

INFORMED CONSENT AFTER COBBS*— HAS THE PATIENT BEEN FORGOTTEN?

*Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .*¹

I. INTRODUCTION

Although the state has closely scrutinized the physician-patient relationship in all civilized societies,² it is only recently that American courts have held physicians liable for failing to disclose to their patients the risks inherent in a proposed course of treatment.³ The physician who has failed to adequately disclose the potential dangers of treatment will be held liable to his patient due to the doctrine of informed consent.

The informed consent concept, clearly enough, separates into two elements: information and consent. A two-fold duty is imposed: the physician must disclose certain information about collateral risks, and he must not proceed without consent to the risks which were, or should have been, disclosed.⁴

* Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

1. Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (J. Cardozo), *overruled on other grounds*; Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

2. The history of malpractice dates back to the Code of Hammurabi. The Babylonian Code provided that, if a surgeon should treat a man with a bronze lancet and cause either death or loss of an eye, the surgeon's hands should be cut off. On the other hand, if the surgeon treated a slave and the slave died, the surgeon need only provide a new slave. Apparently during the Babylonian days it was wise for a surgeon to limit his medical practice to the treatment of slaves.

Pierson, *Failure to Inform Patient of Nature and Hazards of Operation*, Proof No. 7, 7 AM. JUR. PROOF OF FACTS 66, 69 (Supp. 1966); 2 DRIVER & MILES, THE BABYLONIAN LAWS 81 (1955) as cited in Note, 20 OKL. L. REV. 214, 215 (1967).

3. The medical profession makes a clear distinction between treatment and diagnosis. See e.g., STEDMAN'S MEDICAL DICTIONARY 345 (diagnosis) and 1320 (treatment) (3d ed. 1972). While the cases have established a legal duty to disclose risks of *treatment*, it is clear this duty to disclose extends to the risks of *diagnosis* as well. See Salgo v. Leland Stanford etc. Bd. Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957) where the court referred to the physician's duty to disclose the risks of treatment even though the procedure in question was diagnostic.

4. Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U.L. REV. 628, 630 (1970).

This two-fold duty is imposed upon the physician because the doctrine of informed consent is designed to accomplish two separate and distinct objectives, one for the benefit of the patient and the other for the benefit of the physician.

The first objective of the doctrine is to assure the patient a source of information to be utilized in determining which course of treatment, if any, he will pursue. The right of every individual to determine for himself what is to be done with his body is a fundamental precept of American jurisprudence.⁵ Thus, when a particular course of treatment is proposed, the right to decide whether or not that treatment will be performed is the right of the patient, not the doctor. The patient's right to make this decision gives rise to a legal duty on the part of the doctor to adequately disclose the risks inherent in the proposed treatment. Without this information, the patient will be unable to make a knowledgeable decision about what is to be done with his body. It is to guarantee the individual his right of self-determination that the law imposes a duty on the physician to inform.⁶

The second objective of the informed consent doctrine is to insulate the physician from liability for battery. Whenever a person harmfully or offensively touches another, a battery is committed.⁷ However, if the "victim" of the harmful touching consents to it, a complete defense to battery is established.⁸ Therefore, to avoid liability for battery, it is incumbent on the physician to obtain his patient's consent before commencing treatment.⁹

The doctrine of informed consent, then, is a useful legal doctrine for both the patient and the physician. The informational element of the doctrine assures one seeking treatment a source of information upon which he is able to draw in deciding if he will consent to the treatment or not. The consensual element of the doctrine affords the physician a complete defense to liability for battery. When the physician fails to adequately inform his patient of the risks in-

5. *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (J. Cardozo), *overruled on other grounds*; *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S. 3 (1957). *See also*, *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

6. *Woods v. Brumlop*, 71 N.M. 221, 227, 377 P.2d 520, 524 (1962).

7. *See* PROSSER, *LAW OF TORTS*, 34-37 (4th ed. 1971) [hereinafter cited as PROSSER].

8. *Id.*

9. *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1965), *rehearing denied*, 2 Ariz. App. 607, 411 P.2d 45 (1966).

herent in treatment, problems of judicial interpretation of the doctrine have arisen.

