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## Informed Dissent: A New Corollary to the Informed Consent Doctrine

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## INFORMED DISSENT: A NEW COROLLARY TO THE INFORMED CONSENT DOCTRINE?

### *Truman v. Thomas*

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

The doctrine of informed consent is based upon the fundamental concept that an individual has the right to determine his physical welfare.<sup>1</sup> In order for a patient to exercise this right of self-determination, he must receive the information necessary to make intelligent medical decisions. Thus, a duty is imposed upon the physician to disclose adequate information to the patient so that his "informed consent" may be obtained before treatment.<sup>2</sup>

The issues of what constitutes adequate disclosure by the physician and when such disclosure is necessary have been the subject of much litigation.<sup>3</sup> In the recent case of *Truman v. Thomas*,<sup>4</sup> a physician failed to inform a patient of the material risks of not consenting to a Pap smear. The patient subsequently died of cervical cancer.<sup>5</sup> The California Supreme Court held that the trial court erred in its refusal to instruct the jury that it "is the duty of a physician to disclose to his patient all relevant information to enable the patient to make an informed decision regarding the submission to or refusal to take a diagnostic test."<sup>6</sup>

1. *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), *overruled on other grounds*, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957). Judge Cardozo set forth the classic statement that, "[e]very human being of adult years and sound mind has a right to determine what should be done with his own body." 211 N.Y. at 129, 105 N.E. at 92-93. Judge Cardozo's statement has become the basis of the informed consent doctrine. *See, e.g.*, *Karp v. Cooley*, 493 F.2d 408, 419 (5th Cir.) (applying Texas law), *cert. denied*, 419 U.S. 845 (1974); *Cobbs v. Grant*, 8 Cal. 3d 229, 242, 502 P.2d 1, 9, 104 Cal. Rptr. 505, 513 (1972); *Natanson v. Kline*, 186 Kan. 393, 406, 350 P.2d 1093, 1104 (1960); *Sard v. Hardy*, 281 Md. 432, 439, 379 A.2d 1014, 1019 (1977).

2. *E.g.*, *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 242, 502 P.2d 1, 9, 104 Cal. Rptr. 505, 513 (1972); *Salgo v. Stanford Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957); *Nishi v. Hartwell*, 52 Hawaii 188, 191, 473 P.2d 116, 119 (1970); *Sard v. Hardy*, 281 Md. 432, 439-40, 379 A.2d 1014, 1020 (1977); *Woods v. Brumlop*, 71 N.M. 221, 227, 377 P.2d 520, 524 (1962); RESTATEMENT (SECOND) OF TORTS § 892B (1965).

3. *See, e.g.*, *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1965), *modified*, 2 Ariz. App. 607, 411 P.2d 45 (1966); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Williams v. Menehan*, 191 Kan. 6, 379 P.2d 292 (1963). The doctrine of informed consent is governed by state law. *J. LUDLAM, INFORMED CONSENT v* (1978) [hereinafter cited as *LUDLAM*].

4. 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980).

5. *Id.* at 289, 611 P.2d at 904, 165 Cal. Rptr. at 310.

6. *Id.* at 296, 611 P.2d at 908, 165 Cal. Rptr. at 314.

Thus, the California Supreme Court expanded the doctrine of informed consent by requiring the physician to inform his patient of the risks involved when the patient declines a common diagnostic procedure. The court, in effect, created a new doctrine of "informed dissent." This decision is significant since *Cobbs v. Grant*,<sup>7</sup> which the California court relied upon in *Truman*, is considered to be a leading authority in the field of informed consent.<sup>8</sup> Accordingly, the California Supreme Court's recent interpretation of its prior decision in *Cobbs* is likely to set a precedent for other jurisdictions.

To gain a perspective of the issue before the supreme court in *Truman*, this comment will first examine the various standards courts have applied in determining a physician's liability for inadequate disclosure under the informed consent doctrine. It will then discuss the element of causation which must be present for the plaintiff to prevail in a negligence action against the physician and the exceptions whereby the physician need not obtain the patient's informed consent before administering medical treatment. Next, it will analyze the *Truman* decision and show that the California Supreme Court overextended the informed consent theory to substantiate its new theory of "informed dissent." Finally, this comment will propose the enactment of a "Uniform Informed Dissent Disclosure Act" and the implementation of "dissent forms" as an alternative to the unfortunate result reached in *Truman*.

7. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

8. See Beaty & Knapp, *Informed Consent to Medical Treatment*, 19 AIR FORCE L. REV. 63, 68 (1977); Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 409 (1980); LUDLAM, *supra* note 3, at 71-72.

In the following jurisdictions, *Cobbs* has been adopted as authority that a negligence theory should be utilized to determine a physician's liability under the informed consent doctrine or that a "material risk" standard should govern a physician's duty to disclose medical information: *E.g.*, *Dessi v. United States*, 489 F. Supp. 722 (E.D. Va. 1980); *Hales v. Pittman*, 118 Ariz. 305, 576 P.2d 493 (1978); *Lepelley v. Grefenson*, 101 Idaho 422, 614 P.2d 962 (1980); *Perin v. Hayne*, 210 N.W.2d 609 (Iowa 1973); *Miceikis v. Field*, 37 Ill. App. 3d 763, 347 N.E.2d 320 (1976); *Revord v. Russell*, 401 N.E.2d 763 (Ind. App. 1980); *Woolley v. Henderson*, 418 A.2d 1123 (Me. 1980); *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977); *Gerety v. Demers*, 92 N.M. 396, 589 P.2d 180 (1978); *Barnette v. Potenza*, 79 Misc. 2d 51, 359 N.Y.S.2d 432 (Sup. Ct. 1974); *Malloy v. Shanahan*, 421 A.2d 803 (Pa. Super. Ct. 1980); *Miller v. Kennedy*, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 227 N.W.2d 647 (1975).

*Cobbs* is considered to have such a significant effect on physicians actively practicing medicine that the American Medical Association has reprinted the reports of the California Medical Association and the Advisory Panel for Orthopaedic Surgeons of the California Medical Association in its publication on informed consent. These reports address the problems with *Cobbs* and its application to the physician's duty of disclosing medical information. See LUDLAM, *supra* note 3, at 71-84.

## THE DEVELOPMENT OF THE INFORMED CONSENT DOCTRINE

The physician-patient relationship is fiduciary in nature.<sup>9</sup> The average patient is uneducated in the medical sciences and does not possess the same degree of knowledge as his treating physician.<sup>10</sup> Thus, the patient is dependent upon his physician for information essential for making medical decisions.<sup>11</sup> The physician's fiduciary duty requires him to disclose this information to the patient.<sup>12</sup> Informed consent involves the extent of medical information a patient must receive from his physician in order to make an intelligent choice of whether to accept or reject medical treatment.<sup>13</sup>

A review of the applicable case law indicates that significant differences exist as to what constitutes the appropriate standards of the doctrine and how they should be applied.<sup>14</sup> The courts generally engage in three inquiries. The first is whether to apply a negligence or battery theory to determine liability.<sup>15</sup> If a negligence theory is employed, the

9. *Fure v. Sherman Hosp.*, 64 Ill. App. 3d 259, 263, 380 N.E.2d 1376, 1380 (1978); *Miller v. Kennedy*, 11 Wash. App. 272, 282, 522 P.2d 852, 860 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975); *Hunter v. Brown*, 4 Wash. App. 899, 905, 484 P.2d 1162, 1166 (1971), *aff'd*, 81 Wash. 2d 465, 502 P.2d 1194 (1972).

10. *Cobbs v. Grant*, 8 Cal. 3d 229, 242, 502 P.2d 1, 9, 104 Cal. Rptr. 505, 513 (1972).

11. *Id.*

12. *Archer v. Galbraith*, 18 Wash. App. 369, 379, 567 P.2d 1155, 1161 (1977); *Miller v. Kennedy*, 11 Wash. App. 272, 286, 522 P.2d 852, 862 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975).

As far back as the days of Plato, the fiduciary relationship between a physician and a patient was recognized:

The slave doctor prescribes what mere experience suggests—and when he has given his orders, like a tyrant, he rushes off—But the other doctor, who is a freeman, attends and practices upon freemen;—he enters into discourse with the patient and with his friends—and he will not prescribe for him until he has first convinced him; at last, when he has brought the patient more and more under his persuasive influences and set him on the road to health, he attempts to effect a cure.

Halligan, *The Standard of Disclosure by Physicians to Patients: Competing Models of Informed Consent*, 41 LA. L. REV. 1, 1 (1980) (quoting PLATO, THE LAWS, BOOK IV).

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

14. See generally Davis, *Duty of Doctor to Inform Patient of Risks of Treatment: Battery or Negligence?*, 34 S. CAL. L. REV. 217 (1961); Karchmer, *Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug,"* 31 MO. L. REV. 29 (1966); Powell, *Consent to Operative Procedures*, 21 MD. L. REV. 189 (1961); Riga, *Informed Consent*, 10 LINCOLN L. REV. 159 (1977); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628 (1970).

15. *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965) (negligence); *Cooper v. Roberts*, 220 Pa. Super. Ct. 260, 286 A.2d 647 (1971) (battery).

