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Failure To Inform As Medical Malpractice

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I. INTRODUCTION

This note concerns the physician's tort liability for failing to disclose to the patient medical information about his case which the patient should know in order to determine what shall be done with his body. Each medical case requires the attending physician to assemble a vast amount of technical information before he acts; namely, the patient's history, the diagnosis, the general nature of the contemplated procedure, the risks involved, the prospects of success, the prognosis if the procedure is not performed, and the alternative methods of treatment. Nevertheless, many people who have undergone surgery will recall their own ignorance of both the technical nature of the operation and the particular medical risks that threatened disability or death. The physician has traditionally refused to disclose more than the most basic information to his patient before treatment. After treatment, however, the patient may discover that he has sustained a serious and permanent injury resulting from treatment which entailed a high degree of risk. Subsequently, the patient may possibly consult his attorney. If he sues his physician, recovery is likely, for there is a growing line of cases which award damages to patients for unavoidable injuries sustained from medical treatment. These cases reason that the physician wrongfully withheld information from the patient concerning the proposed treatment.

Assuming that the physician is qualified to treat the patient and has gathered the appropriate information, a total failure to inform the patient about the contemplated procedure will have no bearing on the physician's technical performance once the procedure is begun. If the physician does not treat the patient properly and injury occurs, the patient can recover under the general malpractice rules; consequently, disclosure is not a problem. The legal wrong for failing to disclose medical information is independent of improper treatment and usually takes place before the physician treats the patient. Therefore, the cause of action arises not from the physician's negligent performance but from the procedure selected. The injury is simply a bad result which can be foreseen but cannot be avoided by anyone in the medical profession. Although a physician should not be held liable solely because he was unsuccessful, there is an increasing tendency in this country to allow recovery for unexpected bad results when the physician could have warned the patient of the dangers prior to treatment.

II. PATIENT-PHYSICIAN COMMUNICATION: A CORNERSTONE OF EFFECTIVE MEDICAL CARE

A. Protecting the Patient's Right of Free Choice

The right of a person to protect or disregard his own health is inherent in the basic rights of bodily freedom and individual choice. Although the health of the individual citizen is one of society's greatest concerns, it is generally recognized that a competent adult cannot be compelled by the state to submit to medical treatment against his will.[1] Furthermore, since the mere appearance of private coercion in the form of professional solicitation or advertisement is prohibited,[2] an individual is forced to seek out a physician for medical treatment. Thus it is well settled that the relationship between a physician and his patient is a consensual one "wherein the patient knowingly seeks the assistance of the physician and the physician knowingly accepts him as a patient."[3] A physician, therefore, cannot treat a patient unless he has first obtained the patient's consent to act.[4] This rule also protects the patient's right to choose what should be done with his body, because treatment without consent is characterized as a "harmful touching" of the patient's body and, therefore, a battery. This result is not changed even though the treatment may have been beneficial to the patient.[5]

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1. *See* Annot., 9 A.L.R.3d 1391 (1966). Upon application of a physician or hospital, however, a few courts have ordered medical treatment for a non-consenting adult on the ground that the state, as *parens patriae*, has an interest in protecting the patient's life. This is especially true if the patient has children who could become wards of the state upon his death or incapacity. *See, e.g.*, Application of the President & Directors of Georgetown College, Inc., 331 F.2d 1000, *cert. denied*, 377 U.S. 978 (1964).

2. *E.g.*, State Bd. of Dental Examiners v. Bohl, 162 Kan. 156, 174 P.2d 998 (1946) (statutory provisions and administrative regulations were applied to revoke a doctor's license to practice because he advertised in a local newspaper of general circulation); Barron v. Board of Dental Examiners, 44 Cal. App. 2d 790, 113 P.2d 247 (1941) (a dentist's license was suspended because he advertised in the yellow pages of a telephone directory); *cf.* B. SHARTEL & M. PLANT, THE LAW OF MEDICAL PRACTICE § 5-17(2)(c) (1959).

3. Tvedt v. Haugen, 70 N.D. 338, 347, 294 N.W. 183, 187 (1940).

4. Robinson v. Crotwell, 175 Ala. 194, 57 So. 23 (1911); Jackovach v. Yocom, 212 Iowa 914, 237 N.W. 444 (1931); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905); Rolater v. Strain, 39 Okla. 572, 137 P. 96 (1913).

5. In the widely quoted case of Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914), the defendant physician placed the plaintiff under anesthesia. The plaintiff had consented to this treatment for the purpose of an examination only. While the plaintiff was unconscious, the defendant removed an abdominal tumor. In holding that the operation was a trespass, Judge Cardozo stated: "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 129-30, 105 N.E. at 93. Since the plaintiff consented only to an examination, the extension of the treatment to a removal of the tumor was unauthorized and constituted a legal wrong. Liability was imposed even though the surgery may have been beneficial to the plaintiff.

The requirement of a valid consent as a condition precedent to medical treatment can be met in several ways. First, the physician can obtain the *express* consent of the patient either orally or in writing.[6] Secondly, if there is no express affirmation, consent may be *implied in fact* from the actions of the patient who knowingly accepts the treatment recommended by his physician.[7] Lastly, consent may be *implied in law* when the patient, by his age or condition, is unable to evidence his acceptance.[8] Thus, if delay in treatment would threaten the life or health of the patient in an emergency situation, the patient's consent is implied as a matter of law on the theory that the patient would not have withheld his consent if he had been given a choice. Conversely, the law will impliedly designate the physician to be the representative *pro hoc vice* of his patient and will charge him with the responsibility of acting in the patient's interest.[9]

Despite the simple nature of these rules, the conclusion should be avoided that the establishment of a valid consent is merely mechanical. That a patient cannot give a valid consent to treatment about which he knows nothing seems to be a logical proposition. The right of a patient to decide what to do with his body necessarily implies the right to comprehend the information necessary to make an intelligent choice. This reasoning is followed by those courts which recognize that a physician may be liable for failing to disclose medical information to his patient.[10] The case of *Natanson v. Kline*[11] serves as a good example. Mrs. Natanson had undergone an operation for the removal of a cancerous lesion in her left breast. Following the operation, Dr. Kline advised, as a precautionary measure, that Mrs. Natanson undergo radiation therapy to prevent the further spead of cancer. Mrs. Natanson consented, but during the course of the treatment, she suffered severe radiation burns. Dr. Kline had failed to inform Mrs. Natanson of the risk of such burns. The court held that Mrs. Natanson was entitled to a reasonable disclosure by Dr. Kline, enabling her to make an intelligent decision whether to take the cobalt treatment and

6. *E.g.*, Farber v. Olkon, 40 Cal. 2d 503, 254 P.2d 520 (1953); Samuelson v. Taylor, 160 Wash. 369, 295 P. 113 (1931).