Neither the courts nor the commentators have been able to agree upon the application or the standards of the informed consent doctrine.¹⁰ This disagreement has manifested itself in three principal areas: 1) whether liability should be based on battery or negligence,¹¹ 2) what legal standard should be employed in measuring this duty to inform,¹² and 3) whether an objective or subjective standard should be employed in determining if the physician's breach of his duty to inform caused the patient's injury.¹³

10. See generally STETLER & MORITZ, *Doctor and Patient and the Law* 135-38 (1962); Davis, *Duty of Doctor to Inform Patient of Risks of Treatment: Battery or Negligence?*, 34 CALIF. L. REV. 217 (1961); Hagman, *Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A. L. REV. 758 (1970); Karchmer, *Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug,"* 31 MO. L. REV. 29 (1966); Lund, *The Doctor, the Patient, and the Truth*, 19 TENN. L. REV. 344 (1946); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959); McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957); Oppenheim, *Informed Consent to Medical Treatment*, 11 CLEV.-MAR. L. REV. 249 (1962); Plante, *Consent to Operative Procedures*, 21 MD. L. REV. 189 (1961); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970); Comment, *Informed Consent to Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967); Comment, *Valid Consent to Medical Treatment: Need the Patient Know?*, 4 DUQUESNE L. REV. 450 (1966); Comment, *Failure to Inform as Medical Malpractice*, 23 VAND. L. REV. 754 (1970); Comment, *Physician and Patient: Some Problems of Consent*, 2 WASHBURN L.J. 158 (1962); 71 DICK. L. REV. 675 (1967); 75 HARV. L. REV. 1445 (1962); 40 MINN. L. REV. 876 (1956); 16 N.Y. L.J. 863 (1970); 20 OKL. L. REV. 214 (1967); 109 U. PA. L. REV. 768 (1961); 21 SW. L.J. 843 (1967); 44 TEXAS L. REV. 749 (1966); 32 TEXAS B.J. 841 (1969); 18 WES. RES. L. REV. 1018 (1967); 1970 WIS. L. REV. 879 (1970); 79 YALE L.J. 1533 (1970).
11. *Bowers v. Talmage*, 159 So. 2d 888 (Fla. Ct. App. 1963) (battery). *Mitchell v. Robinson*, 334 S.W.2d 11 (Mo. 1960) (negligence), *overruled on other grounds*; *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965).

12. *Di Filippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1960) (same duty to disclose as is the custom of physicians practicing in the same or similar community). *Berkey v. Anderson*, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969) (full disclosure). *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (duty to disclose all information material to the patient's decision). See also, 55 CALIF. L. REV. 1396, 1397 n.5 (1967) for a list of those jurisdictions that had adopted some standard in measuring the physician's duty to disclose as of 1967.

13. *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1956), *rehearing denied*, 2 Ariz. App. 607, 411 P.2d 45 (1966) (subjective standard). *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (objective standard).

The California Supreme Court in the recent case of *Cobbs v. Grant*¹⁴ attempted to reconcile these judicial differences. An understanding of the *Cobbs* case and the effect it will have on the need for producing expert medical testimony and for proving causation is essential for the attorney involved in litigation where the doctrine of informed consent is at issue.

In August, 1964, Ralph Cobbs was diagnosed as having an intractable peptic duodenal ulcer which was causing him lower abdominal pain and nausea. Indicating surgery was necessary, Dr. Dudley Grant explained the nature of the operation to Mr. Cobbs but did not disclose any of the risks inherent in the proposed surgery. Following this operation, Mr. Cobbs developed a second ulcer and suffered serious internal hemorrhaging due to a severed artery at the hilum of the spleen. Both of these adverse consequences are inherent risks in the surgery performed by Dr. Grant. Cobbs filed a malpractice suit against Dr. Grant, alleging alternatively that the doctor was negligent during the course of the operation or that the doctor had breached his duty to adequately inform Mr. Cobbs of the risks inherent in the surgery. With both theories of recovery submitted to the jury, Mr. Cobbs was awarded damages on a general verdict. The supreme court held that there was insufficient evidence for the jury to have found that Dr. Grant negligently performed the operation. The court reversed as it was not apparent whether the general verdict of the jury was based on the physician's failure to inform of collateral risks or on his negligent performance of the operation itself. To assist the court below on retrial, the *Cobbs* opinion is primarily concerned with the doctrine of informed consent.¹⁵

II. THEORY OF RECOVERY—BATTERY V. NEGLIGENCE

When a doctor breaches the duty imposed upon him by the informed consent doctrine, a patient may have a cause of action based on a theory of battery,¹⁶ or on one of negligence.¹⁷ The particular circumstances surrounding the physician's breach as well as the jurisdiction in which the plaintiff brings his case will determine whether or not it can be based on battery or negligence. This distinction may well be crucial to the plaintiff as it is generally easier to plead and prove a case based on a theory of battery.

14. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

15. *Id.*

16. *Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 663 (1966).

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

The battery theory is more advantageous for the plaintiff because expert medical testimony is not always necessary¹⁸ and proving causation is relatively easy.¹⁹ Additionally, punitive damages are possible,²⁰ and, while not an advantage to the patient, it should be noted that the physician's insurance may not cover intentional torts.²¹ Under a negligence theory, however, the plaintiff has two heavy burdens to carry: producing expert medical testimony and proving causation. To the extent these burdens make the plaintiff's case more difficult to prove, it will of course be easier for the physician to defend a negligence suit.

There are some circumstances when the patient will always be able to base his case on a battery theory. This is where a physician fails to obtain his patient's consent at all or when he obtains consent to one form of treatment but performs another.²² For example, if a woman consents to exploratory surgery but the doctor actually performs a mastectomy, liability can always be based on battery.²³

It is when the physician has obtained his patient's consent to the treatment that is performed, but has failed to disclose the collateral risks inherent in the procedure that the courts split; some base liability on battery²⁴ and others negligence.²⁵

The reasoning of those courts finding the physician liable for battery when he fails to inform his patient of potential dangers is either that the failure to inform vitiates the consent²⁶ or that "uninformed consent is no consent."²⁷ Finding the consent ineffectual,

18. *Cobbs v. Grant*, 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972).

19. *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1965), *rehearing denied*, 2 Ariz. App. 607, 411 P.2d 45 (1966).

20. Oppenheim, *Informed Consent to Medical Treatment*, 11 CLEV.-MAR. L. REV. 249 (1962).

21. Note, 55 CALIF. L. REV. 1396, 1400 n.18 (1967).

22. *Cobbs v. Grant*, 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972). *Accord*, PROSSER, *supra* note 7 at 104-06; RESTATEMENT (SECOND) OF TORTS § 15 comment a at 27 (1965).

23. *Corn v. French*, 71 Nev. 280, 289 P.2d 173 (1955).

24. *Belcher v. Carter*, 13 Ohio App. 2d 113, 234 N.E.2d 311, 42 Ohio Ops. 2d 218 (1967).

25. *Carmeichael v. Reitz*, 17 Cal. App. 3d 958, 95 Cal. Rptr. 381 (1971).

26. See PROSSER, *supra* note 7, at 165.

27. Note, 20 OKL. L. REV. 214, 215 (1967).

these courts conclude that “[e]very phase of . . . [the] operation from initial anesthesia to final suture, was a continuing battery for which recovery should be allowed, *even if the operation had been successful.*”²⁸ This seems to be the inevitable result, for consent presumes knowledge of both the beneficial and detrimental consequences of a proposed course of action.²⁹ It is the patient’s lack of knowledge that renders the consent ineffectual, and this should be the result whether the knowledge is kept from him *intentionally or negligently*. Whenever the physician fails to disclose the dangers of treatment, the result is the same—the patient is denied knowledge he has a right to have. Any “consent” given under such circumstances cannot be said to be “informed.”

However, the prevailing view is that liability will be based on negligence in the situation where the doctor performs the treatment consented to, but has failed to disclose the dangers inherent in that treatment.³⁰ This difference in result is partially attributable to the fact that the majority of courts focus their attention on the physician’s duty to inform rather than on the patient’s right to control the decision making process.

The recent case of *Canterbury v. Spence*³¹ analyzed the reasoning of these courts as follows:

In duty-to-disclose cases, the focus of attention is more properly upon the nature and content of the physician’s divulgence than the patient’s understanding or consent. Adequate disclosure and informed consent are, of course, two sides of the same coin—the former a *sine qua non* of the latter. But the vital inquiry on duty to disclose relates to the physician’s performance of an obligation, while one of the difficulties with analysis in the term of “informed consent” is its tendency to imply that what is decisive is the degree of the patient’s comprehension.³²

The *Canterbury* court points out that the former (information) is the *sine qua non* of the latter (consent). Thus, if the physician breaches his duty to provide information, presumably there can be no consent, and the physician would be liable for having performed an operation for which he had not obtained the patient’s consent. The court ignores this logical result by stating that the term “informed consent” is misleading in that it focuses attention on the patient’s comprehension of the proposed treatment rather

28. *Shetter v. Rochelle*, 2 Ariz. App. 358, 367, 409 P.2d 74, 82 (1965), *rehearing denied*, 2 Ariz. App. 607, 411 P.2d 45 (1966) (emphasis original).

