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# INFORMED REFUSAL: PHYSICIAN LIABILITY FOR FAILURE TO INFORM OF THE RISKS ASSOCIATED WITH REFUSING DIAGNOSTIC TESTS

*Traditionally, the doctrine of informed consent governed the presentation of information about methods of treatment by a physician to allow a patient to make an informed choice. Recent decisions in California and Washington have extended the consent doctrine in order to promote patient participation in diagnostic decision making. This Comment considers the policies and problems underlying informed refusal in the diagnostic process.*

## INTRODUCTION

For the past two decades<sup>1</sup> the doctrine of informed consent has been used to promote patient participation in medical treatment decisions.<sup>2</sup> Although informed consent originated in the area of intentional tort,<sup>3</sup> it has become a well-established theory in negligence actions for medical malpractice.<sup>4</sup> The physician's affirma-

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1. The development of informed consent within this twenty year period has been largely confined to negligence after the landmark decision in *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960). In that case the Kansas Supreme Court held that the plaintiff was entitled to jury instructions on negligence. The doctrine of consent to treatment had been recognized as a defense to an action in battery for many years prior to the *Natanson* decision. See *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906); *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914), *overruled on other grounds*, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 1 (1957). See generally W. PROSSER, *THE LAW OF TORTS* § 9, at 34, 35 (4th ed. 1971).

2. The doctrine of informed consent is an action independent of the traditional action for medical malpractice. It is based on a lack of consent not a harmful result. W. PROSSER, *THE LAW OF TORTS* § 9, at 35 (4th ed. 1971); 2 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* §§ 22.01-.09 (1960 & Cum. Supp. 1980).

3. For a collection of cases using the intentional tort of battery as a basis of liability, see McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 383 n.10 (1957).

4. Discussions of informed consent as an action in negligence prior to 1970 are collected in Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U.L. REV. 628, 628 n.1 (1970). For references collected after 1970, see Meisel, *The Expan-*

tive duty to inform the patient about treatment choices is usually measured by a professional standard of care.<sup>5</sup> A recent trend,<sup>6</sup> however, elevates the patient's role in the decision-making process by implementing a standard based on the needs of the particular patient involved.<sup>7</sup>

Recent decisions in California<sup>8</sup> and Washington<sup>9</sup> not only adhere to this trend, but also extend the role of the patient to include participation in diagnostic decision-making.<sup>10</sup> This extension has been termed "informed refusal." While informed consent represents the patient's right to choose among treatments, informed refusal refers to the patient's choice to refuse tests before a diagnosis is made and treatment suggested.<sup>11</sup> Diagnostic decisions have traditionally been made only by physi-

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*sion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51, 74 n.64 (1977).

5. The professional community standard judges the information against the prevailing medical practice in similar communities. See King, *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1262 (1975).

6. The trend is "modern" because it was not recognized by case law until 1972 in *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). It is also "modern" in the sense that it recognizes the influence of social commentators on the value of patient participation in health care. Approximately ten states and the District of Columbia have adopted the patient dominant standard. Annot., 88 A.L.R.3d 1008 (1978).

7. In *Canterbury*, the court advanced three reasons for the imposition of a patient-oriented standard of information evaluation. First, the court stated that "the reality of any discernible custom reflecting a professional consensus on communication of option and risk information to patients is open to serious doubt" because custom may be merely to ". . . maintain silence." *Canterbury v. Spence*, 464 F.2d 772, 783-84 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972). Second, the court found "no basis for operation of the special medical standard where the physician's activity does not bring his medical knowledge and skills peculiarly into play." *Id.* at 785. Finally, and most importantly, the court recognized that "[r]espect for the patient's right of self-determination . . . demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves." *Id.* at 784.

8. *Truman v. Thomas*, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980).

9. *Keogan v. Holy Family Hosp.*, 95 Wash. 2d 306, 622 P.2d 1246 (1980); *Gates v. Jensen*, 92 Wash. 2d 246, 595 P.2d 919 (1979).

10. Although a review of opinions on informed consent might suggest that the patient has always possessed the power to make diagnostic decisions, see, e.g., *Miller v. Kennedy*, 11 Wash. App. 272, 522 P.2d 852 (1974), *affirmed per curiam*, 85 Wash. 2d 151, 530 P.2d 334 (1975) (physician was required to obtain patient's informed consent to a kidney biopsy, a diagnostic procedure), the patient's participation was limited to decisions on tests chosen by the physician. The "informed refusal" doctrine would require the physician to inform the patient of the danger in refusing a test or would require the physician to inform the patient of tests the physician has ruled out as unnecessary.

