in which the material was disclosed caused them to forego treatment or caused them mental or emotional distress, or that physicians "allowed" them to make "wrong" decisions contrary to the physician's best medical judgment. Id.

¹⁵² Methods for obtaining informed consent vary widely among health care providers and the states. In addition to those states which have enacted statutes for obtaining informed consent (see infra note 162 and accompanying text), other states have used additional methods to convey essential information. See, e.g., Foard v. Jarman, 93 N.C. App. 515, —, 378 S.E.2d 571, 572 (1989) (involving a doctor who "gave [patient] a booklet on the procedure and the risks involved in the surgery and asked her to take it home and read it" before signing a consent form); Cary v. Arrowsmith, 777 S.W.2d 8, 11 (Tenn. Ct. App. 1989) (involving a doctor who showed patient a 35-minute informational lecture on video tape).


¹⁵⁴ See Smith v. Kurtzman, 176 Ill. App. 3d 840, —, 531 N.E.2d 885, 889 (1988) (stating that "the elements of a cause of action for intentional misrepresentation are: (a) a false statement of material fact; (2) made by a party who knows or believes the statement to be false; (3) with the intent to induce another to act; (4) action by the other in reliance on the statement's truth; and (5) injury to the other resulting from that reliance"). In Smith, the patient's testimony did not support his claim that he relied on the physician's alleged misrepresentations, causing delay of the second kidney transplant. Id. at —, 531 N.E.2d at 890. See also Hutton v. Craighead, 530 So. 2d 101, 105 (La. Ct. App. 1988) (holding that a written consent signed by patient which complied with statutory requirements was presumed valid absent "proof that execution of the form was induced by misrepresentation").
ment from the treated individual.\textsuperscript{155}

Law suits have been filed resulting from situations in which the claim is not that the doctor exceeded the treatment for which the patient consented, but rather that the doctor should have given the patient more information to the end that the consent would have been made with full appreciation of the risks and alternatives.\textsuperscript{156}

This section will deal with an analysis of the standard methods employed by care providers to inform and obtain consent. The methods include (1) compliance with statutory language; (2) use of forms in the treatment setting; and (3) use of pamphlets explaining risks of treatment.

But before this analytical task is undertaken, the reader should consider the core doctrine of modern informed consent, as outlined in the case of \textit{Canterbury v. Spence}.\textsuperscript{157}

First, material information regarding the proposed treatment must be communicated to the patient. The test generally adopted for this assessment of materiality is whether a reasonable person in what the physician knows or should know to be the patient's position would be likely to attach significance to the risks in deciding to accept or forego the proposed treatment.\textsuperscript{158}

\begin{footnotes}


\item[158] See Truman v. Thomas, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (recognizing that material information is that which a reasonable person would regard as significant when deciding to reject or accept treatment); Gordon v. Nelviser, 478 A.2d 292, 294 (D.C. 1984) (recognizing that a physician is not required to inform a patient of all possible consequences of an operation); Crain v. Allison, 443 A.2d 558, 562 (D.C. 1982) (adopting the \textit{Canterbury} rule that material information concerning the proposed treatment must be communicated to the patient); Precourt v. Frederick, 395 Mass. 689, —, 481 N.E.2d 1144, 1146, 1149 (1985) (holding physician not liable to disclose
\end{footnotes}
Second, once there has been a breach of duty to disclose, the plaintiff must demonstrate a causal relation between the physician's failure to disclose the material information and the injury sustained. The causal connection will be said to exist "when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it."

Third, the analysis should be undertaken by use of an objective test. That is, the question is not what this particular patient would have done if there had been adequate disclosure, but what a reasonably prudent person in the patient's position would have done if adequately informed. This third analytical step is different from the question whether the "professional standard of information" or the "patient standard" is to be disclosed to the patient.

**COMPLIANCE WITH STATUTES**

A number of states have enacted statutes designed to outline the elements which should be present in any written form which purports to convey the patient's consent to treatment. Iowa, for example, enacted such a law in 1975. It states:

A consent in writing to any medical or surgical procedure or course of procedures in patient care which meets the requirements of this section shall create a presumption that informed consent was given. A consent in writing meets the requirements of this section if it:

1. Sets forth in general terms the nature and purpose of the procedure or procedures, together with the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or negligible risks associated with a prescribed drug. *But see* Neal v. Lu, 365 Pa. Super. 464, 530 A.2d 103 (Pa. Super. 1987) (holding that a physician is liable to his or her patient for failing to disclose any risk in the proposed treatment, "or the existence of any alternative method of treatment").