29. BLACK’S LAW DICTIONARY 377 (4th ed. rev. 1968) (consent).

30. *Cobbs v. Grant*, 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972). *Di Filippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961).

31. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

32. *Id.* at 780.

than on the physician's duty to inform. It should be remembered, however, that it is this very right of the patient to comprehend what is to be done with his body that gave rise to the physician's duty to inform in the first place.³³ Why the court feels attention should be focused on the duty to inform rather than on the right which gave it birth does not appear. Judicial attention should properly be focused on the patient's right of bodily self-determination and the effect a breach of the physician's duty to inform has on that right.

Those courts finding liability based on negligence often state that the negligence theory is preferable because the malicious or hostile intent usually associated with battery does not exist in the "good faith" relationship between a physician and his patient.³⁴ Statements to this effect seem to confuse motive with intent.³⁵

The *Cobbs* case held that the informed consent doctrine may give rise to a cause of action based on either battery or negligence depending on the circumstances of the particular case.

The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of *deliberate intent* to deviate from the consent given is present.³⁶

The court appears to be giving credence to the language used in some cases to the effect that a hostile intent is a prerequisite to battery. However, as stated by Dean Prosser,

The intent with which tort liability is concerned is not necessarily a hostile intent, or desire to do any harm. Rather it is an intent to bring about a result which will invade the interests of another in a way that the law will not sanction. The defendant may be liable . . . even where he was seeking the plaintiff's own good.³⁷

33. See text accompanying notes 5-6, *supra*.

34. Oppenheim, *Informed Consent to Medical Treatment*, 11 CLEV.-MAR. L. REV. 249, 259 (1962). McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 424 (1957).

35. See PROSSER, *supra* note 7, at 31.

36. 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972) (emphasis added). If there is an adverse consequence of the proposed treatment that is inevitable as opposed to only a possibility, the failure of the physician to warn of this inevitability will be a battery. See *e.g.*, *Bang v. Charles T. Miller Hospital*, 251 Minn. 427, 88 N.W.2d 186 (1958) (failure to warn that a prostate resection involved tying off sperm ducts).

37. PROSSER, *supra* note 7, at 31.

Further, a physician who obtains consent to amputate one leg and negligently amputates the other will not ordinarily have a "deliberate intent" to do so.³⁸ However, even though the physician did not "deliberately intend" to cause this result, since amputating the wrong leg is obviously a "substantially different treatment for which consent was not obtained,"³⁹ this would be a battery after *Cobbs*.

Where the doctor performs the treatment for which he has obtained consent, but has failed to disclose the potential dangers inherent in such treatment, the *Cobbs* court followed the prevailing view, holding that the plaintiff must plead his case in negligence.⁴⁰ This result obtains because the physician "may have failed to meet his due care duty to disclose pertinent information."⁴¹

While focusing on the doctor's "due care duty to disclose," no mention is made of the effect a breach of that duty will have on the patient's right to determine what will be done with his own body. Like the *Canterbury*⁴² court before it, the *Cobbs* court was more concerned with the nature of the physician's breach of his duty to inform than with the right that gave rise to that duty.

The courts are clearly aware of the fact that the battery theory is preferable from the plaintiff's point of view and that the negligence theory is more favorable to the doctor. Those courts that base liability on battery rather than negligence often do so because they want to lift the "onerous" burdens of producing expert medical testimony and proving causation from the plaintiff's shoulders.⁴³ The *Cobbs* court took a different tack, holding, for policy reasons, that it is better to favor the physician rather than the plaintiff at the pleadings stage of litigation where informed consent is in issue.

That this result [negligence] now appears with growing frequency is of more than academic interest; it reflects an appreciation of several significant consequences favoring negligence over a battery theory.⁴⁴

Two of those "significant consequences" which prompted the court to "favor" the negligence theory over the battery theory are

38. See *Sullivan v. McGraw*, 118 Mich. 39, 76 N.W. 149 (1898).

39. *Cobbs v. Grant*, 8 Cal. 3d 229, 239, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972).

40. 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972).

41. *Id.* at 241, 502 P.2d at 8, 104 Cal. Rptr. at 512.

42. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

43. Note, 20 OKL. L. REV. 214, 217 (1967).

44. 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972). (Emphasis added)

the needs for producing expert medical testimony and for proving that the physician's failure to disclose the risks of treatment caused the patient's injury.

III. THE STANDARD OF CARE REQUIRED—STILL A NEED FOR EXPERTS?

The notion that it is the right of the patient and not the doctor to decide whether or not to pursue a particular course of treatment is at the very heart of the informed consent doctrine. It is this right that gives rise to the duty of the physician to adequately inform his patient of the risks inherent in any proposed therapy. Many have argued, however, that circumstances may arise where a physician, as part of his fiduciary duty to his patient, has a privilege not to inform his patient of the complications of treatment.⁴⁵ Recognizing that no such "privilege" has ever been judicially established, *Cobbs* ruled that ". . . [I]t is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie."⁴⁶ The court went on to establish that, as part of his fiduciary obligation to his patient, the physician must disclose alternative courses of treatment and the dangers inherent in each.⁴⁷

Accepting that a physician has a fiduciary duty to inform his patient of the collateral risks of therapy only poses the real question—by which yardstick is that duty to be measured? The courts have not been uniform in answering this question,⁴⁸ but a majority rule known as the "community standard" has evolved.⁴⁹ The disclosure necessary under this standard is the same disclosure that a medical practitioner of the same school and the same or similar community, under the same or similar circumstances would have

45. Smith, *Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick with Serious or Fatal Illness*, 19 TENN. L. REV. 349 (1946). Accord, McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957). Presumably, this privilege is to be exercised when the physician feels that information regarding the possible adverse consequences of treatment will have a detrimental effect on the patient.

46. 8 Cal. 3d 229, 242, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

47. *Id.* at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514 (1972).

48. See note 12, *supra*.

49. Kaplan v. Haines, 96 N.J. Super. 242, 232 A.2d 840 (1967), *aff'd*, 51 N.J. 404, 241 A.2d 235 (1968). See also, Di Filippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961).

made to his patient.⁵⁰

Where the community standard is applied, expert medical testimony is needed to establish for the jury what reasonable physicians in the defendant's position would have done.⁵¹ The burden on the plaintiff of producing such testimony may be made more difficult due to the supposed "conspiracy of silence."⁵²

Cobbs rejected the majority rule as "needlessly overbroad" and held that a physician must, as a matter of law, "disclose to his patient the potential of death or serious harm. . . ."⁵³ This is the first court to ever impose such a *seemingly* stringent standard on the physicians practicing in its jurisdiction.⁵⁴ The consequence of this ruling is that expert medical testimony is no longer necessary to establish the physician's duty to disclose risks of death or serious bodily harm—that duty has been set by law.⁵⁵ Thus, while the *Cobbs* court placed two heavy burdens on the plaintiff by requiring him to plead his case in negligence, it has ostensibly eased the burden of producing expert medical testimony by establishing the physician's duty to disclose as a matter of law. However, the need for experts has only been eliminated for one purpose, *i.e.*, to establish the physician's duty to disclose the risks of death or

50. *Kaplan v. Haines*, 96 N.J. Super. 242, 232 A.2d 840 (1967) *aff'd*, 51 N.J. 404, 241 A.2d 235 (1968).

51. *Canterbury v. Spence*, 464 F.2d 772, 783 n.38 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

52. The "conspiracy of silence" is the somewhat unfortunate term applied to the supposed reluctance of one member of the medical profession to be the source of evidence which may prove detrimental to another member of the medical profession. A responsible medical journal has declared, "[T]he blunt truth is that the majority of all professional liability claims . . . are without merit." *Medicine and the Law, Medical-Legal Problems and their Solutions*, 165 J.A.M.A. 699, 700 (1967). Some quarters of the legal profession, on the other hand, no longer speculate as to the "conspiracy." See *e.g.*, *Gist v. French*, 136 Cal. App. 2d 247, 258, 288 P.2d 1003, 1010 (1955) where a reviewing court upheld a verdict for the plaintiff even though the trial court judge had made a remark to the effect that doctors were reluctant to testify regarding a fellow physician's negligence. Further, the court said that such a remark was "merely an open recognition of the truth of the popular legend. . . ."