11. The term was coined by the California Court of Appeal when it considered *Truman v. Thomas*, 93 Cal. App. 3d 304, 315, 155 Cal. Rptr. 752, 757 (1979), *rev'd*, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980), to describe a situation requiring

cians.<sup>12</sup> The informed refusal doctrine, however, places an affirmative duty on the physician to disclose the information, risks, and potential consequences of omitting or refusing a diagnostic test.<sup>13</sup>

This Comment explores the validity<sup>14</sup> and development<sup>15</sup> of patient control over the medical information-gathering and decision-making processes. Informed refusal represents an inroad into the realm of physician dominance over patients and should be favored by advocates of patient autonomy.<sup>16</sup>

#### EXPANSION OF INFORMED CONSENT AS A PRELUDE TO INFORMED REFUSAL

An analysis of informed refusal necessarily begins with an examination of the growth of informed consent. Under the intentional tort theory, a physician's unauthorized treatment of a patient was a battery—an unconsented to touching.<sup>17</sup> Unfortunately, the physician often influenced the outcome of early battery decisions and patient consent was found where it appeared to be lacking.<sup>18</sup> Plaintiffs eventually had more success with a negligence theory that placed an affirmative duty on the physician to

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the physician to inform a patient of the consequences associated with refusing a pap smear.

This Comment will use the term to include omitted as well as refused tests. See *supra* note 10.

12. In the case of *Gates v. Jensen*, 92 Wash. 2d 246, 595 P.2d 919 (1979), the physician had *mentally* omitted glaucoma as a cause of patient's symptoms. The new duty imposed by the Washington court required him to inform the patient of further tests that could have conclusively diagnosed or ruled out glaucoma as a cause. *Id.* at 250, 595 P.2d at 923.

Additionally, it has often been stated that a physician is not liable for a mistaken diagnosis, only for a negligent diagnosis. *Hoven v. Kelble*, 79 Wis. 2d 444, 256 N.W.2d 379, 385 (1977). The new doctrine is consistent because the doctor's diagnoses in the informed refusal cases were not characterized as negligent, only invalid due to a lack of patient choice.

13. See *supra* notes 9 and 10.

14. See *infra* text accompanying notes 52-74.

15. See *infra* text accompanying notes 76-107.

16. "Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . ." *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

17. See W. PROSSER, *THE LAW OF TORTS* § 9, at 35 (4th ed. 1971).

18. The administration of anesthesia was said to relieve the physician of the duty to obtain consent in *McGuire v. Rix*, 118 Neb. 434, 225 N.W. 120 (1929), where the physician performed a surgical operation after promising "that cutting would not be necessary" to reduce plaintiff's fracture. See also *McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 394 (1957).

procure the patient's informed consent as a prerequisite to treatment.<sup>19</sup>

The duty to inform was initially measured by a community professional standard.<sup>20</sup> In *Cobbs v. Grant*,<sup>21</sup> however, the California Supreme Court held the use of a professional standard inadequate in light of the legal recognition of the patient's right to decide on a course of treatment.<sup>22</sup> The *Cobbs* court adopted a new standard that emphasized the decision-making needs of the patient as the correct measure of the adequacy of the information imparted.<sup>23</sup> Such a standard recognized the importance of patient participation in medical treatment.<sup>24</sup> The policy of patient autonomy is an important factor in the decision to include diagnostic testing within the realm of patient involvement.<sup>25</sup>

#### BREAKING NEW GROUND: THE CALIFORNIA AND WASHINGTON FORMULATIONS OF INFORMED REFUSAL

The Supreme Court of California considered the application of informed refusal in *Truman v. Thomas*.<sup>26</sup> *Truman* involved a physician's failure to inform a patient of the risks involved in refusing to submit to a pap smear.<sup>27</sup> During the six-year period for which he was primarily responsible for the patient's care, the physician never explained that the test could detect the presence of cervical cancer at an early, treatable stage. A gynecologist subsequently diagnosed and unsuccessfully attempted to treat the cervical cancer. The patient died at the age of thirty.<sup>28</sup>

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19. In *Hunter v. Burroughs*, 123 Va. 113, 96 S.E. 360 (1918), the physician was supposed to warn a patient of the possibly harmful consequences of treatment with radiation therapy; failure to do so constituted negligence. See also McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 590 (1959).

20. See *supra* note 5.

21. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

22. *Id.* at 242, 502 P.2d at 9, 104 Cal. Rptr. at 514.

23. "In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice." *Id.* at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

24. "Blind adherence to local practice is completely at odds with the undisputed right of the patient to receive information which will enable him to make a choice—either to take his chances with the treatment or operation recommended by the doctor or to risk living without it." *Wilkinson v. Vesey*, 110 R.I. 606, 625, 295 A.2d 676, 688 (1972).

25. "[T]he patient has a right to know the material facts concerning the condition of his or her body, and any risks presented by that condition, so that an informed choice may be made regarding the course which the patient's medical care will take." *Gates v. Jensen*, 92 Wash. 2d 246, 250, 595 P.2d 919, 922 (1979).

26. 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980).

27. *Id.* at 289, 611 P.2d at 907, 165 Cal. Rptr. at 314.

28. *Truman v. Thomas*, 27 Cal. 3d 285, 289, 611 P.2d 902, 907, 165 Cal. Rptr. 308, 314 (1980).