159. *Canterbury,* 464 F.2d at 790.


163. IOWA CODE ANN. § 147.137 (West 1989).
figuring scars associated with such procedure or procedures, with the probability of each such risk if reasonably determinable.

2. Acknowledges that the disclosure of that information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

3. Is signed by the patient for whom the procedure is to be performed, or if the patient for any reason lacks legal capacity to consent, is signed by a person who has legal authority to consent on behalf of that patient in those circumstances.\textsuperscript{164}

Louisiana has adopted statutory language similar to that contained in the Iowa law, but has added to the presumption section that rebuttal may take place upon a showing of misrepresentation of material facts.\textsuperscript{165}

The Louisiana law contains another section disallowing the admission of evidence to modify or limit the authorization for performance of the procedure in the written form, and a section stating that where consent is obtained other than in the manner prescribed by statute, the explanation shall, nevertheless, be made and an opportunity given for asking and answering questions.\textsuperscript{166} In 1988 Louisiana amended its law to allow a non-consensual testing of body fluids for AIDS in certain limited circumstances.\textsuperscript{167}

Nebraska's less detailed provision (44-2816) simply states:

\textsuperscript{164} Id.

\textsuperscript{165} Id.

\textsuperscript{166} Id. at § 40.1299.40(B)-(C). Subsection (B) states: "Except as provided in Subsection A of this Section, no evidence shall be admissible to modify or limit the authorization for performance of the procedure or procedures set forth in such written consent." Subsection C states:

Where consent to medical treatment from a patient, or from a person authorized by law to consent to medical treatment for such patient, is secured other than in accordance with Subsection A above, the explanation to the patient or to the person consenting for such patient shall include the matters set forth in Paragraph (a) of Subsection A above, and an opportunity shall be afforded for asking questions concerning the procedures to be performed which shall be answered in a satisfactory manner.

\textsuperscript{167} Id. at § 40.1299.40(D)(1) which states:

Notwithstanding this Section or any other law to the contrary, whenever it is determined by the infection control committee or equivalent body that an agent or employee of a hospital, or a physician having privileges at the hospital, is exposed to the blood or bodily fluids of a patient, and when the exposure is of a type or in a manner sufficient to transmit the virus or other agent believed to cause acquired immune deficiency syndrome, then the hospital may, without the consent of the patient, conduct such tests on blood previously drawn as are necessary to determine whether the patient is, in fact, in-
Informed consent shall mean consent to a procedure based on information which would ordinarily be provided to the patient under like circumstances by health care providers engaged in a similar practice in the locality or in similar localities. Failure to obtain informed consent shall include failure to obtain any express or implied consent for any operation, treatment, or procedure in a case in which a reasonably prudent health care provider in the community or similar communities would have obtained an express or implied consent for such operation, treatment, or procedure under similar circumstances.\textsuperscript{168}

Hawaii has attempted to shift to the state Board of Medical Examiners the responsibility for developing a comprehensive classification of all illnesses and the risks attendant on them.\textsuperscript{169} These standards are to include provisions which are designed to reasonably inform and to be understandable by a patient or a patient’s guardian of the probable risks and effects of the proposed treatment or surgical procedure, and of the probable risks of not receiving the proposed treatment or surgical procedure.\textsuperscript{170}

\textsuperscript{168} NEB. REV. STAT. § 44-2816 (Reissue 1988) (adopting the “professional community” standard).

\textsuperscript{169} On June 1, 1976, Hawaii Revised Statutes, chapter 671, which deals with medical torts, became effective. Act 219, § 2, 1976 Haw. Sess. Laws. 523-533 directed the board of medical examiners . . . to specifically itemize the probable risks and effects of each specific treatment or surgical procedure. It made the resulting specific itemizations, if any, prima facie evidence of what the physician was required to disclose to the patient before obtaining the patient’s informed consent.

Act 223 (1983) asked the Board to establish specific standards for health care providers to follow in disclosing information to a patient before obtaining the patient’s informed consent.