The California Supreme Court in *Cobbs v. Grant*, 8 Cal. 3d 229, 240-41, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972), distinguishes the battery and negligence theories on the basis of whether the physician possessed deliberate intent to deviate from the patient's consent. The requisite element of deliberate intent for the existence of the battery theory is present when the physician performs an operation to which the patient has not consented or performs a treatment different from the one to which the patient consented. The negligence theory does not involve deliberate intent. Rather, the cause of action is based on the physician's failure to meet his standard of due care to disclose relevant information before obtaining consent. *Id.*

courts must then determine what legal standard of care should be applied to measure the duty to inform,<sup>16</sup> and whether an objective or subjective standard should be used to ascertain if the physician's failure to inform caused the patient's injury.<sup>17</sup>

The battery theory has been limited to situations where a physician fails to obtain his patient's consent before an operation or treatment<sup>18</sup> or performs a different treatment from the one for which he obtained consent.<sup>19</sup> In contrast, the negligence theory has been adopted when the physician performs the treatment consented to, but has failed to disclose the risks inherent in the treatment or the alternatives to the treatment before obtaining the consent.<sup>20</sup>

When proceeding on a negligence theory, two standards exist for determining the scope of a physician's duty to disclose medical information. According to the traditional "professional standard," a physician's duty of disclosure is measured by the standards customarily adopted by the medical profession.<sup>21</sup> The second, more modern "mate-

16. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (duty to disclose all material risks and alternatives of the treatment); *Berkey v. Anderson*, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969) (full disclosure); *Haggerty v. McCarthy*, 344 Mass. 136, 181 N.E.2d 562 (1962) (duty to disclose what physicians practicing in the same or similar community would disclose); *ZeBarth v. Swedish Hosp. Medical Center*, 81 Wash. 2d 12, 499 P.2d 1 (1972) (duty to disclose what a "reasonable medical practitioner" would disclose).

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

18. See, e.g., *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906) (removal of plaintiff's uterus and ovaries without her consent); *Rolater v. Strain*, 39 Okla. 572, 137 P. 96 (1913) (bone removed from patient's foot after surgeon's promise not to remove it).

19. See, e.g., *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905) (operation on plaintiff's left ear after obtaining consent to operate on plaintiff's right ear); *Corn v. French*, 71 Nev. 280, 289 P.2d 173 (1955) (mastectomy performed after plaintiff's consent to exploratory surgery).

Merely because a physician feels that an operation would be desirable for his patient who is unconscious under anesthetic does not justify his proceeding with the surgical operation. He will be liable for battery if he does not obtain his patient's consent. An exception to this rule exists if an unforeseen critical emergency arises. The physician is then permitted to assume that the patient would consent if he were conscious and understood the circumstances. W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 104 (4th ed. 1971).

20. See, e.g., *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (peptic duodenal ulcer surgery—5% risk of injury to spleen, development of new ulcer); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972) (radiation therapy—radiation burns).

21. Generally, courts have interpreted reasonable medical custom to mean disclosure that would have been made by doctors practicing in the same or similar community or locality. See, e.g., *Karp v. Cooley*, 493 F.2d 408 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974); *Pegram v. Sisco*, 406 F. Supp. 776 (W.D. Ark.), *aff'd*, 547 F.2d 1172 (8th Cir. 1976); *Ditlow v. Kaplan*, 181 So. 2d 226 (Fla. Dist. Ct. App. 1965); *Borowski v. Von Solbrig*, 14 Ill. App. 3d 672, 303 N.E.2d 146, *aff'd*, 60 Ill. 2d 418, 328 N.E.2d 301 (1975). It has also been interpreted to mean disclosure that would have been made by a "reasonable medical practitioner." See, e.g., *Ohligschlager v. Proctor Community Hosp.*, 6 Ill. App. 3d 81, 283 N.E.2d 86 (1972); *ZeBarth v. Swedish Hosp. Medical Center*, 81 Wash. 2d 12, 499 P.2d 1 (1972). Other courts have required disclosures that are consistent with "prevailing medical practice." See, e.g., *Grosjean v. Spencer*, 258 Iowa 685, 140 N.W.2d 139 (1966); *Hart v. Van Zandt*, 399 S.W.2d 791 (Tex. 1966).

rial risk" standard primarily evolved from two landmark decisions rendered in 1972 by the United States Court of Appeals for the District of Columbia Circuit in *Canterbury v. Spence*<sup>22</sup> and the California Supreme Court in *Cobbs v. Grant*.<sup>23</sup> The "material risk" approach expands a physician's duty to disclose medical information under the informed consent doctrine to include disclosure of all material risks and alternatives to the proposed treatment or operation.<sup>24</sup>

In *Canterbury*, a physician performed a laminectomy<sup>25</sup> on a patient suffering from back pain. The physician failed to disclose a one percent risk of paralysis that might result from the operation.<sup>26</sup> When the patient later developed paralysis of the lower half of his body, he sued the physician and the hospital for the physician's failure to inform him before the operation of the risk of paralysis involved in a laminectomy.

The United States Court of Appeals for the District of Columbia in *Canterbury* found that the sufficiency of the surgeon's disclosure was a question for the jury to decide.<sup>27</sup> In its discussion, the court reasoned that in order for a patient to make an intelligent choice to submit to treatment, a physician must disclose "the inherent and potential hazards of the proposed treatment, the alternatives to the treatment, if any, and the results likely if the patient remains untreated."<sup>28</sup> The court stressed, however, that it would be both prohibitive and unrealistic to require physicians to discuss with their patients every small and remote risk of the proposed treatment.<sup>29</sup> The incidence and degree of harm threatened in a particular medical technique are two relevant factors in determining the materiality of risks that the physician must disclose to the patient.<sup>30</sup>

22. 464 F.2d 772 (D.C.Cir.), cert. denied, 409 U.S. 1064 (1972).

23. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

24. See 464 F.2d at 789; 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

25. J. SCHMIDT, M.D., 2 ATTORNEY'S DICTIONARY OF MEDICINE AND WORD FINDER L-11 (1981) [hereinafter cited as *Medical Words*] defines a laminectomy as follows:

A surgical operation in which the posterior arch of a vertebra is removed. The vertebrae are the bone blocks of which the spine is made. Each vertebra has a hole (like a doughnut), so that when the vertebrae are stacked, a canal is formed through which the spinal cord passes (like a stick through a stack of doughnuts). The hole is not in the center of the vertebra, but towards the back. This arrangement leaves the front part thicker but renders the back part rather thin. This thin half circle of bone is the arch of the vertebra consisting of two laminae or plates, and this is the part cut away in laminectomy.

26. 464 F.2d at 777-78.

27. *Id.* at 778-79.

28. *Id.* at 787-88.

29. *Id.* at 786. See also *Stottlemire v. Cawood*, 213 F. Supp. 897, 898 (D.D.C. 1963); *Yeates v. Harms*, 193 Kan. 320, 333, 393 P.2d 982, 991 (1964), modified, 194 Kan. 675, 401 P.2d 659 (1965); *Bell v. Umstadt*, 401 S.W.2d 306, 313 (Tex. Civ. App. 1966).

30. 464 F.2d at 788.

The *Canterbury* court also emphasized that the physician's liability for nondisclosure is to be decided on the basis of what the "average, reasonable patient" in the patient's position would consider significant to his decision to accept or reject treatment. The court reasoned that basing the physician's liability on what the particular patient before him would consider relevant would place an undue demand on the physician since he would be required to second-guess the patient's conceptions of materiality.<sup>31</sup>

The leading California case in the area of informed consent, *Cobbs v. Grant*,<sup>32</sup> involved a plaintiff who underwent surgery to relieve him of a duodenal ulcer. The doctor explained the nature of the operation to the patient, but failed to disclose the inherent risks of the surgery, such as the formation of a new ulcer and a five percent chance of spleen injury. When both of these conditions developed, the patient brought a malpractice suit against his surgeon, alleging that he negligently performed the operation, or, in the alternative, failed to disclose adequately the risks of the initial surgery, thus vitiating the plaintiff's consent to operate.<sup>33</sup>

In discussing the appropriate standard of disclosure to be applied in informed consent cases, the California Supreme Court in *Cobbs* rejected the medical community standard. The court adopted the materiality test, holding that a physician has the duty to disclose information that would be material to the patient's decision to accept or reject medical treatment.<sup>34</sup>

The court in *Cobbs* emphasized two qualifications to the physician's duty to disclose. First, a physician's duty does not extend to giving patients "a lengthy polysyllabic disclosure on all possible complications"<sup>35</sup> or "a mini-course in medical science."<sup>36</sup> Second, a physician is not required to discuss the relatively minor risks inherent in a common procedure, such as a blood test, when the risks are of very low incidence.<sup>37</sup> Only when complicated medical procedures involving

31. *Id.* at 787.

32. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). The plaintiff's original duodenal ulcer was causing him lower abdominal pain and nausea. After a first operation to relieve this condition, he suffered internal bleeding because an artery in his spleen had been severed. The plaintiff then underwent a second operation for removal of his spleen. Later, he developed a gastric ulcer which necessitated a third operation in which 50% of his stomach was removed.

33. *Id.* at 234-35, 502 P.2d at 4-5, 104 Cal. Rptr. at 508-09.

34. *Id.* at 243-45, 502 P.2d at 10-11, 104 Cal. Rptr. at 514-15.

35. *Id.* at 244, 502 P.2d at 10-11, 104 Cal. Rptr. at 514-15. *Accord*, *Miceikis v. Field*, 37 Ill. App. 3d 763, 768, 347 N.E.2d 320, 324 (1976).

36. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.

37. *Id.* The court, citing T. HARRISON, PRINCIPLES OF INTERNAL MEDICINE 726, 1492, 1510-14 (5th ed. 1966), stated that "the risks inherent in the simple process of taking a common blood

a known risk of death or serious bodily harm are being contemplated must the physician explain the complications that might arise.<sup>38</sup> Before performing a routine procedure, the physician need only ask the patient if the proposed treatment is contraindicated;<sup>39</sup> he need not warn the patient of the remote possibility of death or serious bodily harm.<sup>40</sup>

In addition to *Canterbury* and *Cobbs*, other cases have defined "material risk" in terms of the percentage of incidence and the degree of harm. This approach was utilized in *Mason v. Ellsworth*,<sup>41</sup> which involved the perforation of a patient's esophagus during an esophagoscopy.<sup>42</sup> The patient, who had consented to the procedure, had been informed of the purpose of an esophagoscopy and of the fact that it was a relatively safe procedure; however, she was not informed of its inherent risks. Based upon testimony that the incidence of perforation was minimal, occurring in at most three-quarters of one percent of esophagoscopies, the Washington court of appeals held that the patient had not established a case warranting submission to the jury.<sup>43</sup>

Conversely, a Florida appellate court in *Bowers v. Talmage*<sup>44</sup> held that the issue of whether a neurologist had adequately informed the parents of a nine-year-old boy before his submission to an arteriogram<sup>45</sup> was a question for the jury. The physician failed to inform them of a three percent risk of death, paralysis or other injurious outcome which was incident to the exploratory procedure. When the boy became partially paralyzed as the alleged result of the arteriogram, it remained to be determined whether his parents had given effectual informed consent to the procedure.<sup>46</sup>

An overview of the cases involving the percentage of death or serious disablement in complicated procedures or operations indicates that

sample are said to include hematoma, dermatitis, cellulitis, abscess, osteomyelitis, septicemia, endocarditis, thrombophlebitis, pulmonary embolism and death, to mention a few." *Id.*

38. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515. See, e.g., *Ditlow v. Kaplan*, 181 So. 2d 226 (Fla. Dist. Ct. App. 1966) (gastroscopic procedure including biopsy—punctured esophagus); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965) (insulin shock treatment—coma and organic brain damage); *ZeBarth v. Swedish Hosp. Medical Center*, 81 Wash. 2d 12, 499 P.2d 1 (1972) (radiation therapy—paralysis).

39. For example, a physician would have to inquire if the patient ever had adverse reactions to medication. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.

40. *Id.*

41. 3 Wash. App. 298, 474 P.2d 909 (1970).

42. An esophagoscopy is "[t]he examination of the interior of the esophagus (gullet) by means of a special instrument, the esophagoscope." 1 *Medical Words*, *supra* note 25, at E-116.

43. 3 Wash. App. at 301, 474 P.2d at 912.

44. 159 So. 2d 888 (Fla. Dist. Ct. App. 1963).

45. 1 *Medical Words*, *supra* note 25, at A-295, defines an arteriogram as "[a]n x-ray picture of an artery, especially one taken after the injection of an opaque substance—opaque to x-rays—into the blood. The presence of the opaque material accentuates the outline of the artery."

46. 159 So. 2d at 889.



a balancing test is applied to determine whether a patient must be informed of inherent risks. A physician's duty to disclose risks of low incidence increases as the degree of harm threatened to the patient increases.<sup>47</sup>

### THE NECESSITY OF CAUSATION

A plaintiff bringing a negligence action must prove a causal connection between the physician's failure to inform and his subsequent injury.<sup>48</sup> Two requirements must be met to prove causation. First, the patient must demonstrate that his injury resulted from an unrevealed risk that should have been disclosed to him.<sup>49</sup> Next, the patient must show that he would not have consented to the operation or treatment if he had known of the risk.<sup>50</sup>

Customarily, courts have applied a subjective test in determining whether a particular patient would have consented to the treatment had he been adequately informed of the risks and alternatives.<sup>51</sup> The more recent trend, however, is to use an objective approach and consider what a prudent person in the patient's position would have decided had adequate disclosure been given.<sup>52</sup> This objective approach eliminates any unfairness to a physician whose professional standing is placed in jeopardy by a bitter patient's declaration that he would have declined the treatment if suitably informed of the uncommunicated risk that has

47. Disclosure by the physician of the chance of risk was required in the following cases: *Bowers v. Talmage*, 159 So. 2d 888 (Fla. App. 1963) (arteriogram—3% chance of death, paralysis or other injury); *Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 663 (1966) (exploratory laminectomy—15 to 20% chance of paralysis); *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965), *aff'd*, 412 S.W.2d 299 (Tex. 1967) (stapedectomy with vein graft (ear operation)—1% chance of total loss of hearing). In the following cases, disclosure was not required: *Stottlemire v. Cawood*, 213 F. Supp. 897 (D.D.C. 1963) (prescription of chloromycetin—1/800,000 chance of aplastic anemia); *Yeates v. Harms*, 193 Kan. 320, 393 P.2d 982 (1964), *modified*, 194 Kan. 675, 401 P.2d 659 (1965) (cataract surgery—1.5% chance of loss of eye); *Collins v. Itoh*, 160 Mont. 461, 503 P.2d 36 (1972) (thyroidectomy—.5% to 3% chance of removal of parathyroid tissue); *Starnes v. Taylor*, 272 N.C. 386, 158 S.E.2d 339 (1968) (esophagoscopy—1/250 to 1/500 chance of perforation of esophagus).

48. *Haven v. Randolph*, 342 F. Supp. 538 (D.D.C. 1972), *aff'd*, 494 F.2d 1069 (D.C. Cir. 1974).

49. *Downer v. Veilleux*, 322 A.2d 82, 92 (Me. 1974).

50. *Shetter v. Rochelle*, 2 Ariz. App. 358, 367, 409 P.2d 74, 83 (1965), *modified*, 2 Ariz. App. 607, 411 P.2d 45 (1966). This requirement is an application of the "but for" rule "which comes as close to being of the essence of the proximate cause doctrine as any concept." *Id.* The plaintiff must prove that he would not have had the operation if the disclosure had been made. Only then is the patient's injury proximately caused by the physician's failure to disclose. *Id.*

51. *See, e.g.*, *Poulin v. Zartman*, 542 P.2d 251, 275 (Alaska 1975); *Wilkinson v. Vesey*, 110 R.I. 606, 629, 295 A.2d 676, 690 (1972).

52. *See, e.g.*, *Riedinger v. Colburn*, 361 F. Supp. 1073, 1078 (D. Idaho 1973); *Funke v. Fieldman*, 212 Kan. 524, 537, 512 P.2d 539, 550 (1973); *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977); *Fogal v. Genesee Hosp.*, 41 A.D.2d 468, 474, 344 N.Y.S.2d 552, 560 (1973); *Small v. Gifford Memorial Hosp.*, 133 Vt. 552, 349 A.2d 703 (1975).

now materialized.<sup>53</sup>

### EXCEPTIONS TO THE PHYSICIAN'S DUTY TO OBTAIN INFORMED CONSENT

There are exceptions or defenses available under which a physician will not be liable for administering treatment without a patient's informed consent.<sup>54</sup> The first is the medical "emergency" situation in which the patient requires immediate medical care.<sup>55</sup> Under this exception, an emergency arises when "the patient is unconscious or otherwise incapable of consenting and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment."<sup>56</sup> In this circumstance, the patient's consent is implied because it is assumed that a reasonable person in the patient's position would consent to treatment.<sup>57</sup>

A second exception has been developed for incompetent and minor patients, whereby the patient's parent or legal guardian is given the authority to consent for the patient.<sup>58</sup> The rationale of this approach is that a patient should not be deprived of medical care due to his inability to make medical decisions.<sup>59</sup>

Another exception to the doctrine of informed consent is waiver. A patient may waive both his right to disclosure of information by his physician and his option of rendering or refusing consent to the proposed treatment.<sup>60</sup> Commentators have asserted that the principle of waiver is consistent with the patient's right of self-determination pro-

53. *Canterbury v. Spence*, 464 F.2d 772, 790-91 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

54. LUDLAM, *supra* note 3, at 36. For an in-depth discussion of exceptions to the duty to disclose, see Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413 [hereinafter cited as Meisel].

55. See *Canterbury v. Spence*, 464 F.2d 772, 788 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Pratt v. Davis*, 224 Ill. 300, 309-10, 79 N.E. 562, 565 (1906); *Crouch v. Most*, 78 N.M. 406, 410, 432 P.2d 250, 254 (1967).

56. 464 F.2d at 788.

57. *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972); *Gravis v. Physicians & Surgeons Hosp. of Alice*, 415 S.W.2d 674, 677-78 (Tex. Civ. App. 1967), *rev'd on other grounds*, 427 S.W.2d 310 (Tex. 1968); W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 103 (4th ed. 1971).

58. *Cobbs v. Grant*, 8 Cal. 3d 229, 244, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972); *Ballard v. Anderson*, 4 Cal. 3d 873, 878, 484 P.2d 1345, 1348, 95 Cal. Rptr. 1, 4 (1971).

59. See *In Re Long Island Jewish-Hillside Medical Center*, 73 Misc. 2d 395, 399, 342 N.Y.S.2d 356, 360-61 (Sup. Ct. 1973); *Collins v. Davis*, 44 Misc. 2d 622, 623, 254 N.Y.S.2d 666, 667 (Sup. Ct. 1964); Meisel, *supra* note 54, at 439.