7. *E.g.*, McGuire v. Rix, 118 Neb. 434, 225 N.W. 120 (1929).

8. *E.g.*, Luka v. Lowrie, 171 Mich. 122, 136 N.W. 1106 (1912).

9. *E.g.*, Bennan v. Parsonnet, 83 N.J.L. 20, 83 A. 948 (Sup. Ct. 1912).

10. Naturally, the advisability of a particular course of treatment, from a medical standpoint, is solely within the bounds of the physician's traditional role. The physician, rather than the patient, has the technical knowledge to know what should be done. The patient, however, has the right to say what will be done, since the patient is directly affected by the physician's efforts.

11. 186 Kan. 393, 350 P.2d 1093, *modified*, 187 Kan. 186, 354 P.2d 670 (1960).

hazard the risk that the cancerous condition had not spread beyond the lesion. The court indicated that even though a doctor believes a particular form of treatment is necessary, he cannot substitute his own judgment for that of his patient.[12]

B. Promoting the Patient's Confidence and Trust in his Physician

As in the association between an attorney and his client, the physician and his patient enjoy a fiduciary relationship.[13] The physician is expected to place the interests of his patient above his own and should not engage in "puffing," which is customary and acceptable with the typical vendor. As Professor Curran has pointed out,[14] the professional ethic demands that the physician deal frankly and honestly with his patient. "Hard sell" pitches that are inconsistent with the professional relationship may be dangerous, since the patient may attribute the unexpected result to negligence by his physician.[15]

Although the physician is expected to respect the interests of his patient, Curran has maintained that most physicians favor the withholding of frightening information from the patient; this practice is called "overselling."[16] From the physician's standpoint, overselling is consistent with his traditional role as a fiduciary because it protects the unduly apprehensive patient's chance of recovery by minimizing the possibility of psychosomatic complications. Furthermore, since the physician cannot anticipate a patient's reaction to the disclosure of certain facts, the doctor is justified in taking a conservative approach to the problem. The courts have not disregarded the needs of the unduly apprehensive patient, but there has been little effort to deal with the

12. 186 Kan. at 407, 350 P.2d at 1104: "A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception."

13. *See* McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959).

14. Curran, *Professional Negligence—Some General Comments*, 12 VAND. L. REV. 535 (1959).

15. "There is a well settled ethical foundation here which imposes high demands on the professional man to be frank and honest in his dealings with the client or patient. The client or patient must be told what to expect in services. Good results should not be guaranteed unless this is honestly what is expected. 'Hard sell' pitches are quite foreign to a professional relationship. In the area of professional liability, 'hard sell' tactics can also be dangerous when the promised result does not occur. A client or patient who is led to expect too much may well blame the bad result on negligence by the practitioner." *Id.* at 542-43.

16. "The physician is in the greatest dilemma here. He cannot oversell, but he can't afford to be so honest about the treatment that he raises unnecessary fears and anxieties in the patient. It is often a difficult balance to maintain. Most physicians lean in favor of overselling to avoid disturbing the patient." *Id.* at 543.

issue from a fiduciary standpoint. It is generally accepted, however, that excessive disclosure may amount to bad medical practice.[17]

Although excessive disclosure may be harmful to certain patients, the argument in support of overselling has lost force because the need for promoting public confidence and trust in the medical profession has been overlooked. Many physicians believe that their professional status and technical competence should presumptively command a patient's confidence. This attitude is reflected in the physician's second objection to disclosure; namely, the more sensitive patient will act unreasonably by refusing needed medical treatment for fear of its technical nature or minimal risks.[18] A physician who takes the conservative approach to the problem of disclosure may feel his action is justified because of his superior knowledge. A recent California study has revealed, however, that it is the physician with this attitude who is sued most often for malpractice.[19] On the other hand, the great majority of physicians probably do not have this attitude and will approach the problem of disclosure on a case to case basis with a view to stimulating patient trust and confidence.

C. *Recovery for Failing to Disclose*

The origin of the cause of action based upon the physician's failure to make an adequate disclosure to his patient[20] has been traced by one author[21] to an article by Professor Allan H. McCoid in 1957.[22] After a comprehensive survey of the pertinent cases involving unauthorized medical treatment, McCoid observed as follows:

> One particular obligation which the law may properly exact or impose, however, is the obligation of a doctor to make a reasonable disclosure to the patient of the nature of his illness or infirmity, the nature of the treatment proposed and the

17. *E.g.*, Williams v. Menehan, 191 Kan. 6, 379 P.2d 292 (1963).

18. On the other hand, the right of a patient to refuse treatment, regardless of the motive, is the very right protected by the duty to disclose.

19. *See* Silverman, *Medicine's Legal Nightmare: The Source of the Trouble*, THE SATURDAY EVENING POST, April 25, 1959, at 36.

20. The earliest case concerning the problem of inadequate disclosure was decided by a Canadian court, in Kenny v. Lockwood, [1932] 1 D.L.R. 507 (1931). The court held that the duty of the physician was to deal honestly with the patient about the necessity, character, and importance of an operation. Although this duty included probable consequences and chances for success, it did not extend to discussions of the dangers inherent in any operation or to details which might frighten the patient. American courts have adopted a more demanding rule. *See* notes 24-26 *infra* and accompanying text.