1) The condition being treated;
2) The nature and character of the proposed treatment or surgical procedure;
3) The anticipated results;
4) The recognized possible alternative forms of treatment; and
5) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment or surgical procedure, and in the recognized possible alternative forms of treatment, including non-treatment. \textit{Id.}

\textsuperscript{170} HAW. REV. STAT. § 671-3(b) (1976) stated:

The board of medical examiners shall, insofar as practicable, establish reasonable standards of medical practice, applicable to specific treatment and surgical procedures, for the substantive content of the information required to be given and the manner in which it is given and in which consent is received in order to constitute informed consent from a patient or a patient’s guardian. . . . Probable risks of not receiving the proposed treatment . . . shall be prima facie evidence of the standards of care required but may be rebutted by either party.
That statutory scheme does not, however, comport with the judicially created duty to disclose "all collateral hazards,"171 and the Hawaii Court of Appeals remained puzzled whether the legislature's intent was to supplant the judge-made "ambiguously defined duty of disclosure."172

The Board of Medical Examiners informed the Health and Judiciary Committees of Hawaii that "the range of procedures subject to consent, numbering in the thousands, was so large that the Board found it impossible to develop standards for each procedure."173

As should be apparent from reading these sample statutory schemes, the problems of informed consent are not and cannot be resolved by statutes, even those as ambitious as Hawaii's.174

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171. See Nishi v. Hartwell, 52 Haw. 188, 191, —, —, 473 P.2d 116, 119, 121 (1970) (stating that, as part of the general standards of required disclosure, the physician was required to disclose (1) all collateral hazards that the physician knew of or should have known of, and (2) all risks of harm that a competent physician acting reasonably would have disclosed).

172. Leyson, 5 Haw. App. at —, 705 P.2d at 46. The court later noted that HRS § 671-3 (1976) modified the description of the general standards of disclosures announced in Nishi. Id. Under the legislature's standards, the physician was required to disclose all probable risks of harm that the physician knew or should have known about. Mroczkowski, 6 Haw. App. at —, 732 P.2d at 1258 (citing Act 219, § 2, 1976 Haw. Sess. Laws 523, 524). Subsequently, as of June 8, 1983 the physician was required to disclose all recognized serious possible risks of harm and complications that the physician knew of or should have known of, plus other information. Id. (citing Act 223, § 1, 1983 Haw. Sess. Laws 468, 469). This later standard, however, "[does] not answer the question whether the seriousness of the risk is to be answered from the point of view of the patient, the physician, or otherwise." Id. at —, 732 P.2d at 1258-59 n.1 (citing Note, Leyson v. Steuermann: Is there Plain Error in Hawaii's Doctrine of Informed Consent?, 8 U. Haw. L. Rev. 569, 590 (1986)).


174. At the other extreme, is the Nevada statute, which, by attempting to enumerate, in general terms, the standards of disclosure for the physician, may do more harm than good. Nev. Rev. Stat. 41A.110 (1987) states:

- a physician . . . has conclusively obtained the consent of a patient for a medical or surgical procedure if he has done the following:
  1. Explained to the patient in general terms without specific details, the procedure to be undertaken;
  2. Explained to the patient alternative methods of treatment, if any, and their general nature;
  3. Explained to the patient that there may be risks, together with the general nature and extent of the risks involved, without enumerating such risks; and
  4. Obtained the signature of the patient to a statement containing an explanation of the procedure, alternative methods of treatment and risks involved, as provided in this section.

174. Under Nev. Rev. Stat. 41A.120, a patient's consent will be implied if "1. In competent medical judgment the proposed medical or surgical procedure is reasonably necessary and any delay in performing such procedure could reasonably be expected to result in death, disfigurement, impairment of faculties, or serious bodily harm; and 2. A person authorized to consent is not readily available."
Louisiana discovered this when the case of Hondroulis v. Schumacher\textsuperscript{175} was finally decided. In Hondroulis, the patient sued the physician for failure to obtain informed consent inasmuch as the physician failed to disclose the specific complications the patient suffered as risks associated with the treatment, even though those complications were known risks.\textsuperscript{176}

When the case was first decided by the Louisiana Supreme Court, it held that a medical consent form tracking the statutory language had to specify only medically known, material risks and that the plaintiff failed to overcome the statutory presumption of consent, since she had, in fact, signed a consent form.\textsuperscript{177}

But on rehearing, the court focused on the Louisiana constitutional right of privacy\textsuperscript{178} in juxtaposition to the statute and reversed its previous decision.\textsuperscript{179} It held that the statute establishes a rebuttable presumption of consent to encounter risks described in the form, that providers must disclose known material risks that may foreseeably result in any of the consequences listed in the statute, and that a patient may overcome the statutory presumption of valid consent upon showing that the "consent was induced by misrepresentation."\textsuperscript{180}


\textsuperscript{176} Hondroulis, 546 So. 2d at 468.