60. *Cobbs v. Grant*, 8 Cal. 3d 229, 245, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972); *Putenson v. Clay Adams Inc.*, 12 Cal. App. 3d 1062, 1083-84, 91 Cal. Rptr. 319, 333 (1970); *Holt v. Nelson*, 11 Wash. App. 230, 241, 523 P.2d 211, 219 (1974).

moted by informed consent, for the patient, rather than the physician, decides that disclosure or participation in the decisionmaking process will have a harmful effect upon him.<sup>61</sup>

The "therapeutic privilege" is present when the physician withholds material information from his patient in the belief that disclosure would cause a deterioration of the patient's physical or emotional state.<sup>62</sup> A California appellate court in *Salgo v. Stanford University Board of Trustees*<sup>63</sup> recognized the physician's conflict between disclosing information necessary for the patient to consent intelligently to medical treatment and withholding information that might jeopardize the patient's welfare. The *Salgo* court allowed the physician "a certain amount of discretion," provided that its exercise was "consistent with the full disclosure of facts necessary to an informed consent."<sup>64</sup> Later cases have attempted to clarify the circumstances in which the "therapeutic privilege" may be invoked.<sup>65</sup> These include situations where disclosure will prevent a rational decision, cause psychological damage to the patient<sup>66</sup> or unduly upset or weaken an unstable patient.<sup>67</sup> The only definite restriction is that a physician may not remain silent merely because disclosure might induce a patient to refuse therapy which the physician feels is essential to the patient's well-being.<sup>68</sup>

Additional exceptions include the absence of any duty to disclose risks involved in a procedure when the risks are in fact known to the patient due to a previous experience with the procedure.<sup>69</sup> Physicians are also not required to inform their patients of dangers which persons of average sophistication are likely to know.<sup>70</sup>

The case of *Butler v. Berkeley*<sup>71</sup> illustrates the application of the latter exception. In *Butler*, a patient underwent a surgical operation to

61. See, e.g., Goldstein, *For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent, and the Plea Bargain*, 84 YALE L.J. 683, 692 (1975); Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 U.C.L.A. L. REV. 758, 785 (1970); Meisel, *supra* note 54, at 459.

62. E.g., *Cobbs v. Grant*, 8 Cal. 3d 229, 246, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972); *Wilkinson v. Vesey*, 110 R.I. 606, 628, 295 A.2d 676, 689 (1972); *Nishi v. Hartwell*, 52 Hawaii 188, 191, 473 P.2d 116, 119 (1970).

63. 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).

64. *Id.*

65. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972).

66. *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

67. *Wilkinson v. Vesey*, 110 R.I. 606, 628, 295 A.2d 676, 689 (1972).

68. 464 F.2d at 789.

69. *Id.* at 788; *Butler v. Berkeley*, 25 N.C. App. 325, 339, 213 S.E.2d 571, 580 (1975); *Wilkinson v. Vesey*, 110 R.I. 606, 627, 295 A.2d 676, 689 (1972).

70. 464 F.2d at 778; 25 N.C. App. at 339, 213 S.E.2d at 582; 110 R.I. at 627, 295 A.2d at 689.

71. 25 N.C. App. 325, 213 S.E.2d 571 (1975).

make his face symmetrical. He subsequently brought suit against the hospital and plastic surgeon under a battery theory based on lack of informed consent, alleging that the surgeon had withheld information regarding the risk of infection which ultimately occurred.<sup>72</sup> After reviewing the surgeon's testimony that infection associated with the operation was a rare occurrence and that the *Canterbury* court had recognized that the risk of infection should be known to a person of average sophistication, the North Carolina Court of Appeals affirmed the trial court's granting of the surgeon's motion for summary judgment.<sup>73</sup> Thus, *Butler* supports the theory that awareness of a risk may be imputed to the patient if the existence of the risk is considered to be a matter of common knowledge.<sup>74</sup>

### TRUMAN V. THOMAS

#### *Facts of the Case*

The facts in *Truman v. Thomas*<sup>75</sup> serve as the basis for a unique approach by the California Supreme Court which may strongly influence the future development of the informed consent doctrine. In April, 1963, Rena Truman contacted Dr. Claude R. Thomas, a family physician engaged in general medicine.<sup>76</sup> Mrs. Truman told Dr. Thomas that she had had a Pap smear<sup>77</sup> administered by her former physician within the past year. Due to this, it was not until January 7, 1964 that Dr. Thomas suggested that she have another one.<sup>78</sup> Dr. Thomas served as Mrs. Truman's physician until March, 1969.<sup>79</sup> During this six-year period, Dr. Thomas treated Mrs. Truman for numerous illnesses but failed to perform a Pap smear on her. In addition, he

72. *Id.* at 328, 213 S.E.2d at 572-73.

73. *Id.* at 343, 213 S.E.2d at 582.

74. See *Wilkinson v. Vesey*, 110 R.I. 606, 627, 295 A.2d 676, 689 (1972); Comment, *Physicians and Surgeons—Physician's Duty to Warn of Possible Adverse Results of Proposed Treatment Depends Upon General Practice Followed by Medical Profession in the Community*, 75 HARV. L. REV. 1445, 1448 (1962); LUDLAM, *supra* note 3, at 37.

75. 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980).

76. *Id.* at 288, 611 P.2d at 904, 165 Cal. Rptr. at 310.

77. 3 *Medical Words*, *supra* note 25, at P-17-18, provides the following definition of a Pap smear:

A commonly used test for the detection of cancer of the uterus and the cervix (of the uterus). The test is based on Papanicolaou's discovery that a cancer of the uterus sloughs off cancerous cells into the vagina. The test is performed by removing a sample of vaginal fluid, placing it on a slide (a glass slide for a microscope), staining the material, and then examining it microscopically for signs of cancer. . . . The Papanicolaou test (also called Pap test or Pap smear) for uterine cancer is relatively quick and painless, and it reveals the presence of a malignancy at a stage when it produces no visible symptoms and can usually be cured.

78. 27 Cal. 3d at 297, 611 P.2d at 909, 165 Cal. Rptr. at 315.

79. *Id.* at 288, 611 P.2d at 904, 165 Cal. Rptr. at 310.

treated her children and discussed family problems with her.<sup>80</sup> According to Dr. Thomas's testimony at trial, he frequently recommended to Mrs. Truman that she undergo a Pap smear; however, she repeatedly rejected the proposed diagnostic test. He did not explain to her the risks involved in failing to submit to the test.<sup>81</sup>

Mrs. Truman consulted a urologist on April 1, 1969 concerning a urinary tract infection.<sup>82</sup> He recommended that she see a gynecologist immediately. When Mrs. Truman failed to schedule an appointment, the urologist made one for her with Dr. Ritter. In October, 1969, Dr. Ritter discovered that a cancerous tumor had almost completely supplanted Mrs. Truman's cervix. She died in July, 1970 at the age of thirty after several unsuccessful attempts were made to treat the advanced cancer.

Mrs. Truman's children brought a wrongful death action against Dr. Thomas, alleging that his failure to perform a Pap smear on their mother proximately caused her death. At trial, experts testified that if Mrs. Truman had undergone a Pap smear between 1964 and 1969, the cervical cancer would have been discovered in time to save her life. There was conflicting expert testimony, however, as to how much explanation of the purposes of a Pap smear is required to be given to patients.<sup>83</sup>

The plaintiffs requested two alternative jury instructions<sup>84</sup> under

80. *Id.* at 297, 611 P.2d at 909, 165 Cal. Rptr. at 315 (Clark, J., dissenting). Dr. Thomas treated Mrs. Truman for a cyst on her cheek, an upper respiratory infection, the flu and a urinary tract infection. Mrs. Truman also requested a prescription for birth control pills. *Id.*

81. *Id.* at 289, 611 P.2d at 904, 165 Cal. Rptr. at 310. The California court of appeals emphasized that Mrs. Truman never directly refused to follow Dr. Thomas's recommendation that she submit to the Pap test. Her behavior was classified as procrastination. *Truman v. Thomas*, 93 Cal. App. 3d 304 (opinion omitted), 155 Cal. Rptr. 752, 760 n.3 (1979).

82. 27 Cal. 3d at 288, 611 P.2d at 904, 165 Cal. Rptr. at 310. Dr. Casey, the urologist, discovered that Mrs. Truman was experiencing heavy vaginal discharges and that her cervix was extremely rough. *Id.*

83. *Id.*

84. The following jury instructions requested by the appellants were refused by the trial court:

1. [I]t is the duty of the physician to disclose to his patient all relevant information to enable the patient to make an informed decision regarding the submission to or refusal to take a diagnostic test. Failure of the physician to disclose to his patient all relevant information including the risks to the patient if the test is refused renders the physician liable for any injury legally resulting from the patient's refusal to take the test if a reasonably prudent person in the patient's position would not have refused the test if she had been adequately informed of all the significant perils.
2. [A]s a matter of law . . . a physician who fails to perform a Pap smear test on a female patient over the age of 23 and to whom the patient has entrusted her general physical care is liable for injury or death proximately caused by the failure to perform the test.