21. *See* Plante, *An Analysis of "Informed Consent,"* 36 FORDHAM L. REV. 639, 640-48 (1968).

22. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957).

> danger of using such treatment or alternative treatment, and then permit the patient to decide whether to submit to the treatment or not.[23]

In the same year, the case of *Salgo v. Leland Stanford Jr. University Board of Trustees*[24] held a physician liable for failure to disclose. The *Salgo* court, which upheld a jury instruction,[25] concluded that a physician could not induce a patient's consent by minimizing known dangers of a procedure. The physician violated his duty when he withheld any facts necessary to an "intelligent consent." At the same time, however, the physician was obligated to consider the welfare of his patient above all else. The court recognized that under these guidelines, the physician was placed in an awkward position when dealing with the unduly apprehensive patient. On the other hand, the physician was allowed "a certain amount of discretion," as long as its exercise was "consistent with the full disclosure of facts necessary to an informed consent."[26] As a case of first impression, *Salgo* left many questions unanswered but clearly expanded tort liability for the physician. The number of cases that have followed *Salgo* graphically demonstrates the complexity and seriousness of the problem of disclosure.

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23. *Id.* at 434. Professor McCoid had previously concluded that: "The trial and decision of these unauthorized operation cases would be greatly improved in terms of consistency of theory and appropriateness of liability if there were a single basis for liability in all malpractice cases, other than the occasional instance of an actual assault and battery in the sense of an intentional deviation from practice which does not tend to be beneficial to the patient. The basis of liability should be deviation from the standard of conduct of a reasonable and prudent doctor of the same school of practice as the defendant under similar circumstances. The author believes that under such a standard the patient will be properly protected by the medical profession's own recognition of its obligation to maintain its standards." *Id.*

24. 154 Cal. App. 2d 560, 317 P.2d 170 (1957) (plaintiff paralized as a result of an aortography).

25. *Id.* at 578, 317 P.2d at 181. "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient any risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent." *Id.*

26. *Id.*

III. CONFUSION OVER THE THEORY OF RECOVERY

A. Battery and Negligence Distinguished

The courts have confused the theory of recovery which a plaintiff must adopt when he sues his physician for failing to disclose medical information. The terms "intelligent consent" and "informed consent," as used by the *Salgo* court, have taken root in American law. The use of such simple terms, however, has produced a legal myopia. On one hand, courts are confronted with the rule that any treatment administered without the consent of the patient is unauthorized and, therefore, a battery. On the other hand, the ordinary rules of medical malpractice which impose upon the physician a professional standard of care seem applicable to the problem of disclosure.[27]

In order to understand the difference between battery and negligence as a basis for recovery, the character of the particular information withheld must first be analyzed. It is well recognized that there can be no battery when the patient has given a valid consent to the proposed treatment.[28] Consequently, if the physician, by his silence or misrepresentation, causes the patient to be mistaken as to the essential character or nature of the medical procedure, the patient's consent to the treatment is not valid and the physician will be liable for battery. If the misrepresentation goes only to some collateral matter which merely operates to induce the patient's consent, the consent is valid and there is no battery. In this instance, the patient may have a cause of action against the physician for negligence. The clearest example of this distinction can be demonstrated by the following example. A physician represents to an unsuspecting female patient that intercourse is necessary medical treatment when he clearly intends the contact for his own benefit. Her consent to the treatment is invalid, and the physician is liable for battery.The theory supporting recovery is that the patient was unaware of the nature of the contact; namely, that which made it harmful or offensive. Conversely, if the physician made advances to the patient and secured her consent after giving her a sum of counterfeit money, the consent is valid even though she would not have consented had she known that the money was worthless. In this case, the misrepresentation went only to a collateral fact which concerned the touching and induced the patient's consent.

27. It has been suggested that this confusion was created by the modern pleading rules which do not require the plaintiff to analyze his theory of recovery prior to the trial of the case. *See* Plante, *supra* note 21, at 639-40 & n.4.

28. *See* text accompanying note 5 *supra*.

The patient understood the offensive nature of the touching and cannot sue the physician for battery.[29] Generally, a physician who fails to disclose collateral risks to a proposed operation or procedure should not be held liable for battery since the resulting harm was not intentional. The proper cause of action would be negligence.

B. Informed Consent as Battery

In the case of *Bang v. Charles T. Miller Hospital*,[30] the plaintiff brought an action for assault or unauthorized operation. Suffering from a urinary problem, the plaintiff consulted with the defendant, who diagnosed the condition as an enlargement of the prostate gland. The defendant obtained the consent of the plaintiff to perform a transurethral prostatic resection; subsequently, this operation was performed. The defendant, however, did not inform the plaintiff that the operation required, as a matter of routine, the cutting of the spermatic cords. The plaintiff was rendered sterile by the operation.

The court treated the case correctly as sounding in battery and held that whether the plaintiff consented to the severance of his spermatic cords was a question of fact for the jury. The opinion did not refer to the concept of informed consent, but the *Salgo* case had not yet attracted nationwide attention. Even so, the facts are similar to many subsequent informed consent cases because the defendant had pre-operative knowledge of medical information which should have been disclosed to the plaintiff. The defendant committed a battery since his silence misled the plaintiff as to the essential nature of the operation. This is not a case of inducement to consent by non-disclosure of a collateral fact; rather, the cutting of the spermatic cords was a necessary part of the operation.[31] The failure to disclose this fact rendered the plaintiff's consent ineffective and subjected the defendant to liability for battery.