\textsuperscript{177} \textit{Id.} at 471.

\textsuperscript{178} The court noted that "Art. I, Section 5 of the 1974 Louisiana Constitution expressly guarantee[d] that every person shall be secure in his person against unreasonable 'invasions of privacy.'" \textit{Id.} at 473. The court "conclude[d] that the Louisiana Constitution's right to privacy also provide[d] for a right to decide whether to obtain or reject medical treatment." \textit{Id.} The court noted, however, that "the [individual's] constitutionally protected right to . . . make medical treatment choices [did] not . . . automatically invalidate every state legislative regulation in this area" where such regulation might be justified by compelling state interests. \textit{Id.}

\textsuperscript{179} The court held:

By requiring the doctor to set forth the material risks "in general terms" the statute demands that he describe the main elements of each risk rather than limited details, but it does not permit him to "generalize" in the sense of making vague or indefinite statements that do not understandably communicate the specific material risks to the patient. Any other interpretation of the statute would frustrate rather than promote intelligent self determination by patients and thereby undermine the informed consent doctrine and the patient's right to privacy.

\textit{Id.} at 480.

\textsuperscript{180} \textit{Id.} at 475. The court held that:

under the statute, (1) if it is proved that the patient signed a document purporting to warn him of a risk involved in the proposed surgery or treatment, (2) it is presumed that the patient understood and consented to encounter whatever risk a reasonable person, in what the doctor knew or should have
The court emphasized that consent connotes both awareness and assent. Thus, for a reasonable patient to have awareness of a risk, "she should be told in lay language the nature and severity of the risk [as well as] the likelihood of its occurrence."181

The case, in sum, stands for the proposition that a provider has a duty to disclose all material risks, and not just those related to the narrower list of risks specified in the statute.182

The Louisiana court's finding of a right to privacy associated with the medical decision-making process is not a new phenomenon. In Natanson v. Kline183 a case in Kansas, for example, the court discussed the patient's right to receive information prior to making a medical care decision and held that it is based on "the premise of thorough-going self-determination," and the belief that "each man is considered to be the master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment," even though the doctor may disagree with the determination.185

Even if the dispute over the meaning of a state law is not of constitutional dimensions, a state appellate court can split over the central focus of the enacted law. That happened in Nebraska in the case of Smith v. Weaver,186 and while a bare majority of the court adopted one interpretation of the informed consent statute, three others disputed the central meaning of the law.187

Known to be the patient's position, would have apprehended from the written consent form, and (3) the patient cannot disprove the presumed fact except by showing that his consent was induced by misrepresentation.

Id.

181. Id. at 479. See also Waltz & Schueneman, Informed Consent to Therapy, 64 NW. U.L. REV. 628, 644 (1970).

182. See Note, 35 LOY. L. REV. at 1485.


185. Id. at —, 350 P.2d at 1104. See also, Jones, 47 WASH. & LEE L. REV. at 390.

186. 225 Neb. 569, 407 N.W.2d 174 (1987). In Smith, the patient claimed that the physician had a duty to warn of the possible side effects of a drug and that the physician's failure to do so rendered the consent to the treatment an uninformed one. Id. at 570, 407 N.W.2d at 176. See also Note, When Ignorance is Not Bliss — Informed Consent Law in Nebraska: Smith v. Weaver, 22 CREIGHTON L. REV. 429 (1989).

187. The majority of the court adopted the "professional" theory of informed consent as defined in NEB. REV. STAT. 44-2816. Smith, 225 Neb. at 574, 407 N.W.2d at 179. However, Krivosha, C.J., dissenting, declared that by adopting section 44-2820, Nebraska had committed to the "material risk" theory. White and Shanahan, JJ., joined in the dissent. Id. at 575-76, 407 N.W.2d at 179 (Krivosha, C.J., dissenting).
These examples illustrate only a few of the problems which reliance on a statute for solution of the informed consent conundrum can generate. Lurking behind any statutory scheme is the simple fact that absent both an irrebuttable presumption of validity and the total impossibility of any misrepresentation, constitutional constraints and semantic contortions may doom the legislatively enacted law to no better than any other human solution.