27 Cal. 3d at 290, 611 P.2d at 904-05, 165 Cal. Rptr. at 310-11.

The trial court rejected the first instruction without prejudice primarily because it was confus-

which Dr. Thomas could be held liable for his failure to give a Pap smear to Mrs. Truman. Under the first instruction, the physician had a duty to inform his patient of all relevant information, including the risks of refusing to submit to a diagnostic test. If the physician breached that duty, he would be liable for any legally resulting injury if a reasonably prudent person in the patient's position would not have refused the test had she been adequately informed of the significant perils. The second jury instruction provided that a physician would be liable for injury or death proximately caused by failure to administer a Pap smear to any female patient over the age of twenty-three. Both instructions were rejected by the trial judge in the Superior Court of Butte County. The jury, rendering a special verdict, found Dr. Thomas free from any negligence proximately causing Mrs. Truman's death.<sup>85</sup> The judgment was affirmed by the California Court of Appeals for the Third District.<sup>86</sup>

### *The Majority Opinion*

On appeal, the California Supreme Court reversed the judgment of the court of appeals. It held that the trial court had erred in refusing the jury instruction that a physician must disclose relevant information to enable the patient to make an informed decision whether to submit to or refuse to take a diagnostic test.<sup>87</sup>

The *Truman* court primarily relied upon its prior decision in *Cobbs v. Grant*<sup>88</sup> to support its conclusion. It interpreted the principle in *Cobbs*—that a physician recommending a complicated medical procedure must explain the complications that might result—to mean also that a physician must disclose all material risks to a patient who declines a risk-free procedure.<sup>89</sup> Material information was defined as facts which are not commonly appreciated<sup>90</sup> and which the physician “knows or should know would be regarded as significant by a reason-

ing, not because the court necessarily disagreed with the instruction as a matter of law. 27 Cal. 3d at 290 n.2, 611 P.2d at 905 n.2, 165 Cal. Rptr. at 310-11 n.2. The California Supreme Court held that refusal to give this instruction to the jury amounted to reversible error. The supreme court, however, concluded that the second jury instruction was inapplicable to the *Truman* facts. See note 100 *infra*.

85. 27 Cal. 3d at 290, 611 P.2d at 905, 165 Cal. Rptr. at 311.

86. See *Truman v. Thomas*, 93 Cal. App. 3d 304 (opinion omitted), 155 Cal. Rptr. 752 (1979).

87. 27 Cal. 3d at 295, 611 P.2d at 908-09, 165 Cal. Rptr. at 314.

88. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972). See text accompanying notes 32-40 *supra*.

89. 27 Cal. 3d at 292, 611 P.2d at 906, 165 Cal. Rptr. at 312.

90. *Id.* at 291, 611 P.2d at 905, 165 Cal. Rptr. at 311, citing *Canterbury v. Spence*, 464 F.2d 772, 788 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

able person in the patient's position when deciding to accept or reject the recommended medical procedure."<sup>91</sup> The *Truman* majority rejected Dr. Thomas's contention that a physician's duty to disclose applies only when a patient consents to treatment. The court found this argument inconsistent with *Cobbs's* major premise that individuals should have the right to make meaningful decisions regarding their bodies.<sup>92</sup>

The *Truman* court also rejected Dr. Thomas's assertion that no duty existed to disclose the consequences of declining a Pap smear because the danger involved in not having the test was remote and appreciated by the public to be remote.<sup>93</sup> The court distinguished the low probability of cervical cancer and potential harm of death which might result from failing to detect the cancer at an early stage from the minor risks inherent in procedures such as taking blood samples. The court concluded that it was unreasonable for Dr. Thomas to have assumed that Mrs. Truman was aware of the possible fatal consequences of her behavior.<sup>94</sup>

### *The Dissenting Opinion*

The dissent stressed that the majority had failed to consider the effect its decision would have upon physicians.<sup>95</sup> The dissent main-

91. *Id.* at 291, 611 P.2d at 905, 165 Cal. Rptr. at 311, *citing* *Sard v. Hardy*, 281 Md. 432, 444, 379 A.2d 1014, 1022 (1977); *Wilkinson v. Vesey*, 110 R.I. 606, 627, 295 A.2d 676, 689 (1979).

In *Sard*, a patient underwent a bilateral tubal ligation for the purpose of sterilization. The physician neither informed the patient of the various alternative techniques that could be used to effectuate female sterilization by tubal ligation nor informed her of the possibility that the operation might not be successful. He also did not inform the patient's husband of the possibility of undergoing a vasectomy. The patient signed a consent form without reading it. Her husband, who was functionally illiterate, signed a standard consent form stating that he understood that the operation was not always effective. After the operation, the patient became pregnant. The Maryland appellate court held that the evidence was sufficient to submit the issue to the jury as to whether the information withheld was material to the patient's decision whether or not to undergo sterilization. 281 Md. 432, 436-37, 446, 379 A.2d 1014, 1018-19, 1023.

*Wilkinson* involved a woman who suffered radiation burns as a result of undergoing radiation therapy. The woman claimed that she had not given her informed consent to the radiation treatments. 110 R.I. 606, 629, 295 A.2d 676, 690. The Rhode Island Supreme Court held that the trial court had erred in directing a verdict for the defendants on the issue of informed consent. *Id.* at 630, 295 A.2d at 690.

92. 27 Cal. 3d at 292, 611 P.2d at 906, 165 Cal. Rptr. at 312.

93. *Id.*

94. *Id.* at 294, 611 P.2d at 907, 165 Cal. Rptr. at 313.

95. *Id.* at 297, 611 P.2d at 909, 165 Cal. Rptr. at 315 (Clark, J., dissenting). The dissent cited authority in support of the principle that the "extent of the burden to the defendant and consequences to the community" must be considered before imposing a new duty upon a defendant. *Id.* at 298, 611 P.2d at 909-10, 165 Cal. Rptr. at 315-16, *citing* *Coulter v. Superior Court*, 21 Cal. 3d 144, 153, 577 P.2d 669, 674, 145 Cal. Rptr. 534, 539 (1978); *Rowland v. Christian*, 69 Cal. 2d 108, 113, 443 P.2d 561, 564-65, 70 Cal. Rptr. 97, 100-01 (1968); *Lipman v. Brisbane Elementary School Dist.*, 55 Cal. 2d 224, 229-31, 359 P.2d 465, 467-68, 11 Cal. Rptr. 97, 99-100 (1961).

tained that the duty to explain the purposes of a Pap smear or potential consequences of failing to submit to one was onerous and extended far beyond the scope of the facts in *Truman*. This duty would thus require physicians to explain the purposes of each diagnostic procedure since most medical tests are designed to discover illness which might prove fatal if not timely treated. The dissent further noted that the enforcement of the duty would result in an increase in the cost of medical diagnosis and a reduction of care for patients. Doctors would have to be compensated for the additional time needed to educate the public and patients would be deterred from seeking medical care due to added cost. The dissent also expressed the view that the duty to educate the public should be determined by the legislature, not the courts.<sup>96</sup>

The dissent stated that the majority misapplied *Cobbs*, as well as the other authority<sup>97</sup> relied upon in its opinion. These cases had involved an intrusion to the body which necessitated consent, whereas the situation in *Truman* involved a patient who had refused to allow an intrusion. Thus, the dissent reasoned that consent was irrelevant.

Finally, in addressing the jury instruction issue, the dissent observed that adoption of the first jury instruction, without modification, fails to clarify whether the risks resulting from failure to undergo a Pap smear would have been known to a reasonable person. Additionally, the issue of whether Mrs. Truman would have taken the test if she had been informed adequately by Dr. Thomas is ignored by acceptance of the first jury instruction.<sup>98</sup>

## ANALYSIS

### *Misapplication of the Informed Consent Doctrine*

Although the *Truman* decision is consistent with the rationale underlying *Cobbs* and other informed consent cases that a patient has the right to intelligently make decisions concerning his physical welfare,<sup>99</sup> there appears to be no authority extending this rationale to support the

96. 27 Cal. 3d at 298-99, 611 P.2d at 909-10, 165 Cal. Rptr. at 316.

97. *Canterbury v. Spence*, 464 F.2d 772, 778 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); *Sard v. Hardy*, 281 Md. 432, 444, 379 A.2d 1014, 1022 (1977); *Wilkinson v. Vesey*, 110 R.I. 606, 627, 295 A.2d 676, 689 (1972); *Waltz & Scheuneman, Informed Consent to Therapy*, 64 Nw. U. L. Rev. 628, 639-40 (1970).

98. 27 Cal. 3d at 301, 611 P.2d at 912, 165 Cal. Rptr. at 318. The dissent maintained that the trial court has no duty to modify or edit an instruction offered by the parties in a civil action, and if the instruction is incomplete, the trial court may properly refuse it. See, e.g., *Shaw v. Pacific Greyhound Lines*, 50 Cal. 2d 153, 158, 323 P.2d 391, 394 (1958). Thus, the dissent concluded that refusal of the first jury instruction, see note 84 *supra*, did not constitute reversible error.

99. See note 1 and accompanying text *supra*.



doctrine of "informed dissent."<sup>100</sup> The *Truman* court misapplied prior case law to reach its determination that the trial court had erred in refusing to accept the first jury instruction.<sup>101</sup> Under this instruction, Dr. Thomas would be held liable for breaching his duty of care to Mrs. Truman by failing to disclose the potential consequences of not submitting to a Pap smear. *Cobbs*<sup>102</sup> and the other decisions<sup>103</sup> relied upon by the court require physicians to obtain informed consent before performing a complicated treatment or operation. These decisions indicate that the informed consent doctrine does not apply when the physician is performing a common procedure in which the inherent risks are remote. There is no suggestion in *Cobbs* or in the other case authority relied upon by *Truman* that informed consent should extend to encompass the situation in which a patient declines a common diagnostic test.<sup>104</sup>

100. *Truman v. Thomas*, 93 Cal. App. 3d 304 (opinion omitted), 155 Cal. Rptr. 752, 757 (1979). The California Supreme Court expressly rejected application of the rationale of *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974). In *Helling*, the Supreme Court of Washington held that two ophthalmologists were negligent as a matter of law for failing to administer a glaucoma test to a patient under the age of 40. This test would have detected the glaucoma that later blinded the patient. One of the defendants testified that incidence of glaucoma in persons under 40 years was one out of 25,000 persons. *Id.* at 519, 519 P.2d at 983. Although *Helling* involved physician's liability for not administering a simple diagnostic test, it also imposed a duty upon the ophthalmologists to perform the glaucoma test. *Id.* The majority in *Truman* correctly observed that the *Helling* rule was in contradistinction to the doctrine of informed consent, which mandates that the patient has the ultimate decision as to which medical procedure to undergo. 27 Cal. 3d at 295-96, 611 P.2d at 908, 165 Cal. Rptr. at 314. Rejection of the *Helling* rationale also accounts for the *Truman* court's rejection of plaintiff's second jury instruction. See note 84 *supra*.

101. See note 84 *supra*.

102. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (peptic duodenal ulcer surgery).

103. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972) (laminectomy); *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977) (bilateral tubal ligation); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972) (radiation therapy).

104. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972).

It is interesting to note the Illinois Required Uterine Cancer Test Statute, ILL. REV. STAT. ch. 127, § 55.31 (Supp. 1981) which mandates that every hospital licensed in Illinois offer a uterine cytologic examination to every 20-year-old female in-patient unless she had undergone one within the previous year or her attending physician has indicated that it would be inappropriate for her to submit to one. The statute provides:

To establish and enforce minimum standards for the operation of all general hospitals, which standards shall include the requirement that every hospital licensed by the State of Illinois shall offer a uterine cytologic examination for cancer to every female in-patient 20 years or over unless considered contra-indicated by the attending physician or unless it has been performed within the previous year. Every woman for whom the test is applicable will have the right to refuse such test on the counsel of the attending physician or on her own judgment. The hospital will in all cases maintain records to show either the results of the test or that the test was not applicable or that it was refused.

*Id.* Thus, the *Truman* court held Dr. Thomas accountable to a more stringent standard than that required of Illinois' general hospitals in that he also had the duty to disclose the potential hazards of a patient's declining a Pap smear. To avoid increasing the current state of confusion in the

The majority, in its primary reliance on *Cobbs* to substantiate its decision, erroneously distinguished the risk of cervical cancer from "the relatively minor risks inherent in [such] common procedures" as taking blood samples which does not require disclosure. It reasoned that even though the probability of having cervical cancer was remote, the potential harm of the failure to detect it at an early stage could result in death.<sup>105</sup> Thus, the court ignored the fact specifically mentioned in *Cobbs* that death was also a risk, even though of low incidence, in the taking of a blood sample.<sup>106</sup> The majority attempted to justify its distinction on the basis that the risk of cervical cancer is the major reason why a Pap smear is recommended.<sup>107</sup> This reasoning is weak under *Cobbs* where that court stated that when a doctor proposes a common procedure, no warning is required as to the "remote possibility of death or serious bodily harm."<sup>108</sup>

While there are presently no conclusive statistics regarding the incidence of cervical cancer detected from Pap smear screening,<sup>109</sup> the mortality rate for cervical cancer is estimated as being minimal.<sup>110</sup> Case authority, however, has established that prior to complicated medical treatment or surgical operations, a physician may have the duty to disclose risks of low incidence if the degree of harm threatened is substantial.<sup>111</sup> This principle would not be an effective standard in determining whether a physician should disclose the risks of not consenting to a common diagnostic test. When evaluating the myriad of diagnostic tests available to the patient, it becomes evident that death is nearly always inevitable if a condition goes undetected and is permitted

doctrine of informed consent, uniform guidelines for both hospitals and physicians regarding the recommendation of Pap smears should be established state-wide.

105. 27 Cal. 3d at 294, 611 P.2d at 907, 165 Cal. Rptr. at 313.

106. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.

107. 27 Cal. 3d at 294, 611 P.2d at 907, 165 Cal. Rptr. at 313.

108. 8 Cal. 3d at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515.

109. Controversy exists in the medical profession as to the accuracy and reliability of the Pap smear test in general. For a complete discussion of this controversy, see Foltz & Kelsey, *The Annual Pap Smear: A Dubious Policy Success*, 56 MILBANK MEMORIAL FUND QUARTERLY/HEALTH & SOCIETY 426, 432-36 (1978) [hereinafter cited as Foltz & Kelsey]. For further statistical analysis involving the incidence of cervical cancer and the effectiveness of the Pap smear screening, see Guzick, *Efficacy of Screening for Cervical Cancer: A Review*, 68 AM. J. PUB. HEALTH 125 (1978); Richart & Barron, *Screening Strategies for Cervical Cancer and Cervical Intraepithelial Neoplasia*, 47 CANCER 1176 (1981); Walters, Gallucci, Molbo, Pesznecker & Holmes, *The Association of Numerous Life Changes With Cervical Dysplasia and Metaplasia*, 3 CANCER NURSING 445 (1980).

110. In determining the mortality rate for United States women in 1976, the rate of cervical cancer was found to be five per 100,000. This rate was significantly lower, for example, than the respective mortality rates for heart disease and cerebro-vascular disease among women. Foltz & Kelsey, *supra* note 109, at 430.

111. See note 47 *supra*.

to develop into its critical stage.<sup>112</sup> Thus, the balancing test of probability and substantial harm is an inappropriate guideline to govern the physician's duty of disclosure.

*Failure to Consider Exceptions, Causation and Other Relevant Factors*

As the dissent properly noted,<sup>113</sup> the majority's offered instruction failed to mention the factual issues that would have to be resolved if the physician's new disclosure duty were imposed.<sup>114</sup> Thus, future courts are given no direction as to what to include in jury instructions when confronted with a factual situation similar to that in *Truman*.

Future jury instructions should require the jury to consider whether any exceptions<sup>115</sup> to the physician's disclosure duty are applicable to the case before it. For example, although the emergency, incompetent and minor, waiver and therapeutic privilege exceptions<sup>116</sup> were not applicable in *Truman*, the other defenses of imputed knowledge and previous experience<sup>117</sup> should be examined by the jury.

The jury also should be instructed to analyze the physician's absence of duty to disclose to persons of average sophistication the dangers which they are likely to know or to inform patients of procedural risks known to them due to prior contact with the procedure.<sup>118</sup> In *Truman*, the dissent correctly observed that Dr. Thomas might reasonably have assumed that a woman of childbearing age knew the purposes of a Pap smear test.<sup>119</sup> In addition, Mrs. Truman had informed Dr. Thomas that she had undergone a Pap smear within the past year when she first contacted him.<sup>120</sup> Thus, she purportedly had been exposed to the procedure before and may already have been warned of the dangers of foregoing a Pap smear by the physician who administered the test.

Furthermore, jury instructions should direct the jury to determine whether the element of causation by the defendant which is necessary

112. Examples of conditions and diseases that might prove fatal if undetected by diagnostic tests are: Widal Test—typhoid; Tuberculin Test—tuberculosis; White Blood Cell Determination—presence of infection or leukemia; Schick Test—diphtheria; Dick Test—scarlet fever; Urine Test—kidney disease or diabetes. See M. FISHBEIN, MEDICAL AND HEALTH ENCYCLOPEDIA 718 (1966).

113. 27 Cal. 3d at 294, 611 P.2d at 907, 165 Cal. Rptr. at 318 (Clark, J., dissenting).

114. *Id.* at 301, 611 P.2d at 911, 165 Cal. Rptr. at 317.

115. See text accompanying notes 54-70 *supra*.

116. See text accompanying notes 54-68 *supra*.

117. See text accompanying notes 69-70 *supra*.

118. *Id.*

119. 27 Cal. 3d at 297, 611 P.2d at 909, 165 Cal. Rptr. at 315 (Clark, J., dissenting).

120. *Id.*

for the plaintiff to prevail in a negligence action has been established.<sup>121</sup> Thus, it would be necessary to resolve whether Mrs. Truman would have submitted to a Pap smear had she been informed adequately of the hazard of foregoing the test.<sup>122</sup> Under the facts in *Truman*, it would be improper to assume that Dr. Thomas's failure to inform Mrs. Truman of the material risks of not consenting to a Pap smear was the proximate cause of her death. Hence, the possibility of whether Mrs. Truman would have refused to undergo a Pap smear even when advised of the potential risks also should be examined.<sup>123</sup>

In enunciating the new standard of care of "informed dissent," the *Truman* court accepted an unclear jury instruction.<sup>124</sup> The court's failure to clarify this jury instruction is likely to create confusion when the issue is raised and presented to future jurors. Thus, courts applying the *Truman* rule of "informed dissent" should give clearer instructions to the jury by explaining the relevant legal principles of negligence.

### *Truman's New Theory of "Informed Dissent" and Its Negative Implications*

The California Supreme Court, in effect, created a new standard of care governing a physician's duty of disclosure for common diagnostic tests. Under this new theory of "informed dissent," a physician has the duty to advise patients of all "material risks" that might develop if a common diagnostic medical procedure is declined.<sup>125</sup> The chief flaw in the majority's decision is that it failed to establish guidelines to govern the imposition of this new disclosure standard when applied to other

121. See text accompanying notes 48-53 *supra*. It should be noted that a Pap smear alone does not indicate if a woman has cancer. If abnormal cells are discovered after a microscopic examination of cells removed from the vagina or cervix, a tissue sample is obtained from the cervix and examined by a pathologist. Newton, *Pap Smears: When Do You Need Them?*, 12 FAMILY HEALTH 8 (1980).

122. 27 Cal. 3d at 301, 611 P.2d at 912, 165 Cal. Rptr. at 318. The American Cancer Society has established new guidelines for cancer detection tests. Women were previously advised to get annual Pap smears for cervical cancer. *Cancer Detection: Call for Fewer Tests*, 117 SCIENCE NEWS 197 (Mar. 29, 1980). It is now recommended that women between the ages of 20 and 65 have a Pap test for cervical cancer every three years. *Timetables for Cancer Checks*, 115 TIME 65 (Mar. 31, 1980). The rationale behind this change is based on the finding that cervical cancers by conservative estimate take eight years to develop. *The American Cancer Society Calls for Fewer Checkups and Its President Explains Why*, 13 PEOPLE 97, 99 (Apr. 21, 1980) [hereinafter cited as *Fewer Checkups*].

123. In a recent interview, Dr. Saul Gusberg, president of the American Cancer Society, stated that 20% of all women have never had a Pap smear, while only 51% have undergone the test annually. *Fewer Checkups*, *supra* note 122, at 99. It is estimated that in the next decade 50,000 women may die of cervical cancer due to failure to have a Pap smear test. Chicago Tribune, Oct. 10, 1980, § 1 at 10, col. 3.

124. See note 84 *supra*.

125. 27 Cal. 3d at 292, 611 P.2d at 906, 165 Cal. Rptr. at 312.

common diagnostic tests.<sup>126</sup> As a result of this omission, courts in the

126. The following informed consent form for patients undergoing herniorrhaphy was proposed by Preston J. Burnham as a satire. If doctors become legally obligated to disclose all the possible complications that might result from failure of a patient to undergo a diagnostic test in terms that a patient can completely comprehend, the absurdity of Burnham's proposal set forth below may become a reality:

*Proposed informed consent form for hernia patient:*

I, ..... being about to be subjected to a surgical operation said to be for repair of what my doctor thinks is a hernia (rupture or loss of belly stuff—intestines—out of the belly through a hole in the muscles), do hereby give said doctor permission to cut into me and do duly swear that I am giving my informed consent, based upon the following information:

*Operative procedure* is as follows: The doctor first cuts through the skin by a four-inch gash in the lower abdomen. He then slashes through the other things—fascia (a tough layer over the muscles) and layers of muscle—until he sees the cord (tube that brings the sperm from testicles to outside) with all its arteries and veins. The doctor then tears the hernia (thin sac of bowels and things) from the cord and ties off the sac with a string. He then pushes the testicle back into the scrotum and sews everything together, trying not to sew up the big arteries and veins that nourish the leg.

*Possible complications* are as follows:

- 1) Larger artery may be cut and I may bleed to death.
- 2) Large vein may be cut and I may bleed to death.
- 3) Tube from testicle may be cut. I will then be sterile on that side.
- 4) Artery or veins to testicles may be cut—same result.
- 5) Opening around cord in muscles may be made too tight.
- 6) Clot may develop in these veins which will loosen when I get out of bed and hit my lungs, killing me.
- 7) Clot may develop in one or both legs which may cripple me, lead to loss of one or both legs, go to my lungs, or make my veins no good for life.
- 8) I may develop a horrible infection that might kill me.
- 9) The hernia may come back again after it has been operated on.
- 10) I may die from general anesthesia.
- 11) I may be paralyzed if spinal anesthesia is used.
- 12) If ether is used, it could explode inside me.
- 13) I may slip in hospital bathroom.
- 14) I may be run over going to the hospital.
- 15) The hospital may burn down.

*I understand:* the anatomy of the body, the pathology of the development of the hernia, the surgical technique that will be used to repair the hernia, the physiology of wound healing, the dietetic chemistry of the foods that I must eat to cause healing, the chemistry of body repair, and the course which my physician will take in treating any of the complications that can occur as sequela of repairing an otherwise simple hernia.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Lawyer for Patient

\_\_\_\_\_  
Lawyer for Doctor

\_\_\_\_\_  
Lawyer for Hospital

\_\_\_\_\_  
Lawyer for Anesthesiologist

\_\_\_\_\_  
Mother-in-Law

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Date

\_\_\_\_\_  
Place

future are left to apply the standard on a case-by-case basis. The implications of this application could adversely affect the quality of medical care.<sup>127</sup>

Since the term "material risk" does not define precisely what information must be conveyed,<sup>128</sup> physicians fearing malpractice liability probably will take precautions that are medically unnecessary.<sup>129</sup> Prudent physicians will likely engage in lengthy lectures explaining each diagnostic test since their explanations may someday be evaluated in court.<sup>130</sup> The effectiveness of physicians subsequently may be reduced because they will likely become more concerned with the establishment of a defense for a potential lawsuit than with the treatment of their patients.<sup>131</sup> As a result of the necessity of allotting more time for each patient, the availability of medical care for patients may be decreased.<sup>132</sup> Medical care also may become less accessible to patients as physicians raise the cost of medical care to cover the rising costs of malpractice insurance caused by *Truman*.<sup>133</sup>

The underlying premise of the informed consent doctrine, the belief that a patient has the right to make informed decisions regarding his physical welfare,<sup>134</sup> is also the controlling premise of the majority's new doctrine of "informed dissent." In order to conform to *Truman's* new duty of disclosure, physicians are now faced with the task of reducing the risks of not consenting to a common diagnostic test into terms that a patient can comprehend. Considering the multitude of diagnostic tests involved in a routine physical examination, some guidelines delineating the physician's duty of disclosure must be established. Failure to do so only encourages the current trend of excessive malpractice suits.<sup>135</sup>

152 SCIENCE 448-49 (1966).

127. See 27 Cal. 3d at 298-99, 611 P.2d at 910-11, 165 Cal. Rptr. at 316-17 (Clark, J., dissenting).

128. Mills, *Whither Informed Consent?*, 229 J. AM. MED. A. 305 (1974).

129. See Note, *Handling the Unique Problems of Medical Malpractice Actions*, 10 S.D. L. REV. 137, 139 (1965); Chicago Tribune, Oct. 5, 1980, at 1, col. 1.

130. This is contrary to the position adopted in *Cobbs v. Grant*. See note 35 and accompanying text *supra*.

131. *Starnes v. Taylor*, 272 N.C. 386, 393, 158 S.E.2d 339, 344 (1968).

132. 27 Cal. 3d at 298-99, 611 P.2d at 910, 165 Cal. Rptr. at 316 (Clark, J., dissenting).

133. See Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 940-42.

134. See note 1 and accompanying text *supra*.

135. See Adler, *Malicious Prosecution Suits as Counterbalance to Medical Malpractice Suits*, 21 CLEV. ST. L. REV. 51, 51 (1972); Reuter, *Physician Countersuits: A Catch-22*, 14 U.S.F. L. REV. 203, 203 (1980).

PROPOSED SOLUTION TO THE *TRUMAN* DILEMMA: THE ENACTMENT OF A "UNIFORM INFORMED DISSENT DISCLOSURE ACT"

*Truman v. Thomas* presents the dilemma of reconciling the need for patients to be better educated concerning their health<sup>136</sup> with the necessity of imposing a realistic, functional duty upon physicians. The "informed dissent" doctrine imposes an appropriate standard upon physicians; however, the California Supreme Court in *Truman* failed to enunciate any guidelines to govern the application of the standard in the medical profession. Physicians must be provided with guidance as to what they are required to disclose to their patients under the "informed dissent" doctrine. Without such direction, the impact of *Truman* may be detrimental to both the patient and the medical profession.

The enactment of a "Uniform Informed Dissent Disclosure Act"<sup>137</sup> would alleviate the unpredictability created by *Truman*. Under the Dissent Act, a national panel<sup>138</sup> consisting of an equal number of physicians and attorneys<sup>139</sup> would be established to determine which diagnostic tests require a disclosure of risks when a patient refuses to consent to them. The panel would then decide the extent of disclosure

136. A recent study of 750 blacks living in 20 of the nation's largest cities was conducted by Evaxx, Inc. This American Cancer Society survey indicated that misinformation and myths concerning cancer contributed to the cancer death rate among blacks. Among the misconceptions was the belief that surgery encourages a cancer to spread by exposing it to the air. Since blacks are proportionately more unfamiliar with the early warning signs of cancer, they delay seeking treatment, thus decreasing their survival rate. Chicago Tribune, Feb. 6, 1981, § 1, at 10, col. 3.

137. Hereinafter referred to in the text and footnotes as the Dissent Act. An example of a uniform act enacted in response to the need for a uniformity of law that could be applied in all states is the Uniform Anatomical Gift Act (U.L.A.) § 1. By 1973, all the states had adopted the Act. See Weissman, *Why the Uniform Anatomical Gift Act Has Failed*, 116 Tr. & Est. 264 (1977).

138. The Dissent Act is based on the Texas Medical Liability and Insurance Improvement Act, TEX. HEALTH & SAFETY CODE ANN. tit. 71, art. 4590i (Vernon Supp. 1980). This Act was passed in 1977 in response to the increase in the number of health care liability claims. *Id.* § 1.02. The Act created the Texas Medical Disclosure Panel, composed of six physicians and three attorneys, to compile separate lists of those procedures requiring disclosure and those procedures not requiring disclosure. *Id.* § 6.03. Regarding the former, the panel would also ascertain the general form and substance of the disclosure. These lists are to be published in the Texas Register. *Id.* § 6.04. Disclosure of those risks required by the panel, as evidenced by the signing of a written consent form, creates a rebuttable presumption that the physician complied with the disclosure statutory requirements. Disclosure of risks not required by the panel achieves the same effect. If the physician fails to disclose the risks and hazards in a procedure which has been mandated by the statute, a rebuttable presumption of negligence is created. Exceptions to this presumption of negligence exist for an emergency and situations in which it would not have been medically feasible to make the disclosure. *Id.* § 6.07.