The California Court of Appeal affirmed a directed verdict for the defendant physician,<sup>29</sup> rejecting the plaintiff's claim of liability on the theory of informed refusal.<sup>30</sup> The reasons given for rejecting informed refusal included: the lack of support in California case law; the absence of an analogy to battery; the failure to show that the inherent dependence of the patient upon her physician suggested anything other than a common understanding that his advice should be followed; and the imposition of the duty showing lack of respect for the physician's judgment.<sup>31</sup> The majority intimated that if the patient had made further inquiry, the duty to inform would have arisen.<sup>32</sup>

The Supreme Court of California reversed in a four to three decision.<sup>33</sup> The *Truman* court held that the patient's refusal of a risk-free diagnostic test imposed an additional duty upon the physician to inform the patient of the risk associated with refusing the recommended test.<sup>34</sup> In imposing liability, the court relied principally on the increased duty owed by a physician to his patient.<sup>35</sup> The California court in *Cobbs v. Grant*<sup>36</sup> had characterized this duty as fiduciary in nature. The *Truman* court did not

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29. *Truman v. Thomas*, 93 Cal. App. 3d 304, 155 Cal. Rptr. 752 (1979), *rev'd*, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980).

30. The court reasoned that there was no support for strict medical liability in California and that imposing liability would extend *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974), to absolute liability by requiring the test over the patient's objection. *Truman v. Thomas*, 93 Cal. App. 3d 304, 312, 155 Cal. Rptr. 752, 755 (1979), *rev'd*, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980).

31. *Id.* at 307-09, 155 Cal. Rptr. at 755-59. A persuasive dissent in the court of appeal decision perceives the inconsistencies in the majority's rejection of informed refusal. The dissenter was not impressed by the lack of any analogy between the failure of a physician to inform and the intentional tort approach to consent. The dissent also reasoned that a patient who is abjectly dependent on the physician and yet refuses to allow the gathering of diagnostic information probably does not comprehend the implication of further tests. The dissent concluded that modern medical law demands that the patient be given enough information to allow him to make his decision as to the proposed diagnostic procedure. *Id.* at 320-23, 155 Cal. Rptr. at 761-62.

32. *Id.* at 318, 155 Cal. Rptr. at 759.

33. 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980).

34. "If a patient indicates that he or she is going to *decline* the risk-free test or treatment, then the doctor has the additional duty of advising of all material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure." *Id.* at 292, 611 P.2d at 906, 165 Cal. Rptr. at 312.

35. "It must be remembered that Dr. Thomas was not engaged in an arms-length transaction with Mrs. Truman. Clearly, under *Cobbs*, he was obligated to provide her with all the information material to her decision." *Id.* at 293, 611 P.2d at 906, 165 Cal. Rptr. at 312.

36. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

address any of the other justifications that have been advanced in favor of informed consent,<sup>37</sup> nor did the majority address the arguments raised by the dissent.<sup>38</sup>

In 1979, another version of informed refusal was adopted by the Washington Supreme Court in *Gates v. Jensen*.<sup>39</sup> *Gates* presented the issue of whether a detected physical abnormality gives rise to a duty to inform the patient of simple, inexpensive, and risk-free diagnostic procedures to confirm the existence of disease.<sup>40</sup> The court answered affirmatively and held the defendant physician liable for failing to provide sufficient information to enable the patient to make an informed refusal of the omitted tests.<sup>41</sup>

In *Gates*, the physician administered an ocular pressure test for the detection of glaucoma and noted a slightly elevated, or positive, reading. The physician then examined Mrs. Gates' eyes directly and concluded that her problems were associated with her contact lenses. The record revealed that there were simple, inexpensive, and risk-free tests available for the detection of glaucoma.<sup>42</sup> The court held that the detection of the abnormality triggered a duty to inform the patient of the available alternative tests.<sup>43</sup> This duty was imposed on the physician so that the patient could make an informed diagnostic choice.<sup>44</sup>

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37. See *infra* notes 52-58 and accompanying text.

38. Justice Clark assumed that the majority opinion, carried to its logical end, would require a physician to explain the intricacies of innumerable diagnostic procedures. *Truman v. Thomas*, 27 Cal. 3d 285, 298, 611 P.2d 902, 910, 165 Cal. Rptr. 308, 316 (1980). He stated that "[r]equiring physicians to spend a large portion of their time teaching medical science before practicing it will greatly increase the cost of medical diagnosis—a cost ultimately paid by an unwanting public." *Id.* at 298-99, 611 P.2d at 910, 165 Cal. Rptr. at 316. He proposed that if the goal of educating patients is socially justified, the question of implementation should be left to the Legislature. Justice Clark concluded by saying that *Cobbs* involved lack of consent to treat and "[w]hen no intrusion takes place, no need for consent—effective or otherwise—arises." *Id.* at 300, 611 P.2d at 911, 165 Cal. Rptr. at 317.