**FORMS**

As the aim of a statute is to outline the duties of the provider in informing the patient and in acknowledging the receipt of material information and acquiescence to treatment, so the aim of a form is to reduce that set of transactions to a fileable document.¹⁸⁸

As one authority has commented, "freedom from liability is still not assured unless consent can be proven if it is raised as an issue in court."¹⁸⁹ Spoken or implied consent, if proved, may satisfy the requirement of the law, but such may be difficult to prove.¹⁹⁰

The main purpose served by a written consent is that it provides the most direct, effective proof of a valid consent. Beyond that, a properly designed consent form, supported by appropriate procedures for its use, can serve as a checklist and a guide, facilitating the free interchange of information between doctor and patient that the law seeks to foster.¹⁹¹

The Joint Commission on Accreditation of Hospitals ("JCAH") requires evidence of informed consent in each medical record and mandates that health care providers seeking accreditation adopt policies on informed consent.¹⁹²

Robert D. Miller has reduced the types of consent forms to the

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¹⁸⁸ One writer in this area has noted:
Most hospitals require documentation of consent by the signature of the patient or the patient's representative on an appropriate form. If a proper form is signed by the appropriate person, most courts accept it as proof of consent unless the plaintiff can prove the form should be ignored because of special circumstances.


¹⁹⁰ See, e.g., Arballo v. Nielson, 73 Cal. App. 2d 545, —, 166 P.2d 621, 622 (1946) (holding that evidence of a semi-conscious oral consent could only be resolved by the trier of fact); Bang v. Charles T. Miller Hosp., 251 Minn. 427, —, 88 N.W.2d 186, 190 (1958). See also Kelly v. Gershkoff, 112 R.I. 507, —, 312 A.2d 211, 214-15 (1973) (holding that there was no evidence in the record to prove that members of the dental profession were required to reduce "to writing the information designed to inform the patient of the known risks").

¹⁹¹ II HOSPITAL LAW MANUAL, supra note 188, at 204.

¹⁹² The JCAH standards concerning medical records require "evidence of appropriate informed consent" for procedures or treatments for which informed consent is
following: "(1) blanket consent forms, (2) battery consent forms, and (3) detailed consent forms."\textsuperscript{183}

The first of these authorize any procedure the attending physician desires to undertake. However, these are held not to be evidence of consent to all procedures undertaken in a hospital setting for the very reason that the procedures are not specified.\textsuperscript{184}

The second, the battery forms, indicate that the person signing has been informed of the condition from which he or she is suffering and the consequences, risks, and alternatives to the proposed procedure.\textsuperscript{185} In addition, these forms note that all questions have been answered to the satisfaction of the patient and that no guarantees have been made.\textsuperscript{186} While these forms serve to negate a claim of simple battery, and may support an assertion that the patient was informed, questions may persist regarding whether all material issues

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\textsuperscript{185} See also W. Keeton, D. Dobbs, R. Keeton & D. Owen, Prosser & Keeton on the Law of Torts § 9, at 39 (discussing that the requisite elements of battery are met by showing the wrongdoer intended to inflict a harmful or offensive contact upon the body of the plaintiff).

\textsuperscript{186} Battery claims in which the patient alleges that the physician guaranteed a specific result frequently arise in cosmetic surgery cases. In these cases, a finding of no consent rests on whether a treatment is deemed to exceed a consent given to some different or lesser procedure. See, e.g., Lloyd v. Kull, 329 F.2d 168, 170 (7th Cir. 1964); Meretsky v. Ellenby, 370 So. 2d 1222, 1224 (Fla. Dist. Ct. App. 1979) (holding that tip of nose alteration presented a battery claim despite statute deeming written consent sufficient to relieve doctor of liability); Kinikin v. Heupel, 305 N.W.2d 589, 593 (Minn. 1981) (holding that breast reduction beyond patient consent constituted battery).
have been disclosed.\textsuperscript{197}

Miller’s third category, the detailed consent forms, detail not only the medical condition, procedure, and consequences, but also the risks and alternatives.\textsuperscript{198}

What is it that a form is supposed to accomplish? The answer to this question is found in the elements of a valid and informed consent, which must be based on the following factors:

* the diagnosis
* the nature and purpose of the procedure(s) for which consent is sought
* all material risks and consequences of the procedure(s)
* an assessment of the likelihood that the procedure(s) will accomplish the desired objective(s)
* any reasonably feasible alternatives for treatment, with the same supporting information as is required regarding the proposed procedure(s)
* the prognosis if no treatment is provided\textsuperscript{199}

It is clear that forms which providers may hope will be such as to withstand judicial scrutiny often turn out to be too general.\textsuperscript{200} Thus, one with the following statement is not satisfactory as proof of informed consent: "The nature and purpose of the operation and/or procedures, possible alternative methods of diagnosis or treatment, the risks involved, the possibility of complications and the consequences of the operation or procedures have been fully explained to me. . . ."\textsuperscript{201}

But it is also true that forms may be deceptively exhaustive. Just such a situation was critical to the resolution of the case of Moure v. Raelchele,\textsuperscript{202} where the information exchange between the doctor and the patient involved not only a face-to-face dialogue, but also the execution of a lengthy form.