Most cases, however, are not so easily classified. In *Govin v. Hunter*,[32] the defendant performed a surgical operation upon the right leg of Mrs. Govin for the correction of a varicose vein condition. Mrs. Govin testified that she had been told by the defendant that he would strip the offending vein with one incision behind the knee and one

29. For an excellent discussion of this distinction and the significance to the theory of recovery, see Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74 (1965); RESTATEMENT (SECOND) OF TORTS §§ 55, 57 and illustrations (1965); Plante, *supra* note 21, at 648-50.

30. 251 Minn. 427, 88 N.W.2d 186 (1958).

31. *See* W. PROSSER, TORTS § 18, at 107 (3d ed. 1964).

32. 374 P.2d 421 (Wyo. 1962).

behind the ankle. The vein in question was entirely removed, but the severity of the varicosity necessitated six incisions rather than two. The physicians who testified on the subject claimed that it was impossible to strip this vein with two incisions and that surgeons cannot estimate the number of necessary incisions. The court concluded that "under certain circumstances a physician has a duty to reveal any serious risks which are involved in a contemplated operation."[33] Disclosure is required in order to assure that the patient's informed consent is obtained.

It might be argued that the number of incisions required in an operation of the type performed on Mrs. Govin is a collateral fact. Therefore, the defendant's failure to disclose did not mislead the plaintiff, who consented to an operation which was described to her. The non-disclosed fact, however, went to the nature of the operation rather than to a collateral risk. An incision is a necessary part of an operation. If a physician is uncertain as to the number of incisions which will be required, this does not, however, introduce an element of risk. A similar problem arises in connection with any exploratory type operation: the physician is unable to define the scope of the treatment before it is actually begun. The *Govin* court, therefore, was incorrect since the nature of the operation was not clearly described to the plaintiff prior to surgery. Consequently, the appropriate cause of action was battery and not negligence.

In 1965, a Texas state court was faced with the issue of informed consent in the case of *Scott v. Wilson*.[34] The plaintiff filed an action for malpractice against his physician who had performed an ear operation which rendered the plaintiff completely deaf in the left ear. The defendant had informed the plaintiff that there was a ten percent chance of an unexpected result but did not mention that one percent of such operations resulted in a total loss of hearing.[35] The court reasoned that the question for decision was as follows:

> [W]hether Dr. Wilson reasonably and adequately informed Scott of the dangers and hazards to be anticipated from the stapedectomy operation so as to prepare him to give a knowledgeable consent to the operation.[36]

In reversing a directed verdict for the defendant at the close of the plaintiff's evidence, the court held that:

> The consent whieh Scott gave to have the operation performed is of no effect

33. *Id.* at 423. The court decided in favor of the defendant on other grounds.

34. 396 S.W.2d 532 (Tex. Civ. App. 1965), *rev'd on rehearing*, 412 S.W.2d 299 (Tex. 1967).

35. There was also evidence that the defendant represented that he was experienced in performing such operations. The operation, however, was the defendant's first.

36. Scott v. Wilson, 396 S.W.2d 532, 533 (Tex. Civ. App. 1965).

> unless it was an informed and knowledgeable consent. . . . If Dr. Wilson did not have Scott's informed consent to operate upon him he would be guilty of assault and battery on Scott, and liable for the damages caused by the operation.[37]

Contrary to the position taken in *Govin*, the *Scott* court concluded that an operation without the informed consent of the patient rendered the physician liable for battery.[38]

The previous analysis of the scope of the battery theory in the area of disclosure demonstrates that the *Scott* case was incorrect in relying upon battery as the controlling theory of recovery. Assuming that the defendant failed to disclose the risk of total loss of hearing, this failure merely induced the plaintiff to consent to an operation which he otherwise understood. The plaintiff was not mistaken about the essential nature of the operation since the defendant reviewed and explained the nature of the operation to the plaintiff.[39]

The Arizona Supreme Court stated the following rule in an attempt to define the scope of recovery under a battery theory:

> [C]onsent . . . is effectual if the consentor understands substantially the nature of the surgical procedure attempted and the probable results of the operation. This, as a matter of law, constitutes an informed consent. Lacking this, the operation is a battery unless some special exception pertains. Given an informed consent, liability, if any, must be predicated in malpractice.[40]

This rule is well constructed for it recognizes that to obtain a valid consent the physician must inform the patient what steps are necessary to effect a cure and what positive results are likely to flow from the treatment. A failure to disclose the risks incident to the course of treatment, or any other collateral fact, will not constitute a battery; however, such conduct may be negligent.

The foregoing discussion emphasizes that an attorney should carefully analyze the facts of a case involving inadequate disclosure. While the courts are ambiguous as to the scope of a battery action in this area, the trend is clearly in the direction of treating all types of wrongful nondisclosure as negligence. One writer has suggested that the battery theory should be retained only if the physician operates on an

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37. *Id.* at 535.

38. Despite the conclusion, the court cited 4 cases which suggested a negligence approach: Russell v. Harwick, 166 So. 2d 904 (Fla. App. 1964); Bowers v. Talmage, 159 So. 2d 888 (Fla. App. 1963); Mitchell v. Robinson, 334 S.W.2d 11 (Mo. 1960), *disapproved in part*, Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965); DiRosse v. Wein, 24 App. Div. 2d 510, 261 N.Y.S.2d 623 (1965).

39. On appeal, the Texas Supreme Court held that the proper action was malpractice for a physician's failure to conform to medical standards in obtaining the patient's consent. The court retreated from its position somewhat by saying that this action "need not be pleaded as one for assault and battery." Wilson v. Scott, 412 S.W.2d 299, 302 (Tex. 1967).