39. 92 Wash. 2d 246, 595 P.2d 919 (1979).

40. "The first question is whether the doctrine of informed consent requires a physician to inform a patient of a bodily abnormality discovered during a routine examination and of diagnostic procedures which may be taken to determine the significance of that abnormality." 92 Wash. 2d 246, 247, 595 P.2d 919, 921 (1979).

41. 92 Wash. 2d 246, 247, 595 P.2d 919, 924 (1979). The term "informed refusal" does not appear anywhere in the text of the opinion; however, if informed refusal is characterized as the patient's right to be fully informed before a diagnostic test is refused or omitted, then the applicability of *Gates* is apparent.

42. *Id.* at 247, 595 P.2d at 921.

43. "These tests need only be used when other diagnostic procedures are inconclusive for some reason, or when a red flag of warning has been raised by some abnormality suggesting the risk of glaucoma." *Id.* at 251, 595 P.2d at 924.

44. *Id.* at 251, 595 P.2d at 923. The idea of informed refusal was criticized and a proposal was made that it be limited to the facts in *Gates*. See Comment, *Informed Consent in Washington: Expanded Scope of Material Facts That the Physician Must Disclose to His Patient*, 55 WASH. L. REV. 655, 670-75 (1980).

The Washington Supreme Court reaffirmed the physician's duty in *Keogan v. Holy Family Hospital*.<sup>45</sup> *Keogan* involved a tentative diagnosis of angina indicated by slightly elevated cardiac enzyme tests. The defendant physician did not inform the patient of the tentative diagnosis,<sup>46</sup> nor did he explain the availability of further tests to verify the diagnosis.<sup>47</sup> The supreme court disagreed with the lower court's<sup>48</sup> conclusion that the omitted tests were not simple, inexpensive, or risk-free, observing that "considering the alternative of death by heart attack, [the tests] were relatively simple and risk-free."<sup>49</sup> The court went on to note that the patient's symptoms, the nature and usefulness of the tests, and the potential severity of the disease were all important in imposing a duty to inform.<sup>50</sup> In dictum the court noted that a physician was not required to disclose all tests available to conclusively diagnose all possible diseases.<sup>51</sup>

#### VALIDITY OF INFORMED REFUSAL

Support for informed refusal arises from a consideration of the policies it vindicates<sup>52</sup> and from an examination of its logical relation to informed consent. Criticism of the doctrine focuses on the uncertainty created within the medical profession<sup>53</sup> and the potential impact of another medical malpractice crisis.<sup>54</sup>

Furtherance of patient autonomy is the primary justification given for the additional duty imposed by the California and Wash-

45. 95 Wash. 2d 306, 622 P.2d 1246 (1980).

46. *Id.* at 309, 622 P.2d at 1249.

47. The three tests available at the time were a nitroglycerine test, a treadmill EKG and an angiogram. The court described the tests, but did not provide risk statistics on the first two procedures. It was only with the third procedure that they acknowledged a 0.2-0.3% risk of death. *Id.*

48. 22 Wash. App. 366, 589 P.2d 310 (1979), *aff'd on rehearing*, 24 Wash. App. 583, 601 P.2d 1303 (1979), *rev'd* 95 Wash. 2d 306, 622 P.2d 1246 (1980).

49. *Keogan v. Holy Family Hosp.*, 95 Wash. 2d 306, 320, 622 P.2d 1246, 1255 (1980) (emphasis original).

50. *Id.* at 318-19 n.3, 622 P.2d at 1254-55 n.3.

51. *Id.*

52. In addition to the policies to be discussed hereafter, other policies support the additional duty to inform. These include: 1) increasing the personalization of health care; 2) increasing public understanding of medical facts; and 3) improving the negative public image of medical professionals. For a general discussion of these practical considerations see SENATE SUBCOMM. ON EXECUTIVE REORGANIZATION, MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN, 91st Cong., 1st Sess., 2-5, 447-51 (Comm. Print 1969).

53. See *infra* text accompanying notes 67-71.

54. See *infra* notes 72-96 and accompanying text.



ington decisions.<sup>55</sup> The opinions rely upon the *Cobbs* characterization of the fiduciary nature of the doctor-patient relationship.<sup>56</sup> The doctor owes more than a minimal duty to inform; he is obliged to act in the best interests of the patient by imparting the information the patient needs to make an informed choice.<sup>57</sup>

Patient control of the decisions affecting his body is not the only logical basis for creating a cause of action for informed refusal. Reducing the number of medical malpractice suits caused by patient dissatisfaction,<sup>58</sup> increasing consumer awareness by encouraging patients to choose doctors who treat them as equals,<sup>59</sup> and promoting patient compliance with a chosen treatment or test are also valid reasons for extending the duty to inform.<sup>60</sup>

The logical relationship between refusal and consent provides additional support for informed refusal. Informed consent often requires the physician to disclose available alternatives to a proposed treatment.<sup>61</sup> When the patient chooses one treatment from among the others, he is simultaneously refusing the alternatives and non-treatment. The problem with informed refusal, therefore, is not the "refusal" portion of the doctrine. Rather, the difficulty lies in the fact that the patient is exercising control over diagnostic choices.<sup>62</sup>

Often a physician is unsure of the choices involved with diagnosis.<sup>63</sup> Allowing the patient to participate in diagnosis may be too

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55. See *supra* notes 23-25.

56. The four policy factors considered in *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972), were the unequal knowledge of patient and physician; the right of an adult to determine whether to submit to medical treatment; the need for consent to be informed in order to be effective; and the abject dependence of the patient on the physician which transcends arms-length transactions. *Id.* at 242, 502 P.2d at 9, 104 Cal. Rptr. at 513.

57. *Id.* at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

58. See Waitzkin & Stoeckle, *The Communication of Information about Illness: Clinical, Sociological and Methodological Considerations*, 8 ADV. PSYCHOSOM. MED. 180, 182-85 (1972).

59. See Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 375-76 (1974). Promoting patient equality is an important policy in the research area and in the diagnostic area because both depend upon patient feedback for evaluating results.

60. See Capron, *supra* note 59, at 375-76.

61. For an analysis of the principle that alternatives to treatment must be disclosed, see Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533, 1546-47 (1970).

62. The analogy that can be drawn to research and experimentation is appropriate here. The difficulty in experimentation and in diagnosis lies in the fact that both lead to uncertain results. Nevertheless, the physician is obliged to share the information he does have so patient participation can be encouraged. See generally Capron, *supra* note 59.

63. See H. WAITZKIN & B. WATERMAN, *THE EXPLOITATION OF ILLNESS IN CAPI-*

great a responsibility to visit upon him because he may be faced with a myriad of symptoms, possible causes, and tests to determine causes.<sup>64</sup> The physician's duty is to provide an objective medical evaluation of the information being imparted by the tests. The physician can then assist the patient by placing the diagnostic alternatives in perspective.<sup>65</sup> The patient should not become a barrier to a physician's attempt to elicit diagnostic information. Patient participation should be limited to cases involving devastating diseases whose risks significantly outweigh the risk associated with diagnostic testing.<sup>66</sup>

Informed refusal has been criticized on several grounds. Justice Clark's dissent in *Truman v. Thomas* typifies the concern about the impact of the doctrine.<sup>67</sup> Potential problems associated with informed refusal include uncertainty in the medical profession in determining how to comply with the additional duty to inform<sup>68</sup> and an increase in the volume of medical malpractice litigation.<sup>69</sup>

One danger inherent in the doctrine of informed refusal is that the scope of the physician's duty is unclear.<sup>70</sup> Consequently, a physician might be induced to recommend all possible tests to detect a serious condition in order to protect himself from legal liability.<sup>71</sup> Diagnosis itself is an uncertain science and imposing the

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TALIST SOCIETY 76 (1974); Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 951 (1963).

64. See Epstein & Lasagna, *Obtaining Informed Consent: Form or Substance*, ARCH. INT. MED. 682, 684 (1969).

65. Placing the alternatives in perspective would always interject some degree of physician bias, but this bias may have to be tolerated if the patient is to have the benefit of the physician's specialized training. For a general discussion of physician bias, see Schneyer, *Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices*, 1976 WIS. L. REV. 124.

66. Determining how "devastating" a result may be, and whether diagnostic testing was relevant to the result would probably require expert medical testimony, but should be judged against an ordinary reasonable prudent patient standard.

67. Justice Clark's objections to informed refusal are set out in note 38 *supra*.

68. See *supra* note 63.

69. See *infra* text accompanying notes 98-99.

70. For a general discussion of the development of the law of negligence as a system of loss compensation, see Henderson, *"Crisis" in Accident Loss Reparations Systems: Where We Are and How We Got There*. 1976 ARIZ. ST. L.J. 401.

71. This practice would represent positive defensive medicine, i.e., the physician acts in an affirmative manner to defend himself from liability. For a discussion of defensive medicine and its impact, see *infra* notes 81-82 and accompanying text.

duty to inform of omitted or refused diagnostic tests will certainly increase the complexity of diagnostic decisions. Initially, much of the doctor's legal uncertainty could be reduced if there existed judicial guidelines defining the precise scope of the duty. The courts could then gradually expand the patient's participation as the doctrine develops into an effective means of promoting patient independence.

It is difficult to predict the effect of informed refusal on medical malpractice litigation. Initially, the volume might increase to fill the void created by the failure to recognize the patient's right to participate in diagnosis.<sup>72</sup> As the goal of patient autonomy is furthered, however, we may ultimately see a reduction in the number of legal actions as the patient shares an increased responsibility for diagnostic decisions.<sup>73</sup>

The courts should focus on striking a balance between furthering patient autonomy and reducing the detrimental impact another medical malpractice crisis would have on society.<sup>74</sup> The balancing process may depend on whether a court decides that the doctrine of informed refusal should grow with or without judicial limitation.<sup>75</sup>

#### DEVELOPMENT OF INFORMED REFUSAL

Judicial inquiry into the means of developing the doctrine of informed refusal should consider the problems associated with the rapid expansion and subsequent limitation of informed consent.<sup>76</sup> An analogy to informed consent is relevant because: 1) both doctrines have imposed a duty on the physician to communicate with the patient; 2) each doctrine represents a significant expansion of the prior legal theory upon which liability was predicated; and 3) the development of each is occurring in a contemporary medical environment. If informed refusal mirrors the development of informed consent, then the new doctrine's effect on the cost and quality of health care may be predicted by a model composed of three stages of growth. Initially, judicial resistance to change may

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72. See *supra* note 10 for a discussion of the void left by refusing to recognize patient participation in diagnosis.

73. The reduction would occur in two ways: 1) increasing patient participation will increase patient self esteem and satisfaction; and 2) patients will accept responsibility for their own choices.

74. The balance will be difficult to achieve in the face of our increasingly litigious society. For a discussion of the medical malpractice crisis, see CALIFORNIA ASSEMBLY COMMITTEE ON FINANCE, INSURANCE AND COMMERCE, *MEDICAL MALPRACTICE INSURANCE AND THE ROLE OF THE PRIVATE INSURANCE MARKET DURING THE POST REFORM PERIOD* (1975).

75. See *infra* text accompanying notes 100-107.

76. See *infra* text accompanying notes 91-100.

limit the expansion of the doctrine.<sup>77</sup> The second phase could encompass a period of wide acceptance and use of the doctrine. Finally, we might see judicial and legislative limits placed on the use of the doctrine in response to the problems associated with a period of rapid expansion.

*Development of Informed Refusal Without Limits*

The Washington and California decisions emphasized the devastating results following the physician's failure to inform the patient of the consequences accompanying a refusal or omission of testing.<sup>78</sup> In view of these consequences the doctrine of informed refusal was created to provide a legitimate role for patients in the diagnostic process.<sup>79</sup> If informed refusal follows informed consent, the scope of the new cause of action might be enlarged to compensate victims for less devastating results in other jurisdictions. The doctrine could become another means to justify a large jury award<sup>80</sup> rather than a valid method to include patients in diagnostic determinations.

Rapid expansion of the doctrine may be detrimental to the cost and quality of health care. Costs could be affected in two ways. First, the physician may practice defensive medicine to reduce his potential liability.<sup>81</sup> Defensive medicine may cause a diversion of medical resources from providing treatment to supplying unnecessary testing.<sup>82</sup> Second, the physician often passes the cost of increased medical malpractice insurance premiums on to the patient in the form of increased fees for services.<sup>83</sup>

The impact of informed refusal on the quality of health care

77. Courts are often hesitant to leave the security of stare decisis in search of a cause of action. The Supreme Court of California, however, has always been characterized as a ground-breaker. Tribe, *Trying California's Judges on Television: Open Government or Judicial Intimidation?* 65 A.B.A. J. 1175, 1176 (1979).

78. *Truman v. Thomas*, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (death of patient); *Keogan v. Holy Family Hosp.*, 95 Wash. 2d 306, 622 P.2d 1246 (1980) (death of patient); *Gates v. Jensen*, 92 Wash. 2d 246, 595 P.2d 919 (1979) (functional blindness of patient).

79. See *supra* note 25.

80. See *supra* note 70.

81. See Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 942.

82. *Id.*

83. See, e.g., Comment, *Malpractice Suits: The Increased Costs of Health Care*, 8 TULSA L.J. 223 (1972).

The extended use of third party insurance, however, may cause all patients to pay a higher percentage of their income dollar to meet the expense of insurance

may be more difficult to measure than its effect on cost. Nevertheless, many would agree that the quality of health care is often affected by the legal duty imposed upon physicians, the practices of defensive medicine, and the cost of providing care.<sup>84</sup> The first two factors are results of a fault-based model of medical liability. Imposing fault on the culpable party is designed to serve as a deterrent to future substandard care.<sup>85</sup> Physician overreaction to the threat of liability, however, tends to make physicians overly cautious to the point of reducing the quality of care by channeling their energies into avoiding litigation instead of providing care.<sup>86</sup>

Cost considerations may have an effect on the quality of care in other ways. If the cost of access to the health care system is too large, many patients may be forced to tolerate a disease until the "cost" of the disease to the patient outweighs the entry cost.<sup>87</sup> If the increase in the physician's cost of practicing medicine is significant, it may discourage innovation in the treatment and diagnosis of disease, causing lower quality care.<sup>88</sup>

If the cost and quality of care are tied to the volume of litigation, then the impact on both will be minimal during the initial acceptance of informed refusal. As the volume of litigation increases, however, the detrimental effects on cost and quality could well trigger the type of legislative and judicial response that limited the scope of informed consent.

The increased volume of informed consent litigation contributed to the rising cost of medical malpractice insurance premi-

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protection. See King, *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1227-29 (1975).

84. See King, *supra* note 83.

85. See Roemar, *Controlling and Promoting Quality in Medical Care*, 35 LAW & CONTEMP. PROBS. 284, 294 (1970). But see Carlson, *A Conceptualization of a No-Fault Compensation System for Medical Injuries*, 7 LAW & SOC'Y REV. 329, 353-54 (1973) (professional commiseration and liability insurance's insulating effects may affect the validity of the fault system).

86. The emergence of medical jurisprudence articles warning physicians of new legal decisions is one example of medical energy diverted from patient care. See Hassard, *Patient's Right to Know*, BULL. L.A. COUNTY MED. SOC'Y, Nov. 1, 1973, at 11.

87. See Altman, *Malpractice Rates Drive Up Doctor Fees*, N.Y. Times, July 27, 1975, at 1, col. 4. One hospital had to increase its room rates 12 dollars per day to meet increased insurance costs. *Id.* at 24, cols. 2-3. See also TIME, June 16, 1975, at 50. If the costs continue to rise at this rate, the patient without medical insurance cannot afford to be sick.

88. During the malpractice insurance crisis of the 1970's many physicians were forced to close their practices due to spiraling insurance rates. See Letter from Dr. Lichtman in CALIFORNIA ASSEMBLY COMMITTEE ON FINANCE, INSURANCE, AND COMMERCE, MEDICAL MALPRACTICE INSURANCE AND THE ROLE OF THE PRIVATE INSURANCE MARKET DURING THE POST REFORM PERIOD 400 (1975). If doctors cannot keep their practices open for their patients and the availability of physicians is reduced, it seems logical to assume quality will be decreased.

ums during the 1970's.<sup>89</sup> The cost became so prohibitive that many physicians were forced to practice without insurance, reduce the use of remotely harmful procedures, or close their offices until insurance rates decreased.<sup>90</sup> The outcry from physicians and patients not only led to legislative limitations on the informed consent doctrine, but may also have ensured a hostile reaction to informed refusal.

In response to the medical malpractice crisis, state legislatures enacted laws mandating the use of screening panels<sup>91</sup> or arbitration procedures<sup>92</sup> and restrictively codified the elements of informed consent.<sup>93</sup> States passed laws that reverted to a community professional standard to evaluate the physician's duty,<sup>94</sup> prohibited the pleading of the informed consent cause of action when the physician satisfies a legislatively defined standard, or increased the burden of proof the plaintiff had to meet.<sup>95</sup> Informed refusal could be limited by a judicial attitude resembling that of the legislature. Judicial conservatism might cause a retreat from the policy of promoting patients' rights.<sup>96</sup>

Courts have options for vindicating the policies underlying informed refusal. Courts could directly challenge the validity of restrictive statutes or explore other ideas for recovery. Constitutional invalidity could be argued on the basis of equal protection or separation of powers.<sup>97</sup> If an activist court declines a direct constitutional challenge to a statute, statutory interpretation could provide a basis for reaching a result consistent with the

89. *Id.*

90. *Id.*

91. See Comment, *Constitutional Challenges to Medical Malpractice Review Boards*, 46 TENN. L. REV. 607, 612 (1979).

92. See Baird, Munsterman & Stevens, *Alternatives to Litigation, I: Technical Analysis*, in HEW, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, 217 app. (1973).

93. "In any event, whether clearly stated or thinly disguised, the purpose of the [state] legislation was to make it more difficult for patients to recover in suits brought by them against their physicians." Meisel & Kabnick, *Informed Consent to Medical Treatment: Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 415 (1980).

94. See, e.g., DEL. CODE ANN. tit. 18 § 6852(a)(2) (Supp. 1980); FLA. STAT. ANN. § 768.46(3)(a)(1) (West Supp. 1981); IDAHO CODE § 39.4304 (1977); KY. REV. STAT. ANN. § 304.40-320(1) (Baldwin Supp. 1980); N.C. GEN. STAT. § 90.21.13(a)(1) (Supp. 1981).

95. See Curran, *Informed Consent, Texas Style: Disclosure and Nondisclosure by Regulation*, 300 NEW ENG. J. MED. 482 (1979).

96. *Bly v. Rhoads*, 216 Va. 645, 650, 222 S.E.2d 783, 787 (1976).

97. See Comment, *supra* note 91, at 614-32.

policies supporting informed refusal.<sup>98</sup> The difficulty with judicial activism is that an activist court may be subjected to intense public and legislative scrutiny.<sup>99</sup> This scrutiny may inhibit any attempts to expand informed refusal.

Those attempting to limit rapid development of a legal doctrine often overlook the justifications supporting the origin of the doctrine.<sup>100</sup> A more reasonable proposal might be to avoid the problems associated with uncontrolled extension of recoveries based on informed refusal.