The patient was told during the meeting with the doctor that two procedures existed by which a medical determination could be made about her ability to conceive a child. However, because of the pain associated with one of the tests, the discussion centered on the


\textsuperscript{198} R. Miller, \textit{supra} note 187, at 248.

\textsuperscript{199} II Hospital Law Manual, \textit{supra} note 188, at 205-06.


\textsuperscript{201} II Hospital Law Manual, \textit{supra} note 188, at 208.

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203. One of the tests discussed with Moure was to inject air into the cervix, and if the tubes were open, the air would pass through the tubes and into the abdominal cavity. Because of the pain associated with this test, however, the discussion centered on the laproscopic examination, to which Moure consented. Tuboplasty, as an alternative treatment, and risks to patient's future fertility were never discussed. Moure, 387 Pa. Super. at —, 563 A.2d at 1218.

204. Id. at —, 563 A.2d at 1220.

205. Id. at —, 563 A.2d at 1220-21.

206. Id. at —, 563 A.2d at 1221.

207. The consent form "[was] very vague and [did] not specifically state the type of surgery or the risks of the surgery which the doctor could perform after the initial laproscopic examination. . . ." Id. at —, 563 A.2d at 1221 n.3.

208. Id. at —, 563 A.2d at 1221. "The two procedures discussed with [Moure] were the laproscopic surgery and the injection of dye into her tubes. The only risks which are clearly discussed in the agreement are those risks associated with emergency surgery." Id. at —, 563 A.2d at 1221 n.4.
perform a tuboplastic process about which he had not informed the patient. The consent agreement was silent as to the tuboplastic procedure, the risks associated with tuboplasty, or any of the other alternatives available.209

The tuboplasty was performed without disclosing the risks of surgery. The Pennsylvania court found that a reasonable person in the patient’s position would have found these risks material, and such risks should have been revealed to her.210

Quite simply, the consent form’s exhaustive and technical language simply missed the mark regarding what the doctor decided to do once he had opened the patient’s abdominal cavity.

In the absence of a scheme as ambitious — and seemingly impossible to carry out — as the Hawaii statute’s proposal to prepare standards for every illness suffered by human beings, the task of developing specific standards depends on hospital procedures which are specific enough to supply adequate information to the patient.

At the University of Nebraska Medical Center in Omaha (“UNMC”), the Medical Staff Policy Manual (the “Manual”) outlines the information to be discussed by the physician with the patient.211 This includes each of the elements discussed above plus the identity of the physician or physicians who will be performing the procedure and any additional physicians responsible for performing the procedure.

The UNMC Manual designates the staff physician as the respon-

209. The other alternatives available for the patient to consider were (1) a tuboplasty, (2) consultation with an expert in reproductive medicine and/or a microsurgeon regarding her clubbed fallopian tubes; (3) adoption, (4) in vitro fertilization, or (5) no surgery. Id. at 1221 n.5 (citations omitted).

210. Id. at —, 563 A.2d at 1223. The risks involved with the tuboplasty procedure which the court determined were material were that: (1) “[t]he procedure [was] temporary in nature, creating a very short period of time during which the [patient]” could become pregnant, (2) “the period of enhancement [began] immediately after the ‘cuffing’ procedure,” mandating that conception occur before the patient’s marriage, (3) the end of the fallopian tube, or fimbriae, may be cut off, precluding forever reconstructive surgery through microsurgery, “and (4) the fimbriae are essential for fertilization, and, where [they] are removed during tuboplastic procedure,” the chances of becoming pregnant are very slight. Id. at —, 563 A.2d at 1222-23 (citations omitted).