40. Shetter v. Rochelle, 2 Ariz. App. 358, 370, 409 P.2d 74, 86 (1965).

incorrect area of the body or viciously acts out of anger.[41] While the scope of the action is not restricted to these circumstances, "a physician should be liable like anyone else for an assault of a nature not peculiar to the physician-patient relationship, [and] few would deny the appropriateness of invoking assault and battery principles where the physician deliberately substitutes his own will for that of the patient by carrying on a procedure over the patient's protests, or intentionally indulges in other flagrant misconduct toward the patient."[42] The scope of the battery action is much broader because of the historical significance of the inviolability of the body in Anglo-American society.[43]

Some courts have questioned the propriety of applying a battery theory when the physician acts without fully informing the patient about the contemplated procedure or operation. The reasoning is that traditional battery involves a defendant who is generally acting out of malice or in a manner considered to be antisocial.[44] Prosser has suggested, however, that "the gist of the action for battery is not the hostile intent of the defendant, but rather the absence of consent on the part of the plaintiff."[45] The interest to be protected by an action for battery is the patient's right to know that which makes the recommended medical procedure harmful or offensive before he gives his consent. If the physician fails to reveal this information, he should be liable for battery since he has violated a right of his patient.

C. *Informed Consent as Negligence*

If there has been a failure to disclose a risk and an unexpected injury occurs, the courts have generally treated the problem as one of negligence or malpractice.[46] As with the battery approach, the question is whether the physician has obtained the informed consent of the patient. For example, in reversing *Scott v. Wilson*,[47] the Supreme Court of Texas concluded: "Physicians and surgeons have a duty to make a reasonable disclosure to a patient of risks that are incident to medical diagnosis and treatment."[48] This court indicated that the duty to

41. Note, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1369, 1399 n.18 (1967).

42. 1 D. LOUISSELL & H. WILLIAMS, MEDICAL MALPRACTICE 222 (1969).

43. *Id.* at 223.

44. Wilson v. Scott, 412 S.W.2d 299, 302 (Tex. 1967).

45. W. PROSSER, TORTS § 35 (3d ed. 1964).

46. This result was suggested by the court in Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74 (1965).

47. *See* text accompanying notes 34-38 *supra*.

48. Wilson v. Scott, 412 S.W.2d at 301.

inform was based on the patient's right to information which insures an intelligent decision whether to consent or refuse the treatment. In characterizing the problem as one of negligence—imposing a duty to use reasonable care in informing the patient—the courts are approaching the adoption of a single basis of liability in all malpractice cases.[49]

Furthermore, courts have recognized that disclosure is a relative matter involving a problem of medical judgment.[50] The duty is not absolute; only a reasonable disclosure is required. Many facts collateral to medical procedure are trivial and, in some cases, would only serve to disturb the patient. Also, the physician does not have the time to disclose everything. For example, in deciding whether to disclose a known risk, the physician should consider the state of the patient's physicial and mental health. The physician should also take into account, among other things, whether the risk is serious or likely to occur.[51] Thus the physician must consider a variety of information, not unlike a diagnosis. It is arguable, by analogy, that his handling of this information ought to be scrutinized in terms of negligence to determine whether his disclosure has met the legal standard imposed upon those in his profession.[52]

The principles of negligence allow some leeway in the physician's conduct, since nondisclosure, which might otherwise be negligent, is permitted if it has a certain utility.[53] Nondisclosure, therefore, does not amount to negligence if it serves to protect the patient from undue apprehension. This is an application of the balancing test and describes the approach which the physician must take concerning the problem of disclosure.[54] A physician gets into trouble, however, by failing to recognize that each patient differs and that if there is no disclosure, he may later be asked to justify his conduct. The mere belief that

49. This result has been advocated by Professor McCoid. *See* note 23 *supra*.

50. *E.g.*, Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965); Wilson v. Scott, 412 S.W.2d 299 (Tex. 1967).

51. Aiken v. Clary, 396 S.W.2d 668, 674 (Mo. 1965).

52. *See* 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE 223 (1969). "It is arguable that for this kind of case, the standard of the negligence action—possession and use of due skill and care—better accords with the realities of the physician-patient relationship. After all, the process of procuring a patient's consent to a surgical or other medical procedure, is only a part of the total physician-patient communication problem; and the physician's failure to communicate with reasonable care respecting consent—e.g. failure to have the consent adequately formalized or its limits precisely particularized—is closely akin to other failures thought at worst to be only negligent." *Id.*

53. *See* W. PROSSER, TORTS § 31, at 151-52 (3d ed. 1964).

54. The jury instruction reviewed in the *Salgo* case reflected the balancing approach. *See* note 25 *supra*.

nondisclosure was in the best interest of a particular patient may not convince a jury. Although the jury will never be charged in terms of the balancing test, they will consider any evidence which tends to establish that nondisclosure was in the best interest of the patient.

The withholding of information from the unduly apprehensive patient has been treated by some courts and writers as a matter of privilege.[55] This approach is theoretically incorrect if the question is one of negligence. A privilege is recognized in the area of intentional torts as an affirmative defense to conduct which the defendant admits is wrong. If the physician is justified in refusing to disclose frightening information to the unduly apprehensive patient, his conduct does not amount to a legal wrong; rather, the utility of his conduct outweighs the harm that might result from nondisclosure. There can be no privilege, however, to commit a negligent act.

The failure of a physician to make an adequate disclosure of collateral facts should be measured in terms of negligence since negligence is a matter of unreasonable conduct in the face of a foreseeable risk.[56] Treatment without disclosure may be negligent if the physician knowingly places an unsuspecting patient in a position involving an unreasonable risk. It should be emphasized that in most medical procedures the risk rarely materializes and the results are usually beneficial to the patient. When a risk does develop into injury, however, the physician's failure to inform the patient of that risk may constitute a negligent failure to guard against that risk. Consequently, a physician may be negligent in failing to disclose that a thyroidectomy carries a risk of total paralysis of the vocal cords,[57] that an operation to remove cataracts may result in total loss of sight,[58] or that radiation therapy can cause severe external or internal burns.[59] These risks are unavoidable in the sense that the physician can do little to avoid them once the operation has begun.[60] The physician's negligence arises by not

55. *E.g.*, Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, *modified*, 187 Kan. 186, 354 P.2d 670 (1960) (dicta that there is a privilege, on therapeutic grounds, to withhold the specific diagnosis when the disclosure would seriously jeopardize the recovery of an unstable, temperamental, or severely depressed patient); 75 HARV. L. REV. 1445, 1448 (1962).