53. 8 Cal. 3d 229, 244, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972).

54. In *Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) the duty to disclose is measured by the need of the patient to know. It is quite probable that a jury would always find that a patient's need to know included risks of death or serious harm. To this extent, the standard adopted in *Cobbs* may be different from that adopted in *Canterbury* only in form and not in substance.

55. Lay witness testimony can competently establish a physician's failure to disclose particular risk information, the patient's lack of knowledge of the risk, and the adverse consequences following the treatment.
Id. at 792.

serious bodily harm.⁵⁶ The plaintiff will still be required to produce expert medical testimony to rebut defenses that will surely be imposed by the defendant.

The burden of going forward with evidence of nondisclosure rests on the plaintiff. Once such evidence has been produced, then the burden of going forward with evidence pertaining to justification for failure to disclose shifts to the physician.⁵⁷

These "justifications" for failing to disclose are called "defenses" by the court.⁵⁸ Thus, despite the physician's duty, as a matter of law, to disclose risks of death or serious bodily harm, a doctor who fails to so inform his patient may still avoid liability.

A physician may defend by asserting that the particular injury suffered by the patient was not an inherent danger of the treatment proposed. The plaintiff will be required to rebut this contention with expert medical testimony, for what risks are inherent in a given course of treatment is presumably beyond the ken of the jury.⁵⁹

Additionally, a physician need not disclose inherent risks "if the procedure is simple and the danger remote and commonly appreciated to be remote."⁶⁰ *Cobbs* offers no insight into what is meant by "remote." Again, a physician may defend by asserting that the injury suffered by the plaintiff was only a remote possibility. To establish this quality of "remoteness," experts will surely be called upon by the defendant-physician. A concomitant necessity will thus be placed upon the plaintiff to produce experts to establish that the injury suffered was not remote.

Thus, while *Cobbs* has eliminated the need to establish a "community standard" by producing expert medical testimony, it has

56. Beyond this duty, the physician is obligated to disclose those risks that would have been disclosed by a physician in good standing in similar circumstances. Thus, if the undisclosed risk did not involve death or serious harm, expert medical testimony would be needed to establish what physicians in good standing would have done under the circumstances. *Cobbs v. Grant*, 8 Cal. 3d 244-45, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972).

57. *Id.* at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515 (1972).

58. *Id.*

59. See *McCormick*, HANDBOOK OF THE LAW OF EVIDENCE § 13 (2d ed. 1972).

60. *Cobbs v. Grant*, 8 Cal. 3d 229, 245, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 512 (1972).

created new situations where the plaintiff will be required to produce experts in order to establish that the defendant should be liable.

In rejecting the contention that a physician should have a privilege to withhold risk information from his patient, *Cobbs* recognized that situations can arise where it may be in the best interest of the patient not to be so informed. However, *Cobbs* held that a determination of when a disclosure of risk information will "so seriously upset the patient that the patient would not . . . [be] able to dispassionately weigh the risks of refusing to undergo the recommended treatment" is not a medical decision.⁶¹ When a physician interposes the defense and that risk information was withheld from the patient because it was in the patient's best interest, *Cobbs* has specifically eliminated the need for expert medical testimony. The physician so defending will be required to "prove by a preponderance of the evidence he relied upon facts which would demonstrate to a *reasonable man*" that disclosure was not in the best interest of the patient.⁶² While rejecting the concept of a physician's privilege to withhold information, the court has supplanted a reasonable man test which preserves the individual's right of self-determination and, at the same time, recognizes that situations may arise where the patient is unable to exercise that choice due to his particular psychological make-up.

IV. CAUSATION—SUBJECTIVE V. OBJECTIVE STANDARD

As in all tort actions alleging negligence, the plaintiff must not only prove that the defendant was negligent, but that this negligence was the cause of the harm suffered. In the area of informed consent, this means that the plaintiff must prove a negative, *i.e.*, that had he been informed of the risks of treatment, there would have been no treatment performed.

A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it. The patient obviously has no complaint if he would have submitted to the therapy notwithstanding awareness that the risk was one of its perils.⁶³

It has been assumed by the older cases that the inquiry into what would have happened had the physician not been negligent would be determined by a subjective test,⁶⁴ *i.e.*, what would *this*

61. *Id.* at 246, 502 P.2d at 12, 104 Cal. Rptr. at 516.