211. The University of Nebraska Medical Center’s Medical Staff Policy Manual requires the physician to:

explain the following prior to obtaining a patient’s consent:
1. the patient’s diagnosis;
2. the proposed procedure;
3. the likely risks and discomforts of the procedure;
4. the expected benefits of the procedure;
5. alternative decisions open to the patient;
6. the patient’s prognosis with and without the procedure;
7. the identity of the physician(s) . . . responsible for and who may perform the procedure.

Id. at 6.
sible party for obtaining the consent, but this provider may designate a "house officer" if, in the opinion of the staff physician, the house officer is knowledgeable of the benefits and inherent risks of the procedure and of alternative procedures.\footnote{212} However, the Manual makes the staff physician ultimately responsible for the patient's being informed adequately.\footnote{213}

The UNMC requires a general consent to medical or surgical treatment to be signed by a patient upon admission or being seen in the Emergency Department.\footnote{214} The forms employed in these two situations "provide a record of consent to routine services and medical treatment and inform the patients of participation in the educational programs of the Hospital and Clinic."\footnote{215} The Manual is careful to state that "a general consent cannot be used as a consent for specific procedures."\footnote{216}

UNMC requires specific consents "for all diagnostic or therapeutic procedures which involve special risk to the patient" and, under UNMC policy, "there must be a valid consent form for each procedure or operation."\footnote{217} In addition, "specific consent [is to] be documented in the medical record by a completed Consent to Operation form."\footnote{218}

Finally, special consents may be required in situations which have special risks or involve special hardship for the patient or are required by law. These include autopsy, sterilization, mass media use, human investigation, anatomical gift, and hysterectomy.\footnote{219}

CONCLUSION

As this paper has repeatedly emphasized, no form, no statute, no listing of risks and alternatives can adequately substitute for clear communication between the health care provider and his or her patient. And there can be a breakdown in the oral communication between the patient and the provider as well.\footnote{220}

The recent seminal article by Cathy J. Jones on medical decision-making makes the following observation:

\footnote{212}{Id. at 1.}
\footnote{213}{Id. at 2.}
\footnote{214}{Id. at 6.}
\footnote{215}{Id.}
\footnote{216}{Id.}
\footnote{217}{Id.}
\footnote{218}{Id.}
\footnote{219}{Id. at 7.}
\footnote{220}{See Gordon v. Neviser, 478 A.2d 292, 294-95 (D.C. 1984) (involving a patient who had signed a form which indicated that the possible risks of the surgery had been explained to him with the background information provided by the doctor).}
The informed consent procedures that most [doctors whom she observed during a sabbatical in a large hospital] used, while sometimes meeting the letter of the informed consent doctrine, rarely met what should be its spirit, i.e., providing adequate information and attempting to ensure that patients understand the information so they can make knowing and voluntary decisions about medical care. Most physicians, however, would never be faulted by a court for what they do because they give the appearance of having met the doctrine's requirements and they document everything.221

Jones's article provides a careful discussion of the processes by which physicians convey (or fail so to do) and patients grasp (or fail so to do) information about proposed medical treatment.222

The fact that there is evidence that some physicians cannot or will not take the time and the care to provide adequate and clear information to patients about treatment the patients are to undergo and that some patients may never grasp the information and thus engage in intelligent decision-making,223 is no reason to abandon the doctrine of informed consent.

The doctrine has evolved and survived precisely because this society places a significant value on the autonomy of the human being and her or his right to decide matters relating to medical treatment. Lawmakers, health care providers, and citizen advocacy groups have attempted to fashion schemes which will maximize the information given and received. That these schemes have not always been ade-


222. Jones writes that:
[many physicians disclose to patients the benefits and to a lesser extent the risk elements of proposed medical treatments. There is little or no discussion, however, of alternatives, or if there is a discussion of alternatives, it is not unusual for the information giver to phrase — some might use the word "slant" — the information in such a way that the patient will almost certainly choose the alternative favored by the physician. Rarely does a physician attempt to test a patient's understanding of the information that has been provided, beyond a perfunctory 'Do you have any questions?' to which the patient almost invariably responds in the negative.
Jones, 47 WASH. & LEE L. REV. at 399-400 (footnotes omitted).

223. Jones observed, in discussing with physicians the idea of informed consent, that their responses were consistent: that patients lacked the capacity to understand highly technical, medical information, that testing patients' understanding of what they have been told is too time-consuming and that patients want physicians to make decisions for them. These responses underscore the physicians' beliefs that patients are unable to make decisions regarding their own health care in a knowing, competent manner.
Id. at 407. See also Katz, Informed Consent — A Fairy Tale? Law's Vision, 39 U. PITT. L. REV. 137, 141 (1977) (arguing that the law supports physicians' beliefs that patients are unable to make appropriate decisions concerning their health care).
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quate to the task is no reason to abandon the quest for better informed consent.