56. *See* W. PROSSER, TORTS § 31, at 148 (3d ed. 1964).

57. DiFilippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961).

58. Shetter v. Rochelle, 2 Ariz. App. 358, 409 P.2d 74 (1965).

59. Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, *modified*, 187 Kan. 186, 354 P.2d 670 (1960).

60. The great majority of cases dealing with the duty to inform have involved injuries suffered as a result of surgical operations. The problem of disclosure, however, is also present when the physician intends to use drugs to treat his patient. The inevitable side effects produced by many drugs pose serious threats of permanent injury to the patient.

providing the patient with the opportunity to avoid risks through a refusal of treatment.

The case of *Aiken v. Clary*[61] serves as a good example. The defendant physician advised that the plaintiff take insulin shock therapy as treatment for mental illness. The major risk involved in such treatment is that of "delayed awakening" produced by an overreaction to the drug. This can result in brain injury if not reversed quickly. The defendant did not disclose this risk to the plaintiff but did inform him that the treatment was much like being put to sleep. The insulin administered to the plaintiff caused him to lapse into deep coma; before the plaintiff could be revived, he suffered organic brain damage.

In reversing a jury verdict for the defendant and awarding the plaintiff a new trial, the *Aiken* court held that the facts presented a question of negligent conduct on the part of the physician in failing to disclose the risk of brain injury.[62] The jury may have inferred that the defendant was negligent in subjecting the plaintiff to an unreasonable risk of brain damage by creating a false sense of security which induced consent to the treatment.

D. Consequences of the Choice of Theory

Several considerations are involved in the choice between the two theories of recovery: battery and negligence.[63] On one hand, battery is based on the lack of a valid consent to a touching; therefore, the main question for the jury is whether the plaintiff gave a valid consent. The term valid consent, when used in a battery action based on a failure to disclose, implies that the plaintiff voluntarily accepted medical treatment after a reasonable disclosure of its essential nature. The physician's duty is to disclose the nature of the touching before the patient consents.

On the other hand, an action for negligence is possible even though

61. 396 S.W.2d 668 (Mo. 1965).

62. "The basic philosophy in malpractice cases is that the doctor is negligent by reason of the fact that he has failed to adhere to a standard of reasonable medical care, and that consequently the service rendered was substandard and negligent. In our judgment, this is true whether the alleged malpractice consists of improper care and treatment (the usual malpractice case) or whether it is based, as here, on an alleged failure to inform the patient sufficiently to enable him to make a judgment and give an informed consent if he concludes to accept the recommended treatment." *Id.* at 673.

63. In some states, for example, battery and negligence are mutually exclusive and cannot be pleaded in the same cause of action. Besides the difficulty in drafting the pleadings, a choice between battery and negligence will involve, among other things, the consideration of expert testimony requirements, statutes of limitation restrictions, and insurance coverage. *See* Note, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1399-1400 n.18 (1967).

the patient has given a valid consent. Therefore, the plaintiff must establish and the jury must find the traditional elements of a negligence action. The jury's attention is focused only upon the physician's failure to disclose collateral facts pertaining to a proposed procedure or operation. It is in this area that the duty to inform becomes an independent legal concept, since a physician should not, by his silence or misrepresentation, subject a patient to unreasonable risk of bodily harm.

IV. ESTABLISHING A STANDARD OF DISCLOSURE

A. The Reasonable Medical Practitioner

The overwhelming majority rule is that a physician must disclose what a reasonable medical practitioner of the same school and same or similar community would have disclosed to his patient concerning a given treatment.[64] Therefore, the plaintiff's case will not reach the jury unless he introduces expert testimony establishing that it was customary in his community or in a similar community to disclose the risk of his injury. This rule would seem to prevail even when there is a total absence of disclosure since the burden is on the plaintiff to establish the custom. One court indicated, however, that when there is no disclosure, the plaintiff is relieved from establishing the standard of care by the use of expert witnesses. The underlying reasoning is that regardless of the standard of disclosure, something must be said by the physician.[65] In any event, disclosure is not necessary in an emergency, since the patient is not in a position to choose whether to accept or reject treatment.[66]

In adopting the locality rule as part of the standard of care, courts have been subjected to much criticism. The requirement is patently unfair to the injured plaintiff, for it is doubtful that a custom of disclosure actually exists in a community of physicians. One author has argued that if a custom does exist, it would be too general to be of practical value.[67] Since the use of medical experts to establish a custom

64. DiFilippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961); Williams v. Menehan, 191 Kan. 6, 379 P.2d 292 (1963); Roberts v. Young, 369 Mich. 133, 119 N.W.2d 627 (1963); Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955); Wilson v. Scott, 412 S.W.2d 299 (Tex. 1967); Anderson v. Hooker, 420 S.W.2d 235 (Tex. Civ. App. 1967); Govin v. Hunter, 374 P.2d 421 (Wyo. 1962). For a full treatment of the locality rule, see Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729 (1970).

65. Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, *modified*, 187 Kan. 186, 354 P.2d 670 (1960).

66. *E.g.*, Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962).