### *Controlling the Growth of Informed Refusal*

In order to avoid the pitfalls of unchecked growth, the doctrine of informed refusal must utilize the best features of the California and Washington cases. Informed refusal can borrow its standards from the law of informed consent<sup>101</sup> but should be limited to diagnostic situations with potentially devastating results.<sup>102</sup>

The duty can arise if a patient refuses a risk-free test the physician recommends. The duty can also arise as to available tests if a physical abnormality, combined with an evaluation of the patient's symptoms, suggests that risk-free testing is indicated. The scope of the duty should focus on the nature of the tests involved, the potential for significant harm, the physician's experience with the patient's symptoms and medical history, and the needs of the particular patient.

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98. Indeed, even the Washington Legislature attempted to retreat to a restrictive standard with WASH. REV. CODE § 424.290 (Supp. 1975). Statutory interpretation enabled the Washington Supreme Court to avoid the statute in *Gates*. See generally Moore, *The Semantics of Judging*, 54 S. CAL. L. REV. 151 (1981).

99. See Tribe, *Trying California's Judges on Television: Open Government or Judicial Intimidation?*, 65 A.B.A. J. 1175-79 (1979). For a contrary view see Galanter, Palen & Thomas, *The Crusading Judge: Judicial Activism in Trial Courts*, 52 S. CAL. L. REV. 699, 737 (1979).

100. The legislative response to physician outcry may represent a retreat from many of the advances made in the informed consent area. Meisel & Kabnick, *supra* note 93, at 563, conclude that the "most significant among the effects that some of the statutes may have is that they will preclude the possibility of *judicial liberalization* of common-law rules in a manner that might favor patients" (emphasis added).

101. See D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* § 22.01-09 (1960 & Supp. 1980) for a description of the different standards that could be utilized for evaluating physician disclosure.

102. This limit is imposed to prevent the doctrine of informed refusal from becoming merely a supplemental pleading to justify a request for astronomical damages. The doctrine should be used to promote patient recovery when the remedy under more traditional causes of action is absent. This exclusive use of informed refusal would encourage courts to crystallize the elements of the doctrine so that physician uncertainty can be reduced.

The risk-free and conclusive nature of the tests<sup>103</sup> involved should be a significant factor in the decision to inform. Initially the doctrine should be confined to risk-free testing to help overcome judicial and medical resistance to change.<sup>104</sup> The tests should also be relatively conclusive in order to avoid causation problems. If the tests could not have significantly added to the diagnostic process, their omission should not create informed refusal liability.<sup>105</sup>

Expert medical testimony should be introduced as to whether the potential severity of the result justified the use of tests not classified as risk-free, simple, or inexpensive. Therefore, a balancing test might focus on the foreseeability of the harm versus the nature of the tests. The balance would be tipped in favor of the patient if he could show that his particular needs, which the physician knew of,<sup>106</sup> increased the significance of the result. But the physician should be allowed to testify as to medical factors such as the patient's history of disease, his own medical experience, and the incidence of the disease involved in order to create a defense to liability based on therapeutic privilege.<sup>107</sup>

The balancing test should seek to further patient autonomy while recognizing the physician's diagnostic and legal uncertainty. If a physician is sufficiently concerned about a condition that he recommends a test, his duty to inform would be easier to find. If a physician has only an abnormality upon which to make

103. Although experts may disagree as to whether tests are risk-free and conclusive, the designation may be a useful one in determining a line of causation.

104. See *Baker v. Carr*, 369 U.S. 186, 266-330 (1961) (Frankfurter, J., dissenting), as an example of adherence to legal precedent as the motivating factor in judicial decision-making.

105. See Comment, *Informed Consent in Washington: Expanded Scope of Material Facts That the Physician Must Disclose to His Patient*, 55 WASH. L. REV. 655, 670-75 (1980).

106. If the physician is not aware of a patient's needs he cannot respond to them. The physician may, however, be able to determine some patient fears of a particular condition by examining the patient's medical history.

107. Therapeutic privilege represents the physician's defense of community practice to justify non-disclosure of some risks when therapy may be jeopardized. For a history and analysis of therapeutic privilege, see Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 460-70. For a detailed analysis of the problems of therapeutic privilege with regard to cancer patients, see Comment, *When the Truth Can Hurt: Patient Mediated Informed Consent in Cancer Therapy*, 9 U.C.L.A.-ALASKA L. REV. 143, 184-96 (1979).



his decision to omit a test, more weight should be placed on the medical expertise of the physician.

#### CONCLUSION

The doctrine of informed refusal offers an opportunity for increased patient involvement in the diagnostic arena. The courts, however, should be cognizant of the apprehensions of the medical profession so that the fear of a malpractice crisis does not destroy the effective use of the doctrine. The physician must be careful not to base his practice on avoiding legal liability. Finally, the patient must strive to educate himself about the processes and abnormalities associated with his body and learn to evaluate the information imparted by his partner in health care—the physician.

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