Modern statutes will continue to define the range of necessary information to be shared with patients. Care providers will continue to develop materials — forms and instructional pamphlets, usually — to memorialize the transfer of information to the patient.

But when all is said and done, it is up to the health care provider personally to insure that information is conveyed and that the patient knows what he or she is in for. Time is the enemy of the busy professional. But the seemingly simple technological advancements in voice and visual recordation accomplished with handheld machines make it possible, indeed quite useful, to transcribe the interchange between patient and physician.

A survey of the case law demonstrates that a very significant portion of the suits stem from a patient's claim that the provider did not tell him or her what the risks and alternatives to treatment were. A form, of course, which merely states that the patient has been told of the risks and alternatives to treatment is not of the same evidentiary value as a witnessed sight-and-sound recording of the transaction.

While the parallel is very rough, police officials who have used sight and sound transcription for such purposes as drunk driving

224. In informed consent cases involving third parties, the duty to inform has been found to rest with the patient's primary physician. See, e.g., Lincoln v. Gupta, 142 Mich. App. 615, —, 370 N.W.2d 312, 317 (1985) (holding that a plaintiff must establish as a matter of law that hospital had a duty to obtain informed consent of patient); Kashkin v. Mount Sinai Medical Center, 142 Misc. 2d 863, —, 538 N.Y.S.2d 686, 688 (Sup. Ct. 1989) (holding that a physician who referred patient to another physician for treatment, but retained some participation, had duty to inform patient of risks involved in treatment); Cox v. Haworth, 54 N.C. App. 328, —, 283 S.E.2d 392, 395-96 (1981) (holding that decedent's private physician, not hospital or its personnel, had duty to warn patient of risks of myectomy).

225. This point is emphasized in Jones's article in which she states that physicians have consistently voiced the belief that "testing a patients' understanding of what they have been told is too time consuming in terms of the physician's additional duties to this patient and others." See Jones, 47 WASH. & LEE L. REV. at 407.

226. Not only can television be used to record the exchange between physician and patient, but it can also serve to present explanations of the various procedures which may be used on a given patient. See Krueger, Informed Consent by Videotape, 4 TRIAL DIPLOMATE, No. 3, 40-41 (Fall 1981).

227. In other contexts, assuming the adherence to rules of foundation, the videotape can be a vivid portrayal of the behavior of the parties during the information exchange. See generally, Montana v. Thompson, 773 P.2d 722 (Mont. 1989); Sims v. Texas, 735 S.W.2d 913 (Tex. Ct. App. 1987). Coupled with the well-crafted form, the tape can help preserve the facts needed to determine whether informed consent is present. See also Gardiner, The Nitty-Gritty Essence of Informed Consent, 18 LEGISLATIVE ASSEMBLY MEDICAL PRACTICE No. 3, 3 (Mar. 1988) (emphasizing the importance of written documentation of the question and answer exchange between physician and patient and the use of audio and video tape recordings to supplement written consents).
prosecutions$^{228}$ and the advising of suspects' constitutional rights$^{229}$ find significant decreases in claims arising from perceptual distortion or inadequate warning.

That solution applied in the informed consent context will, at least relieve society of a significant share of the burdensome litigation which devolves into a nasty contest of what was said by whom to whom.

$^{228}$ See Iowa v. Mannion, 414 N.W.2d 119, 120 (Iowa 1987) (allowing jury to view, but not hear, the videotape). See also R. Erwin, Defense of Drunk Driving Cases § 9.03 (3d ed. 1989).

$^{229}$ The commentary to A Model Code of Pre-Arraignment Procedure § 130.4 (1975) suggests that the videotaping of the transaction can avoid a swearing contest between police officers and the defendant and allows the court to make its own independent interpretation, based on an accurate picture of what really happened. In Stephan v. State, 711 P.2d 1156, 1158 (Alaska 1985), it was held that "an unexcused failure to electronically record a custodial interrogation conducted in a place of detention violated a suspect's right to due process under the Alaska constitution." Cf. Ogletree, Are Confessions Really Good for the Soul?: A Proposal to Mirandize Miranda, 100 Harv. L. Rev. 1826, 1843 (1987).