67. 75 HARV. L. REV. 1445, 1447 (1962).

has been criticized in the ordinary malpractice suit,[68] it would seem even more unfair to ask a physician to judge the adequacy of another physician's disclosure without an established professional standard. Furthermore, from a practical standpoint, the physicians of a community may set a low standard of disclosure without fear that the level of professional treatment will be affected.[69] More importantly, however, the locality rule is not needed to protect the physician. The rule was adopted to protect the isolated physician from a higher standard of care imposed upon physicians outside his community.[70] On the other hand, the ability to make an adequate disclosure is not based on the possession and use of modern skills, but rather on common sense, provided the physician is aware of the risks associated with a procedure. Even if the physician was unaware of a risk which culminated in an injury, many textwriters would oppose the application of a community standard to determine whether he should have known of that risk.[71]

A minority of courts do not allow the physician to interpose a defense that his conduct met with the custom of his community. These courts have adopted the rule that the plaintiff is only required to show what disclosure a reasonable medical practitioner would have made under the same or similar circumstances.[72] As with the majority rule, however, expert testimony is required to establish the standard of disclosure. Both the majority and minority rules have been criticized on the ground that disclosure must depend upon the particular facts of each case.[73]

B. Disclosure as a Specific Duty

It has been suggested that the adoption of a specific rule as to the standard of disclosure would serve to protect the interest of the

68. Curran, *Professional Negligence—Some General Comments*, 12 VAND. L. REV. 535, 538-40 (1959).

69. It is doubtful, however, that the physicians of a particular community will deliberately attempt to set a low standard of disclosure so as to protect themselves from liability. Nevertheless, the same result may occur in a community of physicians where the so-called "conspiracy of silence" is a particular problem.

70. *See generally* McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 569-75 (1959); Note, *Standard of Care for Medical Practitioners—The Locality Rule*, 14 S.D.L. REV. 349 (1969).

71. *See generally* Comment, *Expert Testimony in Medical Malpractice Cases*, 17 U. MIAMI L. REV. 182, 189-95 (1962); Comment, *Medical Malpractice—Expert Testimony*, 60 NW. U.L. REV. 834, 837-39 (1966); 46 N.C.L. REV. 680 (1968).

72. *E.g.*, Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965).

73. Note, *supra* note 63; 75 HARV. L. REV. 1445 (1962).

patient.[74] Indeed, when dealing with professional negligence, there is a judicial trend away from general to specific professional duties. This reflects a growing public understanding of medical practice. Some courts have adopted a standard of absolute[75] or full disclosure[76] of risks, even though these standards are suspect because of the radical treatment involved and the allowance of discretion on the part of the physician.[77] There is authority that serious risks should be disclosed under certain circumstances.[78]

One solution to the problem has been suggested:

> A physician is under an obligation (1) to make a full disclosure of all known material risks in a proposed operation or course of treatment except for those risks of which the patient is likely to know or (2) to prove the reasonableness of any lesser disclosure or the immateriality of the undisclosed risk.[79]

Apparently, the physician must disclose only material risks, which are determined by the incidence and the severity of possible injury. The plaintiff would have to call upon expert testimony to establish both elements. Under the majority rule of disclosure, at least one court has held that the plaintiff need not give expert testimony on the incidence of the risk in order to avoid a directed verdict.[80] Nevertheless, the rule does limit the disclosure required of a physician; however, the maximum disclosure is still indefinite because the materiality of a risk is always influenced by the physicial condition of the individual patient. Whether a particular risk is material is a question of fact for the jury.

This rule would also protect the physician who establishes reasonable grounds for the nondisclosure. The burden would be on the defendant to prove that nondisclosure was in the best interest of the plaintiff. The defendant should be allowed to show that if he had disclosed the risks, the plaintiff would not have been able to make an intelligent choice; that is, to understand the effect of a decision to forego treatment. This is analogous to the treatment of an incompetent or a child. If the defendant attempts to raise this as a justification for nondisclosure, his credibility may be impeached by showing that he failed to talk with an available third party, such as the patient's wife or relative. Furthermore, a complete defense to nondisclosure would be that the plaintiff knew or should have known of the risk.

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74. Note, *supra* note 63.

75. Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

76. Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962).

77. Note, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1401 (1967).

78. *See* text accompanying notes 32 & 33 supra.

79. Note, *supra* note 77, at 1407.

80. Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965).

The proposition that there is a specific duty to disclose does not seem sufficiently broad to justify the conclusion reached by the court in *Stewart v. Long Island College Hospital*.[81] Before this decision, the New York courts had held that a physician was obligated to make a reasonable disclosure to his patient of the known dangers which were incident to or possible in the proposed treatment.[82] In the *Stewart* case, the plaintiff, who had contracted german measles during the first trimester of pregnancy, was informed that there was a chance that her child would be born with birth defects. Upon the advice of the four consulting physicians, no abortion was performed. The plaintiff's child was born with serious defects. The plaintiff later learned that two of the four physicians disagreed with the decision not to abort. The court held that the plaintiff was entitled to know that the two physicians did not agree with the course of treatment recommended since that knowledge might have impelled her to seek another opinion.

The *Stewart* holding was clearly an extension of the earlier rule which required a reasonable disclosure of known dangers or risks. A reasonable disclosure in New York now contemplates some discussion of the alternatives open to the patient, as well as the known dangers. This extension of the earlier rule is logical because a patient's consent may be induced by his lack of knowledge of the possible alternatives. This is true even though the patient fully understands the risks inherent in the treatment recommended by his physician.

That a patient can be misled by the physician's failure to discuss alternatives is presented clearly in the factual situation of *Custodio v. Bauer*.[83] The plaintiff was the mother of nine children. The defendant undertook to accomplish a sterilization at the plaintiff's request in order to prevent further conception and to aid in the treatment of troublesome kidney and bladder conditions. Although the defendant removed a portion of the plaintiff's fallopian tubes, the plaintiff later became pregnant. The defendant had failed to inform the plaintiff that since there was a possibility that the severed tubes could grow together, the plaintiff could again become pregnant. He also failed to advise the plaintiff that there were several surgical procedures available which would accomplish a complete sterilization. On the basis of these facts, the court held that the plaintiff had stated a cause of action against

81. 58 Misc. 2d 432, 296 N.Y.S.2d 41 (Sup. Ct. 1968).

82. DiRosse v. Wein, 24 App. Div. 510, 261 N.Y.S.2d 623 (Sup. Ct. 1965) (use of gold compound in treatment of rheumatoid arthritis led to exfoliative dermatitis).