62. *Id.* (emphasis added).

63. *Canterbury v. Spence*, 464 F.2d 772, 790 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

64. *Id.*

patient have done had the risk been disclosed to him. Since it is the patient's right to determine what will be done with his body, a subjective inquiry into what *he* would have done had all facts been known to him seems logical. Never before *Canterbury* had it been suggested that the patient can only refuse treatment if the reasonable, prudent man would have done likewise. Rather, the patient's decision is "a matter [he] is free to decide for any reason that appeals to him."⁶⁵ *Cobbs* accepted this precept when it recognized that the decision was the patient's and not the doctor's even though the patient may cloud that decision with his "individual subjective fears and hopes."⁶⁶ The right of a person to protect or *disregard* the health of his body is a basic right of bodily freedom and individual choice.⁶⁷

However, in order to protect the doctor from the patient's "bitterness and disillusionment," *Cobbs* rejected the subjective standard. What the patient would have done had he been adequately informed of the dangers of treatment is no longer controlling once the physician has breached his duty to inform. Instead, the jury is to consider what "a prudent person in the patient's position [would] have decided if adequately informed of all significant perils."⁶⁸

The *Cobbs* court is asking the jury to determine what *should* have been decided, not what *would* have been decided in the event the physician had met his duty of disclosure. The "*sine qua non*" test usually applied to causation is employed to determine what *would* have happened "but for" negligence—not what *should* have happened "but for" negligence.⁶⁹

If the patient had been informed of risks inherent in the course of treatment when it was initially proposed, he would have had every right to have refused, even if such refusal had been irrational by objective standards.⁷⁰ But, not having been informed of

65. *Id.* Accord, *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1965), rehearing denied, 2 Ariz. App. 607, 411 P.2d 45 (1966); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); Note, 55 CALIF. L. REV. 1396, 1411 (1967).

66. 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

67. Note, 23 VAND. L. REV. 754, 755 (1970). (Emphasis supplied)

68. 8 Cal. 3d 229, 243, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972).

69. See PROSSER, *supra* note 7, at 239.

70. Since the patient bears the entire risk of nonnegligent injury and is concerned with his own interests as no other person can be,

those risks, whatever subjective fears and hopes the plaintiff may have had for refusing treatment are not given an opportunity to function. If the patient is informed of the risks of treatment, he can refuse for any reason he chooses; if he is not informed of the risks of treatment, those reasons become irrelevant. The patient's subjective determination of what will be done with his body is only taken from him and given to the mythical reasonable man when the physician, not the patient, has breached a duty imposed upon him by law.

It is the patient's possible "bitterness and disillusionment" that prompted the *Cobbs* court to adopt the objective standard for determining causation. How the patient testifies in light of the injuries he has suffered should be a function of his credibility as a witness, not a basis for adopting a new judicial standard. The court's fear that the jury would not be able to rationally determine causation based on the testimony of a "bitter and disillusioned" plaintiff could be laid to rest with a properly constructed jury instruction. Such an instruction would direct the jury to take into consideration the plaintiff's possible "bitterness and disillusionment" in evaluating his testimony. Such factors as the ramifications a refusal to have consented to treatment would have had on the patient's future health, and the nature of the illness itself could be included in such an instruction and thus guarantee a sound determination of the plaintiff's credibility.

V. CONCLUSION

For policy reasons, the California Supreme Court determined that it is better to favor the physician over the plaintiff at the pleading stage of a cause of action alleging a failure on the part of the physician to adequately disclose risks inherent in the treatment for which he had obtained consent. By adopting a matter of law duty on the part of the physician to disclose risks of death or serious harm, the court attempted to ease the plaintiff's burden of producing expert medical testimony. However, by so doing, the court created new areas where the plaintiff will inevitably be called upon to produce experts. Finally, by adopting a subjective test for determining causation, the court denies the patient the right to determine, for whatever reason he chooses, what shall be

it is only fair to allow him to choose between accepting or rejecting the hazards of a proposed treatment *even if his choice is irrational.*

Note, 55 CALIF. L. REV. 1396, 1409 (1967) (emphasis added).

done with his body and relegates this decision to the mythical reasonable man. While easing the plaintiff's burden of producing medical experts to testify, the court has made the task of proving causation more difficult for the plaintiff.

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