139. Input by an equal number of physicians and attorneys would prevent the Act from being biased to either profession. It would also preclude physicians from setting their own professional standard. See Comment, *The Effect of the Texas Medical Liability and Insurance Improvement Act on the Texas Standard for Medical Disclosure*, 17 Hous. L. Rev. 615, 631 (1980).

for those diagnostic tests requiring disclosure.<sup>140</sup>

Possible factors to be considered by the panel in ascertaining which diagnostic tests necessitate a disclosure of potential risks would be the degree of intrusiveness and the reluctance the average patient feels toward a particular diagnostic test. For example, physicians might be required to disclose the risks of foregoing a Pap smear,<sup>141</sup> proctoscopy<sup>142</sup> or blood test.<sup>143</sup> This duty, however, might not apply to other common diagnostic tests, such as a urinalysis<sup>144</sup> or a blood pressure test,<sup>145</sup> which are not physically intrusive into the body and which are not likely to be the object of a patient's abhorrence or fear.

The list of diagnostic tests and accompanying risks which must be disclosed when the patient refuses to submit to them would then be published<sup>146</sup> in the *Uniform State Laws*<sup>147</sup> and in medical journals so that they would be accessible to both attorneys and physicians. Due to the constant advancements in medicine, the panel would meet annually

140. See, e.g., TEX. HEALTH & SAFETY CODE ANN. tit. 71, art. 4590i § 6.04 (a-b) (Vernon Supp. 1980).

141. See notes 77 and 121 *supra*.

142. 2 *Medical Words*, *supra* note 25, at P-223, defines a proctoscopy as, "[t]he inspection of the interior of the rectum, especially by means of a rectal speculum or proctoscope, a tube-like instrument designed for this purpose." A proctoscopy is performed to detect cancer of the rectum and the colon. It is recommended by the American Cancer Society that persons over age 40 have a proctoscopy in routine annual checkups. BETTER HEALTH 620 (R. Wagman ed. 1973).

143. A blood test is performed on the blood to analyze its qualities and to detect abnormalities. 1 *Medical Words*, *supra* note 25, at B-63. By examining the blood cells, the pathologist is often able to diagnose diseases such as anemia, infectious mononucleosis, Hodgkin's disease, leukemia and polycythemia vera (which may cause thrombosis (clotting) in blood vessels). THE NEW ILLUSTRATED MEDICAL ENCYCLOPEDIA 136-54 (R. Rothenberg ed. 1967).

144. A urinalysis is defined as "[a]n examination of the urine by chemical and microscopic methods, in order to determine the nature and quantity of the dissolved materials as well as the acidity, specific gravity, particulate matter, color, and other characteristics." 3 *Medical Words*, *supra* note 25, at U-28.

145. Blood pressure is "the pressure exerted by the blood on the walls of the arteries . . . and the resistance of the capillaries . . ." 1 *Medical Words*, *supra* note 25, at B-62. The hazard of hypertension and its complication of widespread vascular disease appears to be associated with higher levels of blood pressure. T. HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 186 (8th ed. G. Thorn, R. Adams, E. Braunwald, K. Isselbacher, & R. Petersdorf eds. 1977).

146. See, e.g., TEX. HEALTH & SAFETY CODE ANN. tit. 71, art. 4590i § 6.04(c) (Vernon Supp. 1980).

147. The purpose of the National Conference of Commissioners on Uniform Laws is to "promote uniformity in state laws on all subjects where uniformity is deemed desirable and practicable." 14 *Uniform Laws Annotated IV* (1972). The National Conference consists of Commissioners from each state, the District of Columbia and Puerto Rico. The appointments are made by the chief executive acting within the scope of express legislative authority or general executive authority. Each jurisdiction usually has three representatives selected from the legal profession. *Id.* If the National Conference decides that a particular subject is an appropriate one upon which to draft a uniform law, it then refers the subject to a special committee for submission of the act. When the act is finally approved by the National Conference for adoption in United States jurisdictions, it is submitted to the American Bar Association for approval. *Id.* The "Uniform Informed Dissent Disclosure Act" could be adopted by the National Conference and American Bar Association by the above-mentioned procedure.



to review new medical diagnostic tests and to update any lists that previously have been published.<sup>148</sup>

The possibility exists that a patient may refuse to submit to a common diagnostic test even after the physician has complied with his duty of disclosing the potential risks required under the Dissent Act. This refusal may result in serious illness or death. If a malpractice suit is instituted, the physician's ability to prove his conformity with the disclosure standard may depend upon the production of evidence establishing the patient's refusal of the diagnostic test even after having been informed of the possible consequences of his decision.<sup>149</sup>

In view of this situation, a patient or a person authorized to "dissent" on the patient's behalf should be required to sign a written "dissent form."<sup>150</sup> For "dissent" to be effective, the form should specifically state the hazards that might result from refusal to consent to the diagnostic test. The potential risks listed would be identical to those designated by the Dissent Act panel. The form would further state that the patient refused to undergo the recommended diagnostic test and that the risks of his decision were explained to him. A competent witness would be required to witness the signing of the "dissent form."<sup>151</sup> The implementation of the Dissent Act and the "dissent form" for common diagnostic tests which patients refuse to undergo, even after having been informed of the potential risks of their decision, would substantially reduce the occurrence of the unfortunate result in *Truman*, as well as set reasonable guidelines for the physician's disclosure duty under the "informed dissent" doctrine.

### *Application of the Dissent Act to Truman*

The application of the proposed Dissent Act to the facts in *Truman* illustrates how the Dissent Act would accomplish the goals of improving the level of patient health education and encouraging physicians to comply with a realistic disclosure duty under the doctrine of "informed dissent." Once the panel determined that physicians had the duty to warn women of the risks of refusing to consent to a Pap smear, a physician then would be required to explain orally those risks to the patient in layman's language. If the patient still refused to submit to the diag-

148. See, e.g., TEX. HEALTH & SAFETY CODE ANN. tit. 71, art. 4590i § 6.04(d) (Vernon Supp. 1980).

149. AMERICAN MEDICAL ASS'N, MEDICOLEGAL FORMS WITH LEGAL ANALYSIS 73 (1973).

150. See *id.* at 73-74.

151. See, e.g., TEX. HEALTH & SAFETY CODE ANN. tit. 71, art. 4590i § 6.06 (Vernon Supp. 1980).

nostic test, the physician would request her to sign a "dissent form," confirming the fact of his disclosure. The requirement that the risks initially be disclosed both orally and in writing would eliminate the contention that the patient did not possess the reading ability to comprehend the language of the "dissent form."<sup>152</sup> Each subsequent annual disclosure of risks would only have to be given in writing. After rereading the "dissent form," the patient would signify adequate disclosure by signing her name by the appropriate date. This latter requirement would reduce the additional time the "dissent doctrine" imposes upon physicians to expend for each patient.<sup>153</sup>

If the patient later developed cervical cancer and sued her physician for failing to disclose the risks of not submitting to a Pap smear, the "dissent form" would create a rebuttable presumption that the physician complied with his statutory duty under the Dissent Act. This presumption would be included in the instructions to the jury. The jury also would be instructed that the physician's failure to produce a signed "dissent form" created a rebuttable presumption that the physician was negligent by failing to disclose the potential consequences of not undergoing a Pap test.<sup>154</sup> Failure to disclose would not be considered negligence if the applicable exceptions of imputed knowledge and previous experience were found to exist.<sup>155</sup> The rebuttable presumption created by the Dissent Act would serve the dual purpose of compelling physicians to adhere to their disclosure duty under the "informed dissent" doctrine and preventing patients from instituting frivolous claims alleging the physician's failure to warn of the risks of not consenting to a diagnostic test.

Since the Dissent Act clearly would define how the disclosure standard was to be applied, the uncertainty created by *Truman* would significantly diminish. Physicians, therefore, would neither be compelled to engage in lengthy lectures explaining each diagnostic test nor forced to increase their malpractice insurance coverage in anticipation of a potential lawsuit. Patients, in turn, would benefit because the quality of medical care would improve without an increase in cost.<sup>156</sup>

### CONCLUSION

The California Supreme Court in *Truman v. Thomas* has created a

152. See text accompanying notes 149-51 *supra*.

153. See text accompanying note 132 *supra*.

154. See note 138 *supra*.

155. *Id.* See also text accompanying notes 69-74 *supra*.

156. See text accompanying notes 128-33 *supra*.

new theory of "informed dissent" which requires that a physician disclose the potential risks that might develop from a patient's refusal to undergo diagnostic tests. It reached this determination by overextending its previous informed consent theory enunciated in *Cobbs v. Grant*.

The *Truman* court's failure to establish guidelines for the application of its disclosure standard presents numerous negative implications. Among these are an increase in the expense of medical care and a decrease in the effectiveness of physicians. The *Truman* decision may also contribute substantially to the current trend of excessive malpractice suits since physicians in California and potentially other jurisdictions which adopt this standard are now charged with the task of informing patients of all possible consequences of refusing to submit to any one of a multitude of common diagnostic procedures.

Since *Cobbs v. Grant* is considered to be a leading case in the field of informed consent, the California Supreme Court's recent interpretation of its holding in *Cobbs* may adversely affect the future status of medical care throughout the country. One viable solution is the enactment of a "Uniform Informed Dissent Disclosure Act" which would establish a panel to set up guidelines as to what physicians are required to disclose to their patients under the "informed dissent" doctrine. The signing of patient "dissent forms" would be required to evidence effective "informed dissent." The implementation of this proposal would limit the scope of the physician's duty of disclosure under the "informed dissent" theory so that a realistic balance between the patient's right to make educated medical decisions and the physician's duty to inform could be achieved.

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