83. 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967).

the physician for failing to use due care with respect to duties owed to the plaintiff.[84]

Assuming that the risk of conception in *Custodio* was not material, it was rendered material by the availability of an alternative procedure which, if followed, would have completely removed the risk of pregnancy. Therefore, a jury should be instructed that the materiality of a risk is affected, not only by its incidence and severity, but also by the presence or absence of a reasonable alternative, which, if employed by the physician, would remove the risk itself while accomplishing the same result sought by the defendant. Under the majority rule, which requires a reasonable disclosure, the jury should be instructed to consider the total circumstances of the case in determining whether a given risk is material. Perhaps it would be to the plaintiff's advantage if the jury were instructed that a physician is under a specific duty to disclose all material collateral facts incident to a proposed operation or course of treatment. This would enable the jury to consider the failure to disclose reasonable alternatives as only one of the circumstances affecting the physician's liability rather than as affecting the materiality of the risk.

V. PROXIMATE CAUSE

The proof of a legal relationship between the defendant's failure to inform the patient and the patient's injuries is an uncertain burden that the injured plaintiff bears. The theory of this element in the plaintiff's cause of action is that had the physician revealed the risk of injury or other appropriate collateral facts, the plaintiff would not have consented to the operation or course of treatment. Therefore, the injury would not have occurred. As stated earlier, the establishment of cause in fact does not depend upon a finding that the doctor was negligent in conducting the operation or in administering the treatment. The technical competency of the physician is not questioned by the plaintiff, although several courts have incorrectly pointed to the lack of any specific negligence in affirming a directed verdict for the physician in actions dealing with informed consent.[85]

The difficulty arises when the plaintiff cannot present any direct proof that his consent would have been withheld. Likewise, if the defendant cannot directly prove the contrary, his only assertion is that he believed that the plaintiff, from all of the objective manifestations of consent, was willing to undergo the operation or treatment.

84. The court also indicated that the plaintiff had stated a cause of action for battery, presumably because the defendant had misled her as to the nature of the operation.

85. *E.g.*, Gravis v. Physicians & Surgeons Hosp., 415 S.W. 2d 674 (Tex. Civ. App. 1967).

Of course, the jury's function is to reach a decision with or without the aid of direct proof. In the professional malpractice case, the issues presented largely involve a question of credibility of the witnesses and parties. For example, in most informed consent cases, the physician testifies that he did disclose the risk of injury while the plaintiff takes a contrary position. Thus the jury may decide the question of breach of duty solely on the credibility of the parties. This determination differs from a finding of proximate cause. In determining proximate cause, the jury considers the plaintiff's state of mind. The defendant is helpless on this point because he cannot know whether the plaintiff would have refused treatment had the plaintiff been told of the risk. In light of this, the question arises whether the jury should be instructed to determine whether a reasonable person would have refused treatment under the same circumstances. Such an instruction would seem to abrogate the plaintiff's right to make his own decision though it may be patently illogical or unreasonable. Such an instruction, however, would aid the administration of justice and serve to protect the physician. The law should serve to protect the patient's right of free choice, but it cannot protect his right to make an unreasonable choice on an after-the-fact basis. The law can only presume that the patient would have acted reasonably, and the physician should be protected to this extent.

Despite the difficulty of proof, the plaintiff should be required to present some evidenee on the question of proximate cause. This would aid the jury in differentiating between the issues of breach of duty and proximate cause, both involving the credibility of the parties. At least one court has allowed the jury to infer negligence in the absence of any testimony by the plaintiff that he would not have consented.[86] This court indicated that such a requirement would make recovery impossible in the case of a patient who had died or was unable to testify. Such a requirement, however, could be made conditional upon the availability of the patient. If the patient is available, the defendant should be allowed the right of cross-examination in order to impeach the plaintiff's assertion that his consent would have been withheld if the proper disclosure had been made.

Once proximate cause is established, the plaintiff may recover for those unexpected injuries which arise as a matter of probability from the operation or course of treatment. The defendant is liable for the bad results of the medical treatment although he used his best efforts

86. Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965).

to prevent the harm from occuring. The imposition of liability for conduct of this nature may at first seem harsh. Professor Curran has observed:

> To the professionals themselves probably the single most disturbing fear is that the law will call them to answer in damages merely because the result they obtained was bad. Lawyers perhaps too often shrug off this complaint. It is a real fear, however, and has some truth in it both as regards filing of claims and even successful litigation by plaintiffs.[87]

On the other hand, the law does not impose liability for the physician's failure to inform his patient merely because the physician's efforts produced a bad result. The bad result, which is not in itself proof of negligence, must be combined with a failure to disclose material information.

VI. CONCLUSION

It has long been recognized in American law that a proper patient-physician relationship is founded upon the technical competency of the physician. Before the advent of cases dealing with informed consent, a patient who had given his consent to proposed treatment could recover for injuries only when the physician had acted incompetently in the administration of the treatment. Within the past fifteen years, however, the courts have recognized that the maintenance of a proper patient-physician relationship depends not only upon the technical competency of the physician, but also upon the presence of effective communication between the two parties. Therefore, recent cases have held physicians liable on a theory of negligence, even though the patient has given a valid consent and the physician has demonstrated a technical competency, when it was established that the communication respecting the proposed treatment was inadequate. This increased emphasis upon effective communication will undoubtably lead to a greater public confidence in the medical profession.

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87. Curran, *Professional Negligence—Some General Comments*, 12 VAND. L. REV. 535, 541 (1959). The physician's basic complaint is that he is being held to a standard of strict liability. He would maintain that where he has selected a form of treatment which is medically sound and has administered this treatment in a manner acceptable within his profession, he should not be held liable if injury results. The physician's liability for failing to inform his patient, however, does not rest on a theory of strict liability. A physician is strictly liable in this sense when he treats the patient without first disclosing what risks will be incurred. A physician must be prepared to compensate his patient if the unexpected injury materializes, even though he took every precaution to avoid it. His liability, however, is not strict because it rests upon an independent wrong; namely, a failure to inform his patient adequately in order that the patient may intelligently decide to accept the risk of injury.