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THE STANDARD OF DISCLOSURE BY PHYSICIANS TO PATIENTS: COMPETING MODELS OF INFORMED CONSENT

*Patrick D. Halligan**

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.

Plato, *The Laws*, Book IV

It appears to me a most excellent thing for the physician to cultivate Prognosis; for by foreseeing and foretelling, in the presence of the sick—he will be the more readily believed to be acquainted with the circumstances of the sick; so that men will have confidence to entrust themselves to such a physician. —Thus a man will be the more esteemed to be a good physician—and by seeing and announcing beforehand those who will live and those who will die, he will thus escape censure.

Hippocrates, *The Book of Prognostics*

INTRODUCTION

An article on informed consent must justify the space in print it seeks to occupy, as much has already been written on the subject. In this paper the purposes are scientific, the thesis is the influence of the tort of common law deceit, and the methods are partly historical. The opinion in *Small v. Gifford Memorial Hospital*,¹ lectures and illustrations by Maitland, and reflection upon fraud allegations in non-medical cases influenced the goals, thesis, and methodology of this work.

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1. 133 Vt. 552, 349 A.2d 703 (1975).

The opinion in *Small* appreciates that recognition of a tort of failure by a physician to disclose risks to a patient, as well as a definition of the tort's elements, are tasks of judicial legislation; and, judicial legislation is limited by prior settled law because courts as a matter of policy do not legislate "abrupt" changes in common law, but rather modify prior forms so that changes in policy appear to be "evolution." To proceed more rapidly would not only invade the province of the legislature, but also might do injustice to a particular party who has relied on prior law. The *Small* opinion suggests that in the law of torts, including the law of "informed consent," analysis of forms is essential to good judicial lawmaking and to justice in a particular case.

This article's thesis is that the tort of deceit is an antecedent from which courts expressly may draw more than they have in making policy for medical disclosure cases; that values reflected in the tort of deceit and ingrained in associated legal thinking unconsciously motivate judicial opinions, which infrequently articulate that tort as a contributor to the new forms; and that articulation of the contribution would be beneficial.

Constituent purposes are implied in the thesis and the main purpose. By articulating the contribution of the tort of deceit and by examining how it combines with negligence and battery to form new remedies, this paper seeks to identify alternatives for judicial legislation, choice among which would not be "abrupt." Another purpose is to locate and dissect the metaphors, analogies, and thought patterns that judges employ, in order to better predict their decisions. The former objective is to aid reviewing courts, legislatures, and their critics, while the latter goal is to aid practitioners and trial judges. Thus, while good law and care in law reform remain the ultimate goal, the content of the paper is primarily scientific, identifying models to describe and predict judicial behavior, by highlighting available and foreseeable alternatives.

The essence of scientific method is the empirical testing of hypotheses. Science, which depends on theories or models to direct or focus empirical observation, develops by the formulation, revision, rejection, and confirmation of models in response to empirical observation of behavior predicted by models. Four distinct models represent how judges behave when they utter the phrase "informed consent," and even these models do not account for all judicial conduct. But they should help lawyers to guide preparation and settlement of most cases, to counsel clients seeking to conform with judicial expectations, and to avoid adverse judicial reaction to conduct of the clients. In short, the four models of adjudication predict how judges will behave in deciding informed consent cases.

Three limitations on the use of models to predict judicial behavior are imperfect compliance with precedent, judicial discretion, and uncertainty. Models constructed from appellate opinions best predict behavior of trial judges who conscientiously follow the law. Unconscientious or unlearned trial judges are more unpredictable. Behavior of appellate courts is harder to predict than that of conscientious trial judges, because appellate courts have more discretion to make policy. They may select from various models, fashion new ones, or change from one to another within the limits of *stare decisis*. Rigid consistency at the policy level can be detrimental to the judicial process. The third limitation to which models are vulnerable is uncertainty. Predictions themselves might influence judicial behavior, either by reinforcing a judge's decision (self-fulfilling prediction) or changing it. A predictive article has side effects; lawyers and judges sometimes choose to follow the prediction, or they may repudiate models they might otherwise have followed.

FAILURE TO OBTAIN INFORMED CONSENT: A PRELIMINARY DEFINITION

Disputes occur between physicians and their patients when an attempted cure not only fails, but in fact aggravates the condition of the patient despite skillful implementation of the technique or method of cure, thus bitterly surprising the patient. The aggravation is called a side effect or a collateral effect. The bitterness of a surprise usually consists in a complaint that the physician knew that the side effect was possible but did not tell the patient. The patient usually suggests that he would not have taken the cure had he been informed and would not, incidentally, have suffered the side effect. These disappointments crystallize in the allegation that the doctor did not obtain informed consent to the cure. Provisionally, lack of informed consent is a doctrine about a doctor's liability for side effects of touching which arise despite manual skill, and which surprise the patient more than they surprise the physician.

When no treatment or harm has occurred, and no physical cause has operated between the two, then there exists no dispute about informed consent as defined here. These points seem obvious, but they have been litigated.

Absence of treatment sometimes signals absence of a treating relationship. For example, in Louisiana a genuine duty issue arose regarding medical disclosure in *Dowling v. Mutual Life Insurance Company*.² The court ruled that an insurer's medical examiner was

2. 168 So. 2d 107 (La. App. 4th Cir. 1964).

not obliged to disclose to an examinee-applicant diagnostic data which he could have taken to his own doctor. A full doctor-patient relationship did not exist, nor was there any treatment or side effect; thus, the case did not deal with informed consent in the usual sense.

In a New York case, *Karlson v. Guerinot*,³ a treating relationship existed, but no laying on of hands occurred. The court recognized no informed consent tort in the case of a doctor who did not advise an expectant mother that her baby might be deformed, on the rationale that there is no laying on of hands or no "intrusion" into the body of the mother which can be said to have produced a side effect.

But a similar case, *Gleitman v. Cosgrove*,⁴ in nearby New Jersey, which might have emphasized that there had been no laying on of hands, chose instead to reason that no cognizable harm had occurred. In *Gleitman*, a pregnant woman had contracted German measles. The defendant doctor who attended her failed to advise her that there exists a 25% likelihood that a child born to a woman with German measles will be deformed. The child was born deformed, but the court reasoned that the treatment had caused no harm and that there was no damage, because the birth of a deformed child is better than the destruction of a fetus.

The questions of what is a side effect and of whether normal consequences of ineffective treatment constitute side effects often surface in sterilization cases. In *Bennett v. Graves*,⁵ a Kentucky court approached the issues by using a malpractice model with a moderately broad therapeutic privilege. The court stated that the amount of information to give about the relative dangers and effectiveness of hysterectomy and tubal ligation methods of sterilization is a matter of medical judgment. The opinion assumes that an unwanted pregnancy can be an actionable side effect. An unwanted result is the sort of *corpus delicti* one might expect in a deceit case, but in a malpractice case a pathological result constitutes the *corpus delicti*, and, though often inadvertent, pregnancy is not pathological.

The term "materialize" can be used to refer to the occurrence or non-occurrence of a deleterious side effect within the ambit of risk that ought to be disclosed. When the risk has not materialized, failure to disclose that risk is not actionable as either negligence or misrepresentation, though nondisclosure might be actionable as a fictional battery. A Maine case, *Downer v. Veilleaux*,⁶ ruled that

3. 57 A.D.2d 73, 394 N.Y.S.2d 933 (1977).

4. 49 N.J. 22, 227 A.2d 689 (1967).

5. 557 S.W.2d 893 (Ky. App. 1977).

6. 332 A.2d 82 (Me. 1974). The case indicates that no compensation is available

there could be no recovery on a record which shows that the undisclosed risk did not in fact materialize.

Materialization, a notion of harm or the absence of harm, addresses the existence or absence of the *corpus delicti*. The most basic materialization issue is the existence of the effect or condition which the plaintiff claims. In *Small v. Gifford*⁷ the defendants disputed the existence anywhere in anyone of the disease which the plaintiff claimed as a side effect of anesthesia during breast surgery. A similar fundamental issue, disputed in *Small*, is whether the plaintiff suffers from a condition or disease known to exist, which could be a side effect of treatment, or suffers instead from a different condition which manifests similar symptoms but is not a side effect. More typical is the issue of whether the treatment did or did not physically and physiologically cause the plaintiff's disease or damage, when such harm is sometimes produced as a collateral effect of the treatment. "Materialization," unless otherwise indicated, means the last of or the collection of these three disputes. Resolution of these kinds of issues requires expert testimony consisting, not of reports of occupational practices or standards, but of scientific opinions on taxonomy and etiology (*i.e.*, on the character and cause of disease).

A Louisiana appellate decision illustrates how *corpus delicti*, cause-in-fact, and proximate cause blend and influence one another in situations where management of risk and uncertainty is the nature of the transaction. In *Parker v. St. Paul Fire & Marine Insurance Co.*,⁸ a physician induced labor and the woman was injured. The plaintiff claimed that she should have received information about alternative methods of inducing labor. But statistical evidence showed that the mishap which occurred was no more prevalent among cases using the method employed than in cases using other methods. The opinion states that when the risk of the particular event in question is no different than the risk of the alternatives, there is no "duty" to compare alternatives. A more traditional approach would say either that there was a duty but that the defendant conformed to standards and thus did not breach his duty, or that there was in fact no deleterious consequence from a breach, or that the physician's unilateral choice of method did not cause the harm.

for the intrusion itself; absent a side effect, there are no damages. That is, there is no room for fictional battery in Maine. The opinion inclines far toward the misrepresentation model and an actual reliance element, but acknowledges that the absence of materialization of the risk made it unnecessary to select a model.

7. 133 Vt. 552, 349 A.2d 703 (1975).

8. 335 So. 2d 725 (La. App. 2d Cir. 1976).

But use of an explanation hinging on causation creates problems. Legal cause-in-fact is the notion of a necessary pre-condition or of an antecedent event (but-for causation). The medical procedure in *Parker* in this sense caused the harm. The ultimate harm was physical damage. But the mediation was creation of risk. Yet there was no increment of added risk created by the choice the physician made. In this sense there was no *corpus delicti*, no prescribed situation, no disruption of order, nor enlargement of jeopardy. The equivalency of hazards created a unitary, unavoidable degree of risk which, though not the same thing as an unavoidable accident, has a similar moral quality. The concept of an unavoidable accident is a causal notion. Heuristically, then, the non-liability of the defendant in *Parker* approximates the non-liability of one who has caused no harm. A less metaphysical rationalization would redirect attention from the culpability and potency of the defendant's deeds to the needs of the plaintiff, *viz.*, materiality: when the risks are the same in severity, quality, and probability, they are irrelevant to the decision.

Subjective response to data is a fact which also will preempt other issues and, in a case of first impression in a jurisdiction, will obviate the need to select a model for a new tort.⁹ It should be obvious that non-causation here is very different from non-materialization, *i.e.*, from the issue of physical causation, which must be distinguished from reliance.

The most celebrated case which turned upon physical or physiological causation was *Karp v. Cooley*,¹⁰ tried by a federal court in Texas applying Texas law. In that case the trial court directed a verdict for the defendant because his *prima facie* case had not proved causation by expert testimony. Dr. Cooley, the defendant, had experimented on the late Mr. Karp with an artificial heart which even the doctor's own university medical committee had not cleared for clinical trial in humans. A risk of the artificial heart is damage to blood cells and kidneys. Mr. Karp experienced that injury, but a hostile doctor called by the plaintiff refused to express an opinion on whether the experimental heart had caused the damage to Karp's blood and kidneys. The reviewing court affirmed the judgment for the defendant. The case illustrates poignantly that the interests the malpractice model primarily protects are good care and avoidance of

9. See, *e.g.*, *Poulin v. Zartman*, 542 P.2d 251 (Alaska 1975). The plaintiff in *Poulin* admitted that the procedure would have taken place even if the information had been given. The absence of actual reliance preempted the other issues. Besides noting reliance as an element, the Alaska law of informed consent is uncertain.

10. 493 F.2d 408 (5th Cir. 1974), *cert. denied*, 419 U.S. 845 (1974).

bad medical consequences, not the dignity of the patient *per se*. The defendant used a dying man in a clinical trial which Baylor University colleagues said should not have been conducted, but was discharged of liability at the close of the plaintiff's case because Texas follows the medical malpractice model.¹¹ In that model, failure to obtain informed consent is a failure of disclosure before a treatment that causes a side effect.

Disclosure before treatment by touching is not the only circumstance in which a doctor or medical worker may be liable for failure to disclose a risk. Warning a patient invitee of dangers on the premises, or of the fact he has been exposed inadvertently to contagion or radiation, or advising him how to use prescribed medicines or appliances which are dangerous unless used properly are obvious examples of obligations to advise which differ from the obligation to disclose in order to obtain informed consent to treatment. Even more obvious is an obligation to have and give knowledge when the patient primarily seeks, not manual finesse, but the information itself. The best example is genetic counselling. A physician who ignorantly says that a condition is not inheritable when it is may be liable, not for want of disclosure incidental to treatment, but for misfeasance in the main task engaged.¹² Other examples are unskillful disclosure to third persons (*e.g.*, employers, insurers) who have employed a physician to examine a person and to report findings; failure to disclose a condition to a public authority (vital statistics and disease control legislation); or nondisclosure to a stranger (*e.g.*, a potential victim of a psychiatrist's homicidal psychotic patient).¹³

Despite its growth, informed consent is a comparatively insignificant source of medical litigation. Informed consent counts usually accompany separate counts of negligent manipulation or mistaken choice of treatment, and no inconsistency exists between such counts. They may be cumulative and not alternative.¹⁴ Plaintiffs may try to gore the defendants on the horns of a dilemma, the points of which are informed consent and *res ipsa loquitur*, as illustrated by the thyroidectomy cases. In *Di Filippo v. Preston*¹⁵ the

11. 493 F.2d at 422.

12. See *Becker v. Schwartz*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978). The decision consolidated two cases. Plaintiffs in both brought so-called "wrongful life" claims regarding handicapped infants. The court pointed out that many disparate torts exist under that umbrella.

13. See *Shea, Legal Standard of Care for Psychologists and Psychiatrists*, 6 W. ST. U.L. REV. 71, 90-96 (1978).

14. *Mayor v. Dowsett*, 400 P.2d 234 (Or. 1965).

15. 53 Del. 539, 173 A.2d 333 (1961). Other thyroidectomy cases blending informed consent and *res ipsa loquitur* include *Collins v. Itoh*, 503 P.2d 36 (Mont. 1972), *Wood*

plaintiff suffered from goiter (inflammation of the thyroid). The defendant surgeon, Dr. Preston, removed the thyroid by the "standard technique," which leaves intact that 5% of the thyroid in which the laryngeal nerves often are found. The competing Lahey technique visualizes and sets aside the nerves and removes almost all of the thyroid. By either method some 2% of thyroidectomy patients suffer nerve damage, vocal chord paralysis, and voice diminution or loss, because the course of nerves through the thyroid varies in each patient, and even slight squeezing or stretching of the nerves can damage them. The *Di Filippo* opinion expressly adopts the malpractice model of disclosure with the comment¹⁶ that informing a patient of a risk might be a deviation from standards if, in the best interest of the patient, competent physicians would not reveal the risk. The opinion affirmed a directed verdict for the defendant on the *res ipsa* point in deference to statistical evidence that voice loss occurs only in 2% of the cases performed even by the best-trained surgeons, and on the informed consent count because all of the expert testimony agreed that the practice among local physicians was not to warn. Other combinations of informed consent and *res ipsa* are the spinal burns in *ZeBarth v. Swedish Hospital Medical Center*¹⁷ and shoulder-arm paralysis in *Martin v. Stratton*,¹⁸ where *res ipsa* was not applied, because the evidence showed a strong chance that the negligence of non-parties had caused the harm. Likewise, the informed consent theory failed in *Martin* because the nerve injury was unprecedented in the observations of the three anesthesiologists who testified and because there was no evidence that competent doctors even recognize, let alone disclose, such risks.¹⁹

By combining informed consent and *res ipsa*, plaintiffs seek to confront their defendants with this dilemma: if the doctor does not testify to the possibility of harm despite manual skill and fails to say that the harm in question represents the materialization of an inherent, collateral risk, the judge may instruct the jury that unexplained harm may itself be evidence of negligence. But if the physician does testify to those things, the plaintiff needs no expert in a

v. *Roberts*, 206 F. Supp. 579 (S.D. Ala. 1962), and *Watson v. Clutts*, 262 N.C. 153, 136 S.E.2d 617 (1964).

16. 53 Del. at 539, 173 A.2d at 339. The version of the new tort urged by the plaintiff conceded a broad privilege not to warn if a warning would have "unduly alarmed" the patient; the court restated the broad privilege so conceded.

17. 81 Wash. 2d 12, 499 P.2d 1 (1972).

18. 515 P.2d 1366 (Okla. 1973).

19. The elements of scienter, medical standards, and materiality having failed, the court affirmed the directed verdict for defendant in the trial court and reversed the intermediate appellate court, but declined to select among malpractice, misrepresentation, or a hybrid, saying all three had failed.

misrepresentation model state to get to the jury on the other count, failure to obtain informed consent. The interaction of the elements of *res ipsa* and informed consent is indeed problematical to medical defendants. With the notion of informed consent in mind, an inquiry into the background and development of the tort is proper.

EVOLUTION OF LAW AND MODELS OF THE TORT OF FAILURE TO OBTAIN INFORMED CONSENT

Common law is evolutionary, and the impetus of its evolution is analogy, as used in attorneys' arguments and in appellate rationales. The following analogies have contributed to informed consent case opinions.

Battery Model

Much judicial behavior is described by a model which supplied an early analogy for the tort of failure to obtain informed consent. The model, which is not concerned with side effects but with the bodily intrusion itself, is the technical battery model.

When a doctor touches a patient, invading his body in a manner or by a treatment to which the patient has not consented, the doctor has committed the tort of battery. Though failure to obtain informed consent differs from actual failure to obtain consent, the tort of battery has contributed much to the appearance of the new tort. Thus battery cases involving the absence of consent by the patient should be studied. Their concept is not gratuitous battery between strangers, but battery arising in the course of treatment by a physician whose patient has consented to some touching.

*Slater v. Baker and Stapleton*²⁰ is strikingly pertinent despite the passage of more than two centuries, and presents both medical misadventure and an instance of exemplary judicial behavior, nicely balancing doctrinal order and justice.

The Chief Justice of the Court of Kings Bench in 1767 was Wilmot who, during Michaelmas term in that year, presided at the trial by jury in the case. Surgeons testified on each side, regarding the proper surgical practice in seeking consent of patients to straighten broken limbs previously set and partially healed. The testimony of the plaintiff and his relatives included repeated assertions that if asked for permission to use the procedure in question, he would not have consented. The testimony on the plaintiff's case, lay and expert, implied a cause of action based on what would now

20. 95 Eng. Rep. 860 (1767).

be referred to as a negligence theory and an element of subjective reliance. Specifically, the plaintiff had pleaded trespass on a special case which evolved to negligence, deceit, and *assumpsit*, among other forms. In *Slater*, contractual and delictual components operated together, since the theory of the plaintiff's cause of action drew also upon contract. The pleading misadventure consisted in the irony that the proof offered was thought by the Chief Justice, by the jury, and even by defense counsel to fulfill the elements of the more culpable tort of trespass *vi et armis*. The jury had returned an extremely large verdict of 500 pounds, and Chief Justice Wilmot complimented the jurors and stated he was "well satisfied" with the verdict, although malpractice insurance did not exist, and the co-defendant Baker was "celebrated" not only for skill, but for humanitarianism in other endeavors. The defense experts praised the defendant and the evidence showed he had for twenty years been first surgeon of St. Bartholomews and had lectured to others upon surgery and anatomy. The other defendant, Stapleton, was an apothecary who sought aid from Baker when Slater asked Stapleton to remove the bandages from the patient's broken leg, which had been set earlier by others.

Baker arrived with an iron machine of his own devising, which was unknown to the other surgeons who testified; he used it to re-break the leg suddenly, then to extend the leg and re-straighten it. The standard method was compression, not extension, and it was the commonly accepted practice to avoid breaking the patient's callous. It appears that the leg healed again but very slowly; the plaintiff sought satisfaction for disability and pain during the delay. The defendants offered no evidence to contradict the plaintiff's testimony about the occurrence of the injury and about what words had been spoken by the doctor. The defendants' experts only testified to the reputation of defendant Baker for skill and kindness. The liability of the apothecary was based on a contractual theory proveable under special case, but the undisguised motive of the judge was to remedy the trespass *vi et armis* committed by both defendants. The judge denied a motion for judgment *non obstante veredicto* and stated that he would not look at the evidence with an eagle's eye to see that it perfectly fit the allegation. But instead, he would adjudge for the plaintiff to the extent that the remedy sought in the writ was justified by the evidence. The record made by the plaintiff on his allegation of trespass on the case was fuller than, but not adverse to, the proof of trespass *vi et armis*; the proof offered tended to corroborate the trespassory culpability of the defendants by showing that surgeons do not presume to straighten bones without consent and do not claim immunity from writs of trespass when acting without permission. Commenting on the novel machine

and the unusual procedure, the Chief Justice reflected upon the irony that most often it is not the least skillful practitioner but the most skillful one who will be tempted to "experiment"; the Chief Justice commented further that there is no right to experiment without express permission and that to do so is rash and wrongful.²¹ Perhaps the strategy of counsel for the plaintiff to prove deviation from professional standards was prompted by fear that the defendants would, by perjury, contradict his client's report and that the jury would believe them. In the defense, counsel and client attempted to interpose a paternalistic privilege which failed; they then attacked the verdict as motivated by misconduct not pleaded. But consideration of three leading American cases which occurred after negligence was well established as a separate tort, distinct from trespass, shows the progenitor tort survives.

The most celebrated decision is *Mohr v. Williams*.²² In that case a patient consented to surgery on the right ear; but the surgeon operated on the left when, during the surgery, he found that the left ear, not the right, needed the operation. The opinion affirms a judgment for the plaintiff and rejects three attractive defense arguments: (1) the benefits to the patient; (2) the absence of an intent to harm; and (3) implied consent. The rejection of the first argument, the benefits of the surgery, underlines the interest protected: "the right to the inviolability" of one's person.

Cited in *Mohr* was the intermediate appellate decision reviewed by the Illinois Supreme Court in *Pratt v. Davis*.²³ Without describing the scope of surgery he contemplated, the defendant surgeon operated twice on the plaintiff and removed her uterus and ovaries. The plaintiff and her husband asserted that neither of them had consented to such extensive procedures. Rejecting defenses like those advanced in *Mohr*, the opinion reasoned that "consent should be a pre-requisite to a surgical operation,"²⁴ and affirmed an award of compensatory and punitive damages.

*Rolater v. Strain*²⁵ and *Schloendorff v. Society of New York Hospital*²⁶ follow *Pratt*. *Schloendorff* gave Judge Cardozo an opportunity to exercise his craft in creating new rights or immunities by ingenious judicial revision of pre-existing entitlements or defenses, and by articulating the new principles so epigrammatically as to make

21. *Id.* at 862-63.

22. 95 Minn. 26, 104 N.W. 12 (1905).

23. 224 Ill. 300, 79 N.E. 562 (1906).

24. 224 Ill. at 305, 79 N.E. at 564.

25. 39 Okla. 572, 137 P. 96 (1913) (unauthorized removal of bone in foot).

26. 211 N.Y. 125, 105 N.E. 92, 133 N.Y.S. 1143 (1914).

them appear puny and foreseeable, when they were latently large, novel, and redistributive. He opined:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation, without his patient's consent commits an assault, for which he is liable in damages.²⁷

In *Mohr, Pratt, and Schloendorff*, the courts brushed aside the benefits defense. If side effects are not the grounds for the action, then rejection of a benefits defense, while not logically necessary, is not surprising. However, if side effects are the gist of the action, the disallowance of a benefits defense is both unlikely and harsh.²⁸ To call attention to benefits accompanying the side effects is like an affirmative partial defense of mitigation. Logically, a plaintiff should have to prove his net damages by demonstrating the benefits he would have lost had he postponed or foregone treatment because he knew the risk of the side effect. But the cases do not recognize this partial defense, nor do they allocate the burdens of pleading or of proof. Alert defense counsel should construct a record that shows the benefits of the treatment undertaken and the deterioration likely to have occurred had plaintiff foregone, postponed, or restricted his treatment. This partial benefits defense is referred to as the Waltz-Inbau credit.

Besides rejecting the benefits defense, the courts in *Mohr, Pratt, and Schloendorff* narrowed the defense of implied consent. The defense is one of actual consent by the patient, implied from surrounding circumstances, except in extreme emergencies when the law constructs the "consent." This concept differs from the notion of "informed consent," which involves information. Though courts often imply consent in medical battery cases, local variations exist, and the implication is not guaranteed.²⁹ Three contemporary

27. 211 N.Y. at 129-30, 105 N.E. at 93, 133 N.Y.S. at 1145.

28. J. WALTZ & F. INBAU, *MEDICAL JURISPRUDENCE* 152-78 (1971).

29. Ironically, the state least willing to apply the informed consent doctrine appears to be Georgia. In *Wall v. Brim*, 138 F.2d 478 (5th Cir. 1943) (applying Georgia law), a doctor cut into a wider area of the face and neck of plaintiff than he said he would when he found that a cyst he sought to remove was more widespread than first supposed. Despite the exercise of care, the doctor injured the plaintiff's nerve in the wider area of surgery. In most jurisdictions, the case would be regarded as an illustration of implied consent; the patient was awake, as a local anesthetic was employed. The patient did not interrupt the surgeon as he cut into the wider areas. The court affirmed a verdict and judgment for the plaintiff. The irony consists in the fact that Georgia does not recognize failure to give information coupled with a harmful effect as a separate cause of action. See, e.g., *Park v. Palmyra Park Hosp.*, 139 Ga. App. 457, 228 S.E.2d 596 (1976).

battery cases from western states deal with interpretation of language to ascertain the scope of consent.

*Cathemer v. Hunter*³⁰ is a novel "reverse battery" case from Arizona in which the doctor did too little. The patient had not consented to a small procedure, but had insisted on a more ambitious operation. The plaintiff specifically asked for a hip replacement like the one he had heard a radio celebrity praise. The doctor boasted that he was the surgeon for the operation. However, he merely secured the hip with a metal pin called a hip prosthesis, which irritated the hip area and had to be removed. The plaintiff had signed a consent to hip prosthesis installation, but no one explained the term to him. The court properly brushed aside the form. The opinion states that actual consent is a question of the reasonable intent of the parties.³¹ The court restated³² the testimony of the plaintiff that he would not have agreed to the installation of the prosthesis had he known the nature of the procedure. The court demonstrated the absence of actual consent rather than subjective reliance, though the terms have similar meanings. The court employed the battery model, the only theory pleaded,³³ but also reversed a directed verdict for the defendant and instructed³⁴ the trial court to allow the plaintiff to amend his complaint to include negligence or breach of contract theories. The opinion states that the plaintiff also may assert battery because the alleged malpractice occurred before the effective date of a malpractice statute. In a footnote³⁵ the court concluded that the legislature had "abrogated" prospectively the right of a patient to sue a doctor for assault or battery. The statutory construction is questionable.³⁶ Arizona physicians may not engage in anti-social conduct, and the legislature did not intend to immunize them from liability for vicious behavior. The only restriction is that if one suffers battery, he should plead that tort, as did the plaintiff in *Cathemer*, and not "malpractice." In *Cathemer* there also appears the most absurd, though charming, of the many concepts created by informed consent cases: analogizing to criminal pleading, counsel for the defense argued that an express bargain for a total hip replace-

30. 27 Ariz. App. 780, 558 P.2d 975 (1976).

31. 27 Ariz. App. at 783, 558 P.2d at 978.

32. 27 Ariz. App. at 782 & 784-85, 558 P.2d at 977 & 979-80.

33. 27 Ariz. App. at 781, 558 P.2d at 976.

34. 27 Ariz. App. at 785, 558 P.2d at 980.

35. 27 Ariz. App. at 783 n.2, 558 P.2d at 978 n.2.

36. In *Reidesser v. Nelson*, 111 Ariz. 542, 534 P.2d 1052 (1975), the court affirmed a summary judgment for defendant but reminded that general adoption of a negligence model does not imply the unavailability of battery remedies for a case in which nondisclosure of risks amounts nearly to nondisclosure of the procedure contemplated and regions affected. Subjective reliance is required.

ment authorizes a hip prosthesis because the prosthesis is a "lesser-included" operation within the replacement.

In the second contemporary western battery case, *Corn v. French*,³⁷ a hostile witness called by the plaintiff corroborated the defendant's testimony that there was no pathologist nearby, although the witness acknowledged that pathological study should precede mastectomy, if possible. The defendant had proposed a biopsy, but during surgery he diagnosed a malignancy and removed the plaintiff's breast. The court reversed a directed verdict for the defendant and reflected that the defense could present a medical exigencies justification that might satisfy a jury on retrial. The case apparently involved an actual, technical battery in which the issue was implied consent and thus was not an authentic informed consent case.³⁸ The plaintiff had signed a consent to mastectomy, but no one defined the word for her, so the court ignored the consent form.

The third case, *Doerr v. Movius*,³⁹ was no more than a technical battery claim for an intrusion to which implied consent was found. The patient asked the surgeon to repair a hernia which the parties thought was on the patient's left side. During the operation the surgeon found the hernia on the right side; he repaired it without causing side effects, though additional scarring occurred. The court ruled for the defendant. Linguistic construction and ascertainment of intent can reconcile this case with *Mohr*. In *Doerr* the parties intended to repair the hernia, and its location was only secondary. In *Mohr*, the plaintiff intended to consent to surgery on only one ear.

The Initiation of the New Tort

The first case to focus on the concept of "informed consent" rather than actual consent was *Salgo v. Leland Stanford Jr. University*.⁴⁰ In *Salgo*, the court defined the doctor's obligation to his patient as not to "withhold any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."⁴¹ This definition created a new obligation, because, unlike the cases discussed previously, *Salgo* required the sharing of information, which is more than assumed actual consent. The case involved an aortograph procedure which resulted in paralysis. The complaint alleged, and the court instructed on, negligence. The rationale did

37. 71 Nev. 280, 289 P.2d 173 (1955).

38. The wide opportunity for the doctor to plead implied consent suggests that in an authentic side effects informed consent case Nevada will opt for a malpractice model with a wide therapeutic privilege.

39. 463 P.2d 477 (Mont. 1970).

40. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

41. 154 Cal. App. 2d at 578, 317 P.2d at 181.

not rest on a battery theory, although the court did not abrogate prior decisions recognizing battery in the absence of actual consent. Instead, the court created a new tort whose remedies cumulate with older forms. The reasoning of the trial court and the appellate opinion are more suggestive of deceit or misrepresentation than of battery or negligence, although the deceit model is not well articulated.

In 1960, a Kansas opinion, *Natanson v. Kline*,⁴² struggled with battery and negligence in seeking a ground for this new cause of action. The court declared that the action was a part of the tort of negligence.

In 1965 the court of appeals of Arizona discussed the issue, acknowledged the confusion between negligence and battery, and concluded that the action lies in either tort. Actually, the informed consent cause of action is not a product of either tort. The opinion is an example of the confusion into which courts fall when analyzing the new cause of action:

Summarizing, we hold that a consent to a surgical procedure is effected if the consentor understands substantially the nature of the surgical procedure attempted and the probable results of the operation. This, as a matter of law, constitutes an informed consent. Lacking this, the operation is a battery unless some special exception pertains. Given an informed consent, liability, if any, must be predicated in malpractice. In malpractice, the duty of the physician to disclose is determined by the normal practices of his profession in the particular community. We do not attempt to determine the law in the case of particularly dangerous operations, when some courts have ruled as a matter of law that disclosure must be made . . . If it is found that the standard of disclosure has been breached in the particular case, and if injury has resulted therefrom, then there is liability in malpractice. Whether there was sufficient evidence in this case, arising from the testimony of the defendant-doctor or otherwise, to go to the jury on the question of whether the defendant-doctor breached a duty to disclose we need not decide because there is no showing here that the failure to disclose resulted in the plaintiff's unfortunate condition.⁴³

A misrepresentation element emerges from these early rulings. The constant attention given to negligence and battery in the first informed consent opinions suggests that the emphasis on misrepresentation in the contemporary decisions is either a new mark or

42. 186 Kan. 393, 350 P.2d 1093 (1960).

43. *Shelter v. Rochell*, 2 Ariz. App. 358, 409 P.2d 79, 86 (1965) (citations omitted).

an atavism. But judicial distaste for misrepresentation or concealment is obvious in *Salgo*, *Natanson*, and *Shetter*. The highlighted traits may be negligence and battery, but the focus on those characteristics does not hide the tort of deceit in the pioneer cases.

An examination of the cases following *Salgo* in California proves this parentage. In *Salgo* the appellate court reversed and remanded because the trial court had instructed the jury that a doctor must advise a patient of "all facts" which affect the interest of the patient and of "all risks, if any."⁴⁴ The appellate court stated that an instruction should contain the proviso that a doctor has discretion to withhold information in order to prevent an adverse reaction, to prevent a reluctant patient from refusing beneficial treatment, or to advance the welfare of the patient. The decision suggests case-by-case evaluation by the trial courts. As stated, the opinion utilizes a malpractice model. But the court stated that the right to choose is a separate right a doctor must balance with good health care and admonished that doctors should not minimize risks or their duty to disclose them. This notion of balancing interests implies a necessary element of objective materiality and requires expert testimony to determine the fulfillment or breach of the duty in any one case; *i.e.*, the standards of disclosure are medical, professional standards. However, by 1972 a concept of a misrepresentation model employing subjective standards had arisen.⁴⁵

In *Cobbs v. Grant*,⁴⁶ the court purported to follow a negligence model⁴⁷ but drastically narrowed the therapeutic privilege of *Salgo* and heightened the importance of the patient's interest in information, unless the patient asks not to be informed of the risks.⁴⁸ The plaintiff often must present medical testimony to establish the existence and probability of risks and to prove the *de facto* materialization of a collateral risk, but he need not present expert testimony concerning other issues. A pre-*Cobbs* appellate case⁴⁹ and

44. 154 Cal. App. 2d at 578, 317 P.2d at 181.

45. Malpractice persisted for a time. See *Dunlap v. Marine*, 242 Cal. App. 2d 162, 51 Cal. Rptr. 158 (1966).

46. 104 Cal. Rptr. 505, 502 P.2d 1 (1972).

47. 104 Cal. Rptr. at 512, 502 P.2d at 8.

48. 104 Cal. Rptr. at 516, 502 P.2d at 12.

49. See *Berkey v. Anderson*, 1 Cal. App. 3d 790, 82 Cal. Rptr. 67 (1969). *Berkey* finds the source of the obligation to disclose in the fiduciary aspects of the doctor-patient relationship and not in a standard of care. *Cobbs* does not totally undercut this reasoning. The motive of the action is the patient's desire for and expectation of information. In this model, patients of doctors are much like clients of lawyers. However, in *Berkey* the doctor performed a myelogram when he had obtained consent for an electromyogram. Consequently, under the facts, a technical battery was at issue, and the informed consent discussion is properly read only as dicta.

Cobbs firmly cement California law to the misrepresentation mold, notwithstanding the insistence in the latter case that negligence is the gist of the tort. These cases imply subjective reliance as an element but concede that expert testimony is required as a foundation.⁵⁰ In *Cobbs* the court was unclear⁵¹ about the relationship between the severity and the incidence of risk as a basis for testimony on reliance; evidence of those things is required not merely as a foundation for proof of reliance, but for other reasons. The court indicated that objective materiality is also required. Yet dicta in one case suggests that expert testimony about the magnitude of a risk may be excused if the existence of the particular risk is established in a less statistically specific manner and if the plaintiff's subjective reliance and the fact of materialization are certain.⁵² Particularly in a consumer model jurisdiction, the defense of "ignorance requested" by the patient⁵³ is recognized. Finally, battery remedies are not abolished but are "reserved"⁵⁴ to cases of a genuine absence of consent. This attention to the materiality of facts and reliance upon them suggests the tort of deceit.

The Deceit Model and Definition of Terms

Elements of the Tort of Deceit

The battery and negligence analogies are mentioned frequently as contributing to the new tort of failure to obtain informed consent. Another doctrinal and ethical influence that is apparent but is less frequently articulated is the tort of deceit, which, like negligence, derived from trespass through case. The equitable doctrine that paralleled deceit was the ground of fraud for cancellation of instruments and contracts; today the word "fraud" often is used to refer to the common law suit as well. Two models must be used to describe adequately the judicial behavior in the United States that followed *Salgo* but deemphasized the battery analogy; these are the professional negligence model and the consumer misrepresentation model. Another model existing in a few jurisdictions, fictional battery, employs freely the tort of battery as an analogy.

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

51. 104 Cal. Rptr. at 515, 502 P.2d at 11.

52. *Morgenroth v. Pacific Medical Center*, 54 Cal. App. 521, 126 Cal. Rptr. 681 (1976). The reliance of the plaintiff was suspect in *Morgenroth*, because he had consented despite having received information about risks of death and of "serious disease."

53. See *Putensen v. Clay Adams, Inc.*, 12 Cal. App. 3d 1062, 91 Cal. Rptr. 319 (1970).

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

The elements of deceit are familiar.⁵⁵ To recover, the plaintiff must prove: (1) a statement, a guilty silence, or a concealment by the defendant of a fact (as distinguished from a promise); (2) the inaccuracy of the statement or of the impression created by silence or concealment; (3) the objective materiality of the fact to the plaintiff's decision; (4) an actual subjective reliance by the plaintiff on the statement or impression; (5) the defendant's knowledge of the falsity of the statement or impression (or reckless or negligent disregard of falsity); (6) an intent by the defendant to produce reliance and to induce action by the plaintiff; (7) a loss suffered by the plaintiff; and (8) causation-in-fact of the loss by the induced action or inaction.

An allegation of common law deceit seeking damages for a side effect occurred in the Virginia case of *Hunter v. Burroughs*.⁵⁶ In *Hunter* the plaintiff alleged that a doctor had not warned of x-ray burns and had misled the plaintiff by inaccurately advising that x-ray treatment would cure his eczema. The plaintiff also alleged that he would not have accepted treatment had he been warned. The plaintiff alleged both negligence and misleading conduct of the physician. The court overruled a demurrer, commenting that the failure to warn was not negligence *per se*. The opinion stresses the importance of subjective reliance but does not excuse the allegations of scienter, materiality, and the other elements of deceit.

Concealment means an affirmative act to frustrate an inspection or otherwise to prevent access to a fact. A guilty silence differs in that it constitutes nondisclosure and not affirmative action. Absent a statute requiring disclosure, silence is actionable only when preceded by an erroneous, ambiguous, or incomplete statement of a defendant who later learns that his prior statement is misleading or will produce an unexpected reliance. The two other exceptions to nondisclosure are fiduciary relationships and a trade custom of disclosure. The last exception, custom, reaches only "basic" facts.⁵⁷ The affirmative duty to disclose risks in informed consent cases can be grounded on the theory that the relationship between patient and physician is one of trust and confidence.⁵⁸ But this notion is used primarily in cases testing the validity of contracts and conveyances and is not meant to define the nature of the professional relationship. Moreover, the institutional nature of modern medicine makes this conception of the doctor-patient relationship untenable. Indeed,

55. See, e.g., 1 F. HARPER & F. JAMES, *THE LAW OF TORTS* § 7 (1956); W. PROSSER, *THE LAW OF TORTS* §§ 520-72 (4th ed. 1971).

56. 123 Va. 113, 96 S.E. 360 (1918).

57. RESTATEMENT (SECOND) OF TORTS § 550-51 (1976).

58. 61 AM JUR. 2D *Physicians, Surgeons, and Other Healers* § 100 (1972).

the absence of trust spawns informed consent cases. The doctrine of informed consent is a new exception to the requirement of an affirmative act or a statement in the torts of misrepresentation and deceit where those models control informed consent litigation.

The defendant's knowledge of the falsity of his statement or of the patient's impression is called scienter.⁵⁹ A doctor is not expected to be aware of unusual risks unknown even by specialists in the field.⁶⁰ Similarly, the courts will not require the physician to disclose familiar risks associated with a hidden complication.⁶¹

Materiality and reliance differ, and a plaintiff usually must prove both. Those elements become confused because the facts proving one often tend to establish the other. Materiality is rational importance considered objectively; reliance is actual subjective decision-making and risk aversion.

In deceit cases "proximate cause" need not be proved. The name of that doctrine is a misnomer, as it has nothing to do with cause and effect; but rather, the concept serves to limit liability to some, but not all, actual consequences resulting from a tort.⁶² This limitation is appropriate in negligence cases but rarely in intentional torts, and deceit usually is considered an intentional tort. In addition, deceit does not conform to the classical uses of the phrase "proximate cause" in speaking of materiality or reliance. Materiality and reliance should not be confused with each other and neither of them should be confused with "proximate cause." Actual reliance is a necessary, though not always a sufficient, cause-in-fact in deceit cases.⁶³ However, in this paper cause-in-fact denotes the materialization (not the materiality) of the risk, *i.e.*, the occurrence, during or after the treatment, of the potential harm of which the doctor should have warned.

From deceit have emerged many modern causes of action allowing consumers and investors to cancel transactions and to recover their money or consequential damages. As in other actions evolving through case, some deleterious consequence beyond mere anger is a necessary element. The artifice and the fact of having been duped are not actionable. Deceit thus differs from battery, in which the invasion is *per se* actionable and damages are presumed. But both

59. F. HARPER & F. JAMES, *supra* note 55, at § 7.13.

60. Campbell v. Thornton, 368 Mass. 528, 333 N.E.2d 442 (1975).

61. See, *e.g.*, Black v. McKay, 80 S.D. 469, 126 N.W.2d 808 (1964) (complications producing the risks not noticed until late in surgery and afterwards; no obligation to disclose risks).

62. W. PROSSER, *supra* note 55, at §§ 253-58.

63. See F. HARPER & F. JAMES, *supra* note 55, at § 7.13.

deceit and battery may support an award of punitive damages if the intent includes not only the animus to touch or mislead but a design to hurt, exploit, or humiliate the plaintiff. The availability of punitive damages depends on the intent *vel non* dichotomy and not upon the trespass-case dichotomy.

Unless punitive damages are sought, the only relevant intent is one to create a false impression and to induce reliance; an intent to harm a person or property need not be established. But a defendant's desire to aid the plaintiff (*e.g.*, to make him rich or to heal him) is no defense, since the interest protected by a deceit action is the information needed for a decision, although not every invasion of the interest is actionable.

If scienter and materiality are the gist of the action, expert testimony on the standards of disclosure of persons engaged in the defendant's trade, occupation, or profession apparently has no place. The important question is how the law should measure materiality in the medical context, since medical concerns differ from those in financial or investment settings.

Materiality And Its Calculus

The magnitude of the harm and the likelihood of a side effect are two factors of obvious interest to a rational patient. The rational importance of information to a patient is the product of the magnitude and likelihood of risk; the model of objective materiality seeks to measure the importance of information in terms of a certain or constant amount. This model resembles Learned Hand's formula for measuring clear and present danger as announced in *United States v. Dennis*.⁶⁴ The problem is defining an appropriate constant or standard. Few cases provide answers, but commentators identify two primary means of measurement and a third middle ground. One measure is a degree of materiality which would deter treatment. Another is an amount that would "influence" the patient's decision or would provoke serious reflection. Without addressing the issue expressly, cases following the consumer model generally employ the "influential" version of materiality. A third measure combines the influence and deterrence by defining materiality as the importance to which a typical patient "attach[es] significance" when deciding to "undergo" a treatment.⁶⁵ The third formulation became law in the District of Columbia Circuit in *Canterbury v. Spence*.⁶⁶

64. 183 F.2d 201, 212 (2d Cir. 1950).

65. Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 268, 640 (1969).

66. 464 F.2d 772 (D.C. Cir. 1972).

The *Canterbury* opinion makes the District of Columbia a misrepresentation model jurisdiction.⁶⁷ The weakest aspect of the opinion is particularly relevant: the court stated that part of the issue of causation-in-fact is whether disclosure would have produced a decision against treatment. However, by insisting that courts should resolve the causality issue "on an objective basis,"⁶⁸ *Canterbury* collapses reliance into materiality and requires only the latter. The court followed the Waltz-Scheuneman analysis⁶⁹ in equating materiality and reliance.

The risk materializing in *Canterbury* had a probability of only 1%. But, as the risk approaches zero probability, even the District of Columbia relieves the doctor of a duty to warn.⁷⁰ *Canterbury* and *Haven* together require actual subjective reliance and a measure of objective materiality, despite the fact that *Canterbury* could be read as imposing a duty to reveal a 1% risk. The calculus of materiality, however, erases such a suggestion. The opinion provides that the first step in ascertaining materiality is to multiply the severity of a risk times its frequency or probability.⁷¹ Thus, the decision did not announce a 1% rule for every risk.

Alternatively, liability may be determined by comparing the product of severity of harm times its likelihood to the probable benefits of the treatment or costs to the patient's health of postponing, restricting, or foregoing the treatment. Inserting the third variable into the calculation computes negligence by the three-variable algebraic method Learned Hand defined in *United States v. Carroll Towing Co.*⁷²

The continuous, linear model of *Carroll* is not the only possible method. For example, the harm element may be paramount for

67. The position evolved partly from a warranty analogy. See *Johnson v. Rodis*, 251 F.2d 917 (D.C. Cir. 1958). Under *Canterbury*, the duty to disclose exists independently of medical custom. 464 F.2d at 786. Expert testimony is not required except when causation of the claimed side effect or the question of magnitude of the risk is at issue. *Id.* at 791. But the defendant may use expert testimony to establish an affirmative defense of therapeutic privilege which is narrowly circumscribed and which must be based on the opinions and practices of those who reject paternalistic theories of medicine. *Id.* at 789. At the same time, the court stated that a feared reaction by the patient must be "menacing" to constitute cause to invoke the privilege. The risk that a patient might forego needed therapy is likely to constitute a menacing reaction only rarely.

68. *Id.* at 790-91.

69. Waltz & Scheuneman, *supra* note 65.

70. See, e.g., *Haven v. Randolph*, 494 F.2d 1069 (D.C. Cir. 1974). *Haven* broadens the emergency exception to conditions which are "life threatening" in the short run.

71. 464 F.2d at 788.

72. 159 F.2d 169 (2d Cir. 1947).

grievous harms, even though the probability of occurrence is minute. And use of a linear continuous model to deliberate on one issue (*e.g.*, materiality) need not require the use of that model for other issues (*e.g.*, negligence). Applying Learned Hand's methods often will explain a case and dissipate precedential anomalies. The methods are valuable in a broad range of non-extreme variables or pairs of variables. As a first step, the District of Columbia cases use the bivariate algebra of materiality. This calculation would be more precise were it recognized as a means of determining the basic elements of materiality or the standard of disclosure, instead of being treated as an isolated rule of decision or as a matter of "duty." For example, the stages of analysis will multiply unnecessarily if extreme unlikelihood of occurrence is coupled with non-severity of a risk to constitute a special defense providing relief from an otherwise existing duty to disclose.

Unneeded complexity arose when a federal district court read the Tennessee precedents to create a cause of action following the medical model and directed a verdict for the defendant; all medical witnesses testified that it was not the local practice to warn patients of the risk of contracting hepatitis from blood received in transfusion. The court of appeals⁷³ affirmed but construed the precedents to create a tort that does not turn on medical practice. Without using the term "materiality," the opinion specifies⁷⁴ that the test involves likelihood and severity, but the decision does not explain how to integrate the two variables. The case implies, however, that the product of the two is the variable to be measured. No guide or standard of comparison is given but, by affirming the directed verdict, the decision suggests that the value of the severity-times-likelihood product sometimes may fall so low that the issue is to be resolved by the judge, not the jury. The opinion notes that hepatitis is "not necessarily fatal" and "frequently responds to treatment."⁷⁵ This language indicates that the continuous bivariate model of materiality applies and that severity is not preemptive. But these conclusions directly contradict *Longmire v. Hoey*,⁷⁶ the federal court's principal precedent. The Tennessee Appellate Court in *Longmire* stated⁷⁷ that the factor of severity is "paramount" to any "percentage figures of occurrence."

The federal court also cited *Ball v. Mallinkrodt Chemical*

73. *Sawyer v. Methodist Hosp.*, 522 F.2d 1102 (6th Cir. 1975).

74. *Id.* at 1106-07.

75. *Id.* at 1107.

76. 512 S.W.2d 307 (Tenn. App. 1974).

77. *Id.* at 310.

Works,⁷⁸ which suggests a medical negligence model and recognizes a narrow therapeutic privilege to withhold information to avoid upsetting the patient, but only when the risk is "remote."⁷⁹ The opinion conversely stipulates that where the consequences are serious and substantially certain to occur, the doctor has a duty to disclose the risk despite a danger of upsetting the patient; apparently, disclosure is an obligation independent of medical custom. *Ball* suggests a rule of law, appropriate to the function of the judge and not the jury, in instances where both materiality variables are elevated. The federal opinion applies a converse rule of law when the materiality is very low, even though severity or likelihood of the risk is high. The rule favoring plaintiffs in *Ball* is weak authority for the converse rule which benefits defendants in *Sawyer*. The error of the federal court opinion is its concentration on *Ball* in discussing "remote" risks. In *Ball*, the concept of remote risks limits the therapeutic privilege to withhold information to those risks that are remote; the concept is not an invitation to the courts to direct verdicts for defendants in the case of remote risks. The notion restricts defenses and does not define the minimum likelihood a plaintiff must show in a particular case.

Misconstruing *Ball* and contradicting *Longmire*, *Sawyer* fails adequately to consider another Tennessee case. After *Ball*, but before *Longmire* and *Sawyer*, came *Hastings v. Huges*,⁸⁰ in which a doctor did not advise the patient of the risk of a broken tooth when the patient bit an anesthesia tube during back surgery. The court ruled that, absent warning of the risk, the defendant's common risk defense must go to the jury and that the plaintiff need not produce expert testimony on the informed consent issue to reach the jury.

Examined together, *Ball*, *Hastings*, and *Longmire* create a tort following the misrepresentation model that requires proof of at least minimal objective materiality by consideration of the product of severity and likelihood; however, disproportionate weight is given to severity in instances of grievous side effects. Tennessee physicians probably can assert an affirmative defense of medical practice not to disclose a remote risk whose disclosure is likely to upset the patient, even though the patient risks a very serious side effect. This construction not only reconciles the Tennessee decisions but renders them consistent with the federal case. *Sawyer* is reconcilable, since the record showed that Mrs. Sawyer had had emotional problems and might have reacted adversely to disclosure. Medical practice

78. 53 Tenn. App. 218, 381 S.W.2d 563 (1964).

79. 53 Tenn. App. at 225, 381 S.W.2d at 567.

80. 59 Tenn. App. 98, 438 S.W.2d 349 (1968).

was not to disclose the risk because, though serious, it was remote. *Sawyer* treats the doctor's discretion and the patient's mental condition as mere makeweights whereas, together with remoteness and despite severity, they are genuine justifications for a directed verdict for the defendant. The court should have stated as its rationale such matters of special defense.

Materiality as a Standard

The element of materiality may be recast into a standards element. A Wisconsin court in *Trogun v. Fruchtmann*⁸¹ did so by adopting a misrepresentation model by not requiring proof of medical practice as evidence of the standard of disclosure. The court stated that the standard of disclosure is whether the anticipated effect of disclosure on the patient's decision is significant. This test is equivalent to objective materiality. The source of the standard is the community of patients. *Trogun* requires proof of objective materiality and seemingly appreciates the difference between materiality and scienter.⁸² A similar case is *Joy v. Chau*,⁸³ which follows a misrepresentation model and requires the element of objective materiality. By requiring "reasonable disclosure" of "material" facts,⁸⁴ the opinion is sounds like a discussion of standards. The misrepresentation model requiring objective materiality, but not explicitly imposing the element of actual subjective reliance, is the model most often used.

Confusion about the measure of materiality and the source of standards of disclosure arose in an Oregon opinion, *Getchell v. Mansfield*,⁸⁵ in which the court dismissed a suit because the plaintiff failed to present expert testimony about the existence of feasible alternatives and the materiality of the information withheld. The *Getchell* court insisted on manipulating the "duty" concept when speaking of the standard of conduct (disclosure) and the question of

81. 58 Wis. 2d 569, 207 N.W.2d 297 (1973).

82. 58 Wis. at 604, 207 N.W.2d at 315. The case articulated the difference between technical battery and the new tort by noting that the new tort does not deal with touching or intent to touch without consent.

83. 377 N.E.2d 670, 676-77 (1978). The court stated that the duty to make reasonable disclosure arises and must be imposed as a matter of law. The court seemingly was of the view that choosing among competing models was unnecessary because the charge to the jury, fairly construed, tended toward the rule more stringently enforcing disclosure, but nevertheless the jury found for the defendant.

84. Other misrepresentation model cases, requiring proof of objective materiality, include *Small v. Gifford Memorial Hosp.* 133 Vt. 552, 349 A.2d 703 (1975), and *Fogal v. Genesee Hosp.*, 41 A.D.2d 468, 344 N.Y.S.2d 552 (1973) (prior to New York legislation on informed consent).

85. 260 Or. 174, 489 P.2d 953 (1971).

breach. The opinion contradicts itself by stipulating that the existence of a duty is a "question of law" but also by concluding that the content of the "duty" depends on the particular circumstances. Still, the policy of the opinion is clear. The misrepresentation model is adopted; the decision does not require proof of deviation from medical customs of disclosure, but encourages expert testimony on the question of materiality. In the calculus of materiality, *Getchell* adds to severity and likelihood the variable of feasibility of alternatives. Since Oregon decidedly rejects the malpractice model,⁸⁶ the intended source of the standards of disclosure is the patient population; medical testimony about materiality is relevant only to establish underlying scientific and statistical bases.

In a sense, requiring proof of objective materiality as an element is like requiring proof of the standards of disclosure of ordinary people dealing with the important matter of their own persons. Proof of standards of disclosure is not usually enumerated as an element of deceit not because it is not required but because such an element would be redundant. Taking this argument one step further, one could say that if a jurisdiction requires proof of subjective reliance as an element of the plaintiff's case in an informed consent suit but does not require a plaintiff to prove either objective materiality or the standards of disclosure among physicians, then the source of the standards of disclosure is the plaintiff himself. This deduction, however, leads to absurdity. Subjective reliance has significance independent from materiality and from standards of disclosure, as usually conceived. Standards as a separate category is most meaningful in the negligence model, while objective materiality is most significant in the misrepresentation model; subjective reliance is significant in both models. Louisiana apparently is one misrepresentation model state that requires proof of both objective materiality and subjective reliance.⁸⁷ However, one case⁸⁸ adopts an objective rule. A jurisdiction requiring a plaintiff to prove subjective reliance, but not an element of objective materiality, presents an interesting contrast.

Immateriality as a Defense

In a jurisdiction that follows the misrepresentation model or a malpractice model but does not require the plaintiff to prove objec-

86. See *Holland v. Sisters of St. Joseph of Peace*, 522 Or. 208, 522 P.2d 208 (1974).

87. See, e.g., *Goodwin v. Aetna Cas. & Surety Co.*, 294 So. 2d 618 (La. App. 4th Cir. 1974); *Zachary v. St. Paul Fire & Marine Ins. Co.*, 249 So. 2d 273 (La. App. 1st Cir. 1971).

88. *Percele v. St. Paul Fire & Marine Ins. Co.*, 349 So. 2d 1289 (La. App. 1st Cir. 1977).

tive materiality, an issue arises as to whether the defendant can interpose objective immateriality as an affirmative defense. Though that defense is not recognized expressly, inarticulate authority provides support in some cases which rule that a defendant does not have a duty to inform the patient of slight risks of non-serious injury. Such cases may be emphasizing materiality, though unwilling to impose it as a necessary element of the plaintiff's case. Also, the legislature of one American jurisdiction in effect made objective immateriality an affirmative defense.⁸⁹ Just as plaintiffs use analogies to build theories of claims, defendants must be creative in analogizing to establish defenses.

Information is material if a prudent man would consider it. Knowledge of a fact should be distinguished from possible contemplation of it by an ordinary person. No special defense of common knowledge need arise if the only obligation is not to deceive or not actively to conceal; failure to disclose a well-known fact is not concealment, much less misrepresentation. But if there is a duty of affirmative disclosure, a common knowledge defense is logical, whether the model is negligence or deceit. However, what is common knowledge for some persons may be a mystery to others. Thus, commonality in a particular case depends partially on the patient's knowledge and ability. In *Bush v. St. Paul Ins. Co.*⁹⁰ a Louisiana court held that the disclosure made to an "intelligent" woman constituted full disclosure. Some courts will not assume knowledge of even the commonplace risk of infection following surgery by persons other than "well-educated patients."⁹¹ But in a malpractice model jurisdiction, the fact that a risk is commonly recognized may enter the case, not as a separate defense, but as an aspect of medical custom because the commonplace apprehension of a risk influences medical behavior in disclosing it.⁹²

One court defined the common knowledge defense as an affirmative defense for the doctor to raise and accepted expert testimony and other evidence of objective materiality as relevant.⁹³ Com-

89. VT. STAT. ANN. tit. 12, § 1909(c) (1977).

90. 264 So. 2d 717 (La. App. 1st Cir. 1972).

91. *Butler v. Berkeley*, 25 N.C. App. 325, 213 S.E.2d 571 (1975). Distinctions of this sort parallel the securities cases which state that the affirmative obligation to disclose fully dissolves when the defendant deals with investors who can fend for themselves.

92. *Roberts v. Young*, 369 Mich. 133, 119 N.W.2d 627 (1963). Michigan follows the malpractice model and requires expert testimony on the medical practice of disclosure or nondisclosure of a risk. See, e.g., *Miles v. Van Gelder*, 1 Mich. App. 522, 137 N.W.2d 292 (1965).

93. *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972), follows the misrepresentation model and requires proof only of subjective reliance and not of objective materiality.

mon knowledge and objective immateriality seemingly are probative of the credibility of the plaintiff in testifying to ignorance and subjective reliance, respectively. As a result, the court and jury are not bound by such testimony, though it be contradicted by circumstantial evidence only. A special excuse from the disclosure of commonly known risks differs from non-imposition of the duty to disclose remote risks or risks of little consequence. The latter two defenses touch upon objective materiality and may not be special rules, but just extreme instances of the independent variables in the calculus of risks. All three excuses may co-exist.⁹⁴ Relevant here is the ruling in a New Jersey case: even when the defendant breaches some standard, there is no cause for action if the patient knew the risk in advance by discovering it from another source.⁹⁵

The Pure Malpractice Model: Duty, Standards, and the Difference Between Them

Medical Standards and Expert Testimony

Many cases since *Salgo* are infected with its deceit overtones; frequently, other cases utilize battery analogies. In *Kenny v. Lockwood*,⁹⁶ a Canadian case, the court declared that the physician had an obligation to "exercise skill" in giving and withholding advice and information. The relationship creating the obligation, *i.e.*, the source of the duty, is the relationship of the ill person and the skilled care provider. The court refused to characterize the relationship as fiduciary and thoroughly rejected any preconceived policy favoring full disclosure. The source of the standard of disclosure, though ultimately a matter for legislation or judicial policy, is more immediately the medical profession. The members of the profession must conform to the minimum standards of the profession but need not give more information than minimally competent advisors provide. Under *Kenny* the discretion of doctors is broad; if the professional standards are contested, a plaintiff in Ontario must prove them by expert testimony.

The requirement of expert testimony to establish, not only physiological processes and biomedical statistics, but also medical customs of disclosure, is the badge of the malpractice theory, despite consumerist language in opinions.

For example, Massachusetts is a consumer-oriented common-

94. See *Winkjer v. Herr*, 277 N.W.2d 579 (N.D. 1979) (malpractice model; objective materiality).

95. *Fleishman v. Richardson-Merrell, Inc.*, 94 N.J. Super. 90, 226 A.2d 843 (1967).

96. [1932] 1 D.L.R. 507.

wealth and the language of its informed consent decision⁹⁷ reflects the sentiment. The opinion requires expert testimony on causal and scientific questions and views the special nature of the relationship of trust between patient and doctor as the source of the obligation of extensive disclosure. Yet the opinion notes that the discovery of the standard of disclosure requires reference to medical practice. This condition usually will require expert testimony on that issue. Ultimately, Massachusetts uses the malpractice model.

Therapeutic Privilege

Besides requiring expert testimony on standards, the Canadian case provides that physicians occasionally have a privilege to conceal information in order to induce the patient to take a course of treatment he might otherwise refuse. This privilege in malpractice jurisdictions is broad but not unqualified.

Ignoring special problems of psychiatry and outright misrepresentation, the privilege to withhold information is qualified by the principle of necessity. The qualification may be weak or strong. An example of a nearly unqualified privilege is *Roberts v. Wood*,⁹⁸ involving Alabama law. The case adopts the malpractice model and does not explore reliance or materiality. After a bench trial, the judge ruled for a surgeon who had removed the thyroid of the plaintiff without mentioning the high risk of voice loss which increases in a second operation. The surgeon testified that the plaintiff was "anxious" about other matters (unrelated surgery) and that the explanation of the risk might be too technical for her to understand. The judge excused the nondisclosure for those reasons. Since the explanation of this risk is relatively simple and since most surgical patients have some anxiety, the judge allowed a nearly unqualified privilege.

Another broad privilege is suggested in apparent dicta in a Texas case.⁹⁹ The minimum standard of disclosure appears to require advising a patient who has expressed fear of stroke only that an angiogram is the most extensive test the patient will experience and involves great risks. However, the record indicates that the doctor also noted clearly the risk of stroke to the patient.

A third case suggesting a close qualification but allowing a broad privilege is *Nishi v. Hartwell*,¹⁰⁰ which follows *Salgo v. Leland*

97. *Haggerty v. McCarthy*, 344 Mass. 136, 181 N.E.2d 562 (1962).

98. 206 F. Supp. 579 (S.D. Ala. 1962).

99. *Stinnett v. Price*, 446 S.W.2d 893 (Tex. Civ. App. 1969).

100. 52 Hawaii 188, 473 P.2d 116 (1970).

Stanford Jr. University. The opinion in *Nishi* creates a malpractice tort for instances in which a doctor does not adequately balance the interests of the patient. The interests are knowledge and self-determination on one side, and the avoidance of patient trauma and the need for treatment on the other. The opinion specifies that if treatment is obviously necessary and risks are minimal, the doctor may withhold information. An aortographic procedure in *Nishi* led to the loss of bowel control in the patient. Testimony established a custom not to warn of that risk. The fact that the patient was a dentist has interesting ramifications. On one hand, he was in a better position to ask for information; on the other, he was a person in whom the chance of irrational refusal was so small that his right to information should be honored. Hawaii law, emphasizing avoiding refusal of needed treatment, is paternalistic in affording a wide therapeutic privilege.¹⁰¹ This attitude means that a theory of reliance is irrelevant.

A jurisdiction which makes the privilege an affirmative defense tends also to construe the privilege narrowly. Thus, the hybrid jurisdictions exhibit a narrower privilege.¹⁰² Neither a pure deceit model or a battery model recognizes the privilege, nor may courts in a fictional battery jurisdiction be expected to create any but the narrowest privilege. However, the privilege presents special problems in cases involving a two-pronged tort.

Because later cases and legislation¹⁰³ seem to have placed Arizona into the malpractice camp, Arizona is not in the two-pronged tort group. But *Shetter v. Rochelle*¹⁰⁴ earlier held that a physician must explain the essential hazards to obtain actual consent and to avoid battery and that the obligation to reveal more than those risks is measured by the tort of negligence. *Shetter* also holds that a doctor has a broad therapeutic privilege to withhold information if revelation might evoke an unfavorable psychosomatic response.

The privilege is particularly troublesome if extended to even the essentials which might evoke an unfortunate response. A court could qualify the privilege more narrowly for essential hazards than for serious, yet non-essential, risks. The choice to distinguish privi-

101. Some jurisdictions that follow a malpractice model and appear to afford the doctor a wide discretion are Virginia, *see, e.g.*, *Bly v. Rhoads*, 222 S.E.2d 783 (1976), Texas, *see, e.g.*, *Hart v. Van Zandt*, 399 S.W.2d 791 (Tex. 1965), and Delaware, *see, e.g.*, *Di Filippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961).

102. *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977).

103. See note 35, *supra*, and accompanying text.

104. 2 Ariz. App. 358, 369-70, 409 P.2d 74, 85-86 (1965).

leges arising under different facts should be exercised by legislative reasoning. Fine analysis about the relative qualifications of privilege on different points of a two-pronged tort identifies alternatives and avoids inadvertent enactment of a broader privilege than intended.

Media of Disclosure

Full disclosure and a privilege to withhold are quantitative notions of information. The vehicle of disclosure rarely is examined, except to note that written forms using undefined terms are ineffective. In a pure malpractice jurisdiction the adequacy of the means of warning also would be determined by reference to medical standards. Dicta in two malpractice informed consent cases suggest that the standards for the media of disclosure are medical. In *Grosjean v. Spencer*,¹⁰⁵ a patient had died of peritonitis after intestinal surgery. The testimony showed that the disease was a leading cause of death in surgery wards. The court affirmed a directed verdict for the defendant, who had used a drawing¹⁰⁶ to describe the disconnection and reconnection of the intestines. The physician had warned about leakage of gastric juices, a statement from which a risk of inflammation could be inferred. However, he did not caution expressly about peritonitis. The court reasoned that the plaintiff failed to prove a medical practice to warn of peritonitis. However, language emphasizing the physician's choice of how to discharge his duty,¹⁰⁷ coupled with the evidence of the drawing and the warning about leakage, suggests that the court will permit doctors to decide which mixture of pictures, words, and other media is adequate. This approach departs from the usual claim that the construction of words and other expressions and the determination of the adequacy of notices, memoranda of bargains, and written warnings are functions of the trial judge.

Other dicta about the media of disclosure are found in *Goven v. Hunter*.¹⁰⁸ That case affirmed a directed verdict against the plaintiff who complained that the surgeon made six incisions, rather than the two promised, on her right leg to strip varicose veins. Since the health of the plaintiff was indisputably improved and the surgery proceeded well, the case in effect was a battery claim for the four extra scars. However, the court and counsel approached the case as one of informed consent, and the court adopted a malpractice model expressly requiring only subjective reliance. The proof failed

105. 258 Iowa 685, 140 N.W.2d 139 (1966).

106. 258 Iowa at 687-88, 140 N.W.2d at 141.

107. 258 Iowa at 694, 140 N.W.2d at 145.

108. 374 P.2d 421 (Wyo. 1962).

because the plaintiff admitted she would have had the operation even if the surgeon had not mentioned a maximum number of incisions.¹⁰⁹ The opinion also discusses the credibility of testimony about the conversation before surgery and whether a maximum number of two scars was discussed. The court noted that the manner in which a surgeon should discharge an obligation to warn is a question of professionally competent practice. The record indicated that the plaintiff had undergone prior varicose vein surgery and that she had discussed the problem at least twice with one doctor who brought in a second physician to assist him. The latter doctor visited the plaintiff on the eve of surgery to examine externally the course of the vein. Without manipulating the duty concept or denying a primary relationship between the plaintiff and the second doctor, the court implied that it was reasonable for the defendant to rely on the first physician for warnings. These facts intimate that the division of labor between the surgeon and the referring physician and the modes of disclosure of surgical risks are choices for doctors to make; expressive techniques such as reminding a patient of past episodes and using a physical examination to reveal the scope of the procedures and risks can fulfill medical standards of disclosure. However, this conclusion derives from dicta, because the medical evidence in the case showed that surgeons cannot and do not predict or disclose how many incisions they will make in varicose vein operations. In pure malpractice theory the minimally competent physician determines not only the content, but the medium of communication and often is privileged not to communicate at all.

This "privilege" is not an unmitigated boon to doctors. If the obligation is to use skill in disclosing and withholding information, liability may exist not only for withholding information but also for disclosure which creates harm.¹¹⁰

Affirmative Defenses

The use of the word "privilege" in this context is misleading. The privilege in *Kenny* is not merely a defense or immunity or justification which the physician may assert affirmatively. Rather, the absence of the therapeutic reason or custom must be proved by the plaintiff. The privilege is not a bar but a no-claim rule.

Duty, Standards, Breach, and Fulfillment

Use of the concept of "duty" as an analytical or policy-creating

109. *Id.* at 423.

110. See *Williams v. Menehan*, 191 Kan. 6, 10-11, 379 P.2d 292, 294 (1963).

device is modern.¹¹¹ The term is a shorthand way of describing relationships and is employed in discussions of the problem of the unforeseen victim.¹¹² But patients and doctors, though no longer well acquainted, are not strangers. A designation of the persons to whom a doctor owes professional obligations is easy. A few cases present real questions of duty (e.g., referral to another doctor, resignation from a case, membership on a team headed by one physician). But most cases manipulate the "duty" concept too much, diluting its discriminating force.¹¹³ Only the misuse of the concept of "proximate cause" exceeds the misapplication of the notion of "duty" by courts dealing with claims of failure to obtain informed consent. The opinions discussing "duty" intend to address actual or constructive knowledge of a risk (scienter) or to inquire about the standards of conduct or of disclosure. Duty is rarely a true issue; usually the issue is breach. The basic component of the breach issue is a battle of credibility over the doctor's representations and omissions. These battles are not too frequent; the question of breach often devolves into the question of the materiality of the disclosures made and withheld. The doctor must be conscientious about giving advice and withholding it. "Duty" is thus a spurious issue, since the real issue is the standard by which to judge the disclosure.¹¹⁴

One genuine duty issue is hospital liability. No case has awarded judgment against a hospital or defined any duty of a hospital to provide information. The reasons may be that (1) the institutional relationship of the hospital and the patient does not contemplate a dialogue about the risks, or (2) the relationship of doctor and patient intervenes and dominates in such matters.¹¹⁵

Hospitals may volunteer to exceed the requirements of disclosure imposed by law. One author suggests that a hospital

111. W. PROSSER, *supra* note 55, at § 166.

112. Dean Prosser called the problem "the unforeseen victim." *Id.* at §§ 168-69.

113. *Id.* at §§ 167-68.

114. *But see* F. HARPER & F. JAMES, *supra* note 55, at § 1058 (defense of the "relative duty" device).

115. *Scaria v. St. Paul Fire & Marine Ins. Co.*, 227 N.W.2d (Wisc. 1975). But consider dicta in *Fiorentino v. Wenger*, 19 N.Y.2d 407, 418, 227 N.E.2d 296, 301, 280 N.Y.S.2d 373, 381 (1967), about the duty of a hospital to prevent a surgeon from performing surgery which is illegal or fraudulent and dicta in *Ohilgschlager v. Proctor Memorial Hosp.*, 6 Ill. App. 3d 81 (1972). Also reflect upon the atypical situation in which the physicians obliged to inform a patient are servants of the hospital as in *ZeBarth v. Swedish Hosp.*, 81 Wash. 2d 12, 499 P.2d 1 (1972). Finally, compare the different rationales of Justice Cardozo for acquitting hospitals of vicarious liability for negligence and battery of physicians and the role of communications between the patient and the nurses in *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92, 133 N.Y.S. 1143 (1914).

which disseminates the 1972 Patients' Bill of Rights of the American Hospital Association will volunteer itself as a surety of physicians.¹¹⁶ The American Hospital Association is producing audio-visual public relations materials explaining rights to patients. If the intent is to avoid liability by inducing patients to ask more questions, to assume more risks, and to seek more answers from physicians, the effort is doomed not only to fail, as ethically it should, but also to divest hospitals of an immunity they presently enjoy. On the other hand, if the motives of the hospitals are humanitarian and self-critical, then the courts should be more charitable in deciding the legal effect of information volunteered by hospitals and expressed in powerfully suggestive media which will induce reliance in ailing persons. But the ancient proviso is that one who volunteers even with kind motives must perform well; negligent, gratuitous efforts to prevent harm or to rescue are better not performed, since they may foreclose successful efforts by a more prudent volunteer.¹¹⁷

The "duty" issue again arose in *Bell v. Umstattd*;¹¹⁸ the court applied a "captain of the ship" rule to surgical teams and excused an anesthesiologist from the duty of procuring informed consent, holding the surgeon in charge answerable. A Kansas case in point is *Stovall v. Harms*.¹¹⁹ The court ruled that if one doctor refers a patient to a specialist, the specialist should inform the person about special treatments. In this situation use of the "duty" concept is analytically precise because the essence of the case is the extent of each of the doctor-patient relationships. Another referral case was *Pegram v. Sisco*,¹²⁰ in which the judge awarded damages to the plaintiff in a bench trial. Two medical specialists testified that the information given by the specialist defendant was inadequate as measured by local medical standards and that specialists did not assume that their patients had been briefed on risks by the referring physician.¹²¹

Variations in plaintiffs also produce differences in the duty owed. The scope of the treating relationship often extends to the unborn. Under a New York decision,¹²² an infant who during delivery suffers

116. See Comment, *Patients' Rights and Informed Consent: An Emergency Case for Hospitals*, 12 CALIF. W.L. REV. 406 (1976) (reproducing the patient's "Bill of Rights").

117. *Nelson v. Union Wire Rope Corp.*, 39 Ill. App. 2d 73, 187 N.E.2d 425 (1963).

118. 401 S.W.2d 306 (Tex. Civ. App. 1966).

119. 214 Kan. 835, 522 P.2d 353 (1974).

120. 406 F. Supp. 776 (W.D. Ark. 1976).

121. The federal court heard the case by means of diversity jurisdiction; Arkansas state law governed. However, the court lacked precedents to guide it.

122. *Shack v. Holland*, 89 Misc. 2d 78, 389 N.Y.S.2d 988 (1976).

an injury which is a side effect of the delivery method may sue; the doctor who selected that method is liable if he does not advise the mother of alternative methods and of the risks of each to the baby. Stated differently, infants hurt during delivery have standing to sue for want of informed consent by their mothers.

Delegation of Law Making and the Reserved Power of Courts

Although either the community at large or the law is the immediate source in a consumer misrepresentation or deceit model, the medical profession is the direct source in jurisdictions which follow a malpractice model. The later jurisdictions delegate a great deal of policymaking to the medical profession, while reserving power to the courts to change the model should the medical profession fail to produce a good standard. An element of paternalism inherent in this delegation suggests the possibility of privileged lying. However, such jurisdictions do not go that far. For example, the practice among psychiatrists in England is to reveal nothing to patients about the risks of fracture and other severe injury from electroshock, to encourage the treatment if it is indicated, and to answer only a patient's direct questions. That practice passes judicial scrutiny in malpractice model jurisdictions,¹²³ but the courts clearly should frown upon plain lying.

A New Mexico case which follows a malpractice model with a potentially enormous therapeutic privilege is an exception. In an electroshock case, *Woods v. Brunlop*,¹²⁴ the court stated that a doctor is free to withhold information if he believes the patient unwisely might refuse treatment on account of a minimal risk or if the doctor believes that the disclosure would produce apprehension interfering with therapy. The implication is that the plaintiff must present expert testimony to establish medical standards of disclosure. However, the alleged facts in *Woods* were extraordinary. The jury found for the plaintiff, who had sued a psychiatrist who recommended electroshock but did not herself administer the therapy.¹²⁵ At the trial, the testimony of the two parties collided.¹²⁶ The patient claimed to have asked if the therapy could cause harm and alleged that the defendant had lied by saying bluntly that it was a very safe treatment. The plaintiff asserted a fracture and a hearing loss as side effects. The trial court submitted those effects as possible elements of loss to the jury. But, the record showed that the plaintiff had been

123. *Bolan v. Friern Hosp.*, [1957] 2 ALL E.R. 118.

124. 71 N.M. 221, 377 P.2d 520 (1962).

125. 71 N.M. at 222-23, 377 P.2d at 521.

126. 71 N.M. at 227, 377 P.2d at 524.

losing her hearing before the shock, and the defense disputed causation.¹²⁷ Even the expert witness called by the plaintiff was unwilling to express a firm opinion about shock as a cause of hearing loss. The error in submitting that element to the jury compelled a new trial. The informed consent dicta are noteworthy. The opinion stipulates that the decision to impose liability for giving false answers to the questions of a patient should be made by asking the same questions about the therapeutic benefits of treatment and about disclosure asked by the court in evaluating silence or nondisclosure by a psychiatrist.¹²⁸ The opinion states that therapeutic intent may justify a lie, but adds that the defendant had not raised an intent defense until after trial;¹²⁹ rather, the physician testified that she had warned the patient of various risks. The patient testified to her subjective reliance: she would not have undertaken shock treatment had she known the risks.¹³⁰ The opinion seems satisfied with this argument without positing an objective materiality element. In future litigation, New Mexico probably will not tolerate proven instances of actual deception by doctors. The suggestions in the *Woods* dicta are paternalistic attempts to justify the misrepresentation that historically has exploited incompetents. Although the model is negligence, an entire industry or profession cannot be permitted to set its own uncontrolled standards.¹³¹ That prohibition ought to apply perhaps more emphatically¹³² to psychiatrists than to any others.

The extent to which jurisdictions delegate standard-setting varies. Some jurisdictions have nearly immunized physicians and place substantial trust in the medical profession by delegating broadly, optimistic that self-regulation will enforce full disclosure. If hopes are often disappointed, the law intervenes. A jurisdiction in point is North Carolina, which recognized the new tort but greatly restricted it.¹³³

127. 71 N.M. at 223, 377 P.2d at 522.

128. 71 N.M. at 227, 377 P.2d at 524.

129. 71 N.M. at 229, 377 P.2d at 525.

130. 71 N.M. at 227, 377 P.2d at 524.

131. *The T. J. Hooper*, 60 F.2d 737 (2d Cir.), cert. denied, 287 U.S. 662 (1932). See W. PROSSER, *supra* note 55, at § 136.

132. Compare the dicta in *Woods* with *Bolan v. Friern Hosp.*, [1957] 2 ALL E.R. 118. Both the English courts and the British psychiatric profession draw the line at lying. The posture of the record in *Woods* does not reveal how New Mexico's practitioners act.

133. North Carolina recognized a "duty" of sorts to inform patients, but the standard of disclosure was met easily. The court began by recognizing virtually no obligation in *Hunt v. Bradshaw*, 242 N.C. 517, 88 S.E.2d 762 (1955). In *Hunt*, a surgeon characterized an operation as simple; it was not. During the course of the operation, the patient suffered a collateral injury when the doctor attempted to remove a piece of

North Carolina may have been evolving the two-pronged tort, in which general warning suffices to deflect only the misrepresentation prong; the plaintiff is allowed to assert malpractice by using expert testimony to establish a deviation from good medical practice. But the cases indicate further movement in North Carolina toward a malpractice model encompassing nearly all cases with a relaxed standard, a broad therapeutic privilege, an element of objective materiality, and little room for distinction between total non-disclosure and partial nondisclosure.

A contemporary case of the *Starnes* line is *Koury v. Fallo*,¹³⁴ which illustrates that even in a jurisdiction like North Carolina, there are limits to the delegation of standard-making to a professional community; the North Carolina judges reserve the power to disregard a custom that does not serve citizens. In *Koury* the defendant prescribed medicine whose benefit was far outweighed by the risk of deafness. The court found that the failure to disclose the risk violated the standard of disclosure, despite the low frequency of the side effect and regardless of the uncontradicted medical testimony that doctors do not disclose the risk. However, the real basis of liability was not the failure to warn but the negligence in prescribing the particular drug. Whether prescription or concealment is the implicated behavior, the technique used to evaluate the culpability of the conduct is the three-variable formula of Judge Hand in *United States v. Carroll Towing Co.*,¹³⁵ applied with no more apology to custom than Hand himself expressed in *T.J. Hooper*.¹³⁶

*Materiality and Reliance as Elements in a
Tort Modelled on Negligence*

A jurisdiction's requirement of proof of subjective reliance as an element of an informed consent suit is compatible with a pure malpractice model. The addition of objective materiality contaminates the pure malpractice model, because litigation of the materiality of information is characteristic of deceit cases; the materiality issue implies a standard of disclosure which views the community at large as the source of the standard. This concept competes with the central feature of the malpractice model—the location of the source of standards of disclosure in the medical profes-

steel accidentally lodged in plaintiff's chest. *Hunt* states that the surgeon's characterization of the operation was mistaken but not negligent. Standards found in later cases were only a little more demanding. See, e.g., *Starnes v. Taylor*, 272 N.C. 386, 158 S.E.2d 339 (1968); *Watson v. Clutts*, 266 N.C. 153, 136 S.E.2d 617 (1964).

134. 272 N.C. 366, 158 S.E.2d 548 (1968).

135. 159 F.2d 169 (2d Cir. 1947).

136. 60 F.2d 737 (2d Cir.), cert. denied, 287 U.S. 662 (1932).

sion and not the community at large. In the pure malpractice model the average patient's interest in information is evaluated by the doctor as a part of his professional judgment and conduct.

But informed consent cases applying a malpractice model are tinged with misrepresentation. An example is the Delaware "rare hazard defense"; the state uses the malpractice model and favors a subjective reliance concept tempered by the objective provision that a doctor need not inform patients of risks which are very "uncommon."¹³⁷ Like other issues in informed consent cases, the rare hazard exception is analyzed in terms of the duty of the defendant rather than in terms of breach of standards or of objective materiality (as distinguished from actual reliance). The reason for the creation of such complexities is difficult to ascertain. The disutility of an uncommon hazard defense is illustrated by a record showing uniform medical practice to warn of a very rare risk when the motive for disclosure is a conviction that the admonition will help the cure, perhaps by impressing the patient with the importance of his cooperation. A jurisdiction otherwise serious about the malpractice model probably would not excuse nondisclosure by applying the uncommon risk defense.

The standards element swallows materiality and its components in a pure malpractice approach, but even a pure negligence model does not destroy the distinct significance of actual subjective reliance. At least two jurisdictions follow the malpractice model and require that the plaintiff prove both subjective reliance and objective materiality. Those jurisdictions are Massachusetts¹³⁸ and Illinois.

Illinois in *Green v. Hussey*¹³⁹ acknowledged a new tort and fashioned it to favor heavily the defendant. In *Green*, the court adopted a malpractice model and, consistent with that, required expert testimony about custom to establish standards of disclosure. The opinion does not deal directly with reliance but suggests a concept of objective materiality. *Miceikis v. Field*¹⁴⁰ seems to state that materiality is an objective construct and requires expert testimony.¹⁴¹ One notion possibly advanced by the case is that doctors know what information is important to ordinary, reasonable patients and that the courts must recognize the benefit of physicians' experience. An alternative interpretation of the case is that actual patient reliance is irrelevant; self-determination is not a separate

137. *Wagner v. Olmedo*, 365 A.2d 643 (Del. 1976).

138. *Schroeder v. Lawrence*, 372 Mass. 1, 359 N.E.2d 1301, 1303 (1977).

139. 127 Ill. App. 2d 174, 262 N.E.2d 156 (1970).

140. 37 Ill. App. 3d 763, 347 N.E.2d 320 (1976).

141. 37 Ill. App. 3d at 767-68, 347 N.E.2d at 324.

end, but only a therapeutic resource to be manipulated skillfully by the doctor. The former reading is probably more correct. First, the latter interpretation would conflict with the values expressed in *Pratt*.¹⁴² Second, the opinion dwells at length on the existence of evidence that the plaintiff "insisted" on the utilized medical alternative. This fact allows defense lawyers to argue that state law requires proof of both the objective materiality of withheld information and actual subjective reliance upon the silence by the plaintiff.¹⁴³ Both elements may be required in a third jurisdiction which follows the malpractice model. Missouri started with battery,¹⁴⁴ added misrepresentation,¹⁴⁵ and replaced that with the malpractice model. The court in *Mitchell v. Robinson*¹⁴⁶ rejected both the defense of emergency and the defense of the plaintiff's incompetence to choose among treatments. The court noted that the patient was mentally ill; however, he was sufficiently rational to balance his mental health against his orthopedic well-being. The implication is that actual reliance, but not objective materiality, is an element of the tort. The actual decision of the ill plaintiff and not the supposed mentality of a reasonable, healthy person, is the important factor.

Later, in *Aiken v. Clary*,¹⁴⁷ the court overruled *Mitchell* in another insulin shock case and required expert testimony about both medical practice and materiality. The opinion is extremely defense-oriented. *Aiken* states that materiality is not what an average, reasonable man would consider significant to his choice, but rather what information or opportunity for choice a competent doctor

142. *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906).

143. One other comment regarding *Miceikis* is useful. The court states that expert testimony is usually required on the issue of causation-in-fact of the supposed side effect by the procedure. But the court carelessly uses the phrase "proximate result," which suggests proximate cause or a notion of limitation of liability for indirect or unforeseen consequences; surely the issue is really cause-in-fact.

Furthermore, the Illinois informed consent cases do not suggest abolition of the technical battery tort, but the defense of implied consent usually makes that tort unavailable in the medical field in all but the most outrageous cases.

144. In *Steele v. Wood*, 327 S.W.2d 187 (Mo. 1959), the court ruled for the plaintiff on a battery model and did not invoke implied consent when the plaintiff proved that defendant had not been fully informed that he would perform a hysterectomy. The intrusion *per se* was compensable.

145. In *Mitchell v. Robinson*, 343 S.W.2d 11 (1960), the court expressed the view that one may recover from a doctor who obtains consent to electroshock without informing the patient of the risk of fractures; the plaintiff need not present evidence of a medical practice of advising patients. Plaintiff presented no expert testimony of any kind. However, defendants testified that there were risks, that they knew about them, and that they did advise the plaintiff. Thus, the gist of the case was credibility.

146. 334 S.W.2d 11 (Mo. 1960).

147. 396 S.W.2d 668 (Mo. 1965).

believes a patient should possess. The case notes that in *Mitchell* the doctors implicitly conceded that large risks existed; since good practice necessitated disclosure of the risks, the question of the source of the standards was not presented. But in the process of overruling *Mitchell*, the court did not suggest that a plaintiff who admits that he imprudently would have undertaken the risks may recover by proving that a prudent man would not have done so; the tone of the reversal suggests otherwise. While Missouri adopted a new model when the first proved uncongenial, other jurisdictions have combined forms.

Hybrid Forms and Two-Pronged Torts

Any jurisdiction which recognizes a new tort fashioned by analogy to deceit or misrepresentation provides a plaintiff two theories for his suit as misrepresentation cumulates with negligence. The plaintiff may seek to prove the physician's lack of skill in giving advice on a pure malpractice model, employing expert testimony. Thus, such jurisdictions have a two-pronged tort of failure to obtain informed consent. In acknowledging a misrepresentational tort, a court may choose to supplement only slightly the plaintiffs' remedies and to leave most of the work to the tort of negligence. Cases in Kansas, Florida, and Minnesota illustrate this alternative. In Kansas the misrepresentational prong is short and blunt.

In the leading case of *Natanson v. Kline*,¹⁴⁸ the trial court employed a consumer approach, by instructing that a doctor must tell all known risks. The reviewing court placed the case nearer to a malpractice model by opining that the doctor has some discretion. The opinion holds that expert testimony usually is required to prove medical custom and practice. The record showed that the doctor had provided some information, but in dicta the court suggested that a plaintiff need not produce expert testimony about custom if he proves that the defendant gave no warnings. The decision also lets the doctor affirmatively defend by proving that his withholding conformed to accepted practice. This pattern of burden-shifting varies the character of the tort in the defense context, but only in cases in which the defendant gave no warning of all the risks. The court also required the element of actual reliance, but inferred reliance from the plaintiff's testimony and the pleadings, although they did not claim reliance expressly.¹⁴⁹

148. 186 Kan. 393, 350 P.2d 1093 (1969).

149. A Washington decision, *ZeBarth v. Swedish Hosp.*, 81 Wash. 2d 12, 499 P.2d 1 (1972), found for the plaintiff, despite his failure to state his reliance expressly. *Williams v. Menehan*, 191 Kan. 6, 379 P.2d 292 (1963), represents a distinction between

Kansas requires expert testimony or other scientific proof of the existence and magnitude of alleged risks as a basis for proof of actual reliance.¹⁵⁰ Although maintaining vigilance in cases of total nondisclosure and actual misrepresentation, Kansas is well imbued with the logic of negligence.¹⁵¹ Kansas courts now require objective materiality¹⁵² in addition to subjective reliance.

Florida cases are either in conflict or present something like a two-pronged tort. Florida acknowledged a cause of action on the consumer disclosure model without excusing nondisclosure of the "commonly known" hazard of infection following surgery in *Russell v. Hardwick*.¹⁵³ The consumer metaphor was reinforced in *Bowers v. Talmage*,¹⁵⁴ in which the failure to disclose a 3% risk of serious injury as a breach of the duty to inform and the issue of subjective reliance were treated as jury questions. These cases suggest that the failure to warn even of remote hazards is a breach; the duty includes the obligation to disclose remote risks. The plaintiff need present only sufficient expert testimony to establish the risk and its magnitude; then he may testify that a risk of that size would dissuade him from treatment. But, *Ditlow v. Kaplan*¹⁵⁵ stated that a doctor who advises a patient that a procedure is serious and "risky" should be discharged, unless the plaintiff presents expert testimony that the custom is to volunteer more detailed information. This treatment suggests the distinction between total and partial nondisclosure in Kansas case law. In Florida a strict fiduciary duty to disclose risks of serious injury with a probability greater than 3%, and a duty of professional care to disclose other risks when minimally

total nondisclosure and partial disclosure. The court formulated a moderately broad therapeutic privilege; a doctor need not alarm his patient. Liability may follow if he does. 191 Kan. at 8, 379 P.2d at 294.

150. *Collins v. Meeker*, 198 Kan. 390, 424 P.2d 488 (1967). *Collins* should be read in light of *Charley v. Cameron*, 215 Kan. 750, 528 P.2d 1205 (1974). Together they restate and reinforce the two-tiered pattern. The hybrid employing an affirmative defense of privilege exists only for those cases in which the plaintiff has proved that the defendant mentioned no risks. When the defendant mentioned some of the more significant risks, the plaintiff, to prevail, must prove that the disclosure did not conform to good medical practice. Distinguished from the two-pronged tort, this is the two-tiered tort. It affords a hybrid misrepresentational form to govern the most egregious records.

151. *Funke v. Fieldman*, 212 Kan. 524, 512 P.2d 539 (1973).

152. 212 Kan. at 537, 512 P.2d at 550. An earlier Kansas case, declaring that there is no duty to disclose slight risks, may be explained as introducing an element of objective materiality or constraining further the limited misrepresentational prong for total nondisclosure. *Yeates v. Harms*, 194 Kan. 675, 393 P.2d 982 (1964).

153. 166 So. 2d 904 (Fla. 3d Dist. Ct. App. 1964).

154. 159 So. 2d 888 (Fla. 3d Dist. Ct. App. 1963).

155. 181 So. 2d 226 (Fla. 3d Dist. Ct. App. 1965).

competent doctors would disclose them, may exist. This scheme would constitute a two-pronged tort.

One prong is the legal obligation created by the law. The second obligation is created by the medical profession with power delegated by the courts. This idea of a cumulation of torts finds recent expression in *Tetson v. Adams*.¹⁵⁶ A strict obligation to disclose all known facts was held to arise from the confidential nature of the relationship between doctor and patient. The *Tetson* court also contemplated the liability of physicians for active concealment of facts. A state providing a new two-pronged tort while retaining battery for proper instances is Minnesota. Minnesota is known for recognition of actual, technical battery in the medical context because of *Mohr v. Williams*.¹⁵⁷ More recently, in *Bang v. Charles T. Miller Hospital*,¹⁵⁸ a surgeon successfully corrected the prostate problem of a patient who consented generally to the operation. To prevent infection, the defendant severed the sperm ducts without advising the patient that the procedure usually is recommended to minimize post-surgical infection. The court affirmed a money judgment for the plaintiff. The computation of damages gave no suggestion of a *Waltz-Inbau* credit for the cure the surgeon effected or the risk of infection he avoided. The damages were for the intrusion itself; this follows the battery mode. However, the opinion concludes that the failure to warn of risks would be negligence, pointing toward a malpractice model. But, in *Cornfeldt v. Tongen*,¹⁵⁹ the court suggested a two-pronged tort by opining that a doctor's deviation from medical standards is a sufficient, but not a necessary, condition for liability for nondisclosure. This opinion may be no more than the classic reservation by the courts of law-making power when a trade to whom regulation has been delegated does not satisfy basic expectations.

A two-pronged tort may be a stage of development toward the full adoption of the misrepresentation model. Before legislation embraced a malpractice model, New York courts appeared to prefer

156. 373 So. 2d 362 (Fla. 1st Dist. Ct. App. 1979). *Accord*, *Brown v. Wood*, 202 So. 2d 125 (Fla. 2d Dist. Ct. App. 1967).

157. 95 Minn. 261, 104 N.W. 12 (1905).

158. 251 Minn. 427, 88 N.W.2d 186 (1958).

159. 262 N.W.2d 684 (1977). The opinion devotes separate attention to the scientific element of physical cause and requires the plaintiff to prove it. As between subjective reliance or objective materiality, the court suggests that either will suffice, but "prefers" objective materiality. The court calls the reliance-materiality element the causal element, which suggests that the real factor motivating the court is reliance. The preference for proof of objective materiality is a fear of plaintiffs' perjury rather than a substantive rule of disclosure. In addition, the court required proof of at least constructive knowledge of the risk by the doctor.

the consumer misrepresentation model¹⁶⁰ and did not require any expert testimony about medical practice. *Barnette v. Potemza*,¹⁶¹ a case alleging total nondisclosure of a risk, announced a rule which arguably excuses expert testimony only on the extreme end of nondisclosure. However, *Zelevnik v. Jewish Hospital*¹⁶² extended the misrepresentation model to cover most cases.

Distinct from the notion of a two-pronged tort is that of a hybrid tort generally excusing expert testimony on medical custom in the plaintiff's case. This hybrid tort also makes available an affirmative defense of conformity to medical custom and entitles the defendant to judgment if the plaintiff does not contradict the evidence of conformity. The limited form of this tort is the Kansas two-tiered tort or shifting presumption. A comprehensive version is found in *Martin v. Bralliar*,¹⁶³ which resisted defense arguments that the plaintiff is excused from proving nonconformity to good medical practice only if he pleads and proves failure to mention any risks.¹⁶⁴

Evolution toward the hybrid form is illustrated further by New Jersey and Washington cases. The initial New Jersey position, stated in *Kaplan v. Haines*,¹⁶⁵ was the malpractice model requiring proof of subjective reliance. But a noticeable shift occurred in *Lopez v. Swyer*,¹⁶⁶ to a theory of misrepresentation by silence; that theory allows the plaintiff's case to reach the jury without expert testimony, as long as the existence, materialization in fact, and nondisclosure of the risk are conceded or otherwise proved and subjective reliance is expressed. But the ruling was interlocutory, since the decision merely reversed a summary judgment for the defendant. More recently, New Jersey moved toward the hybrid model and objective materiality in *Calabrese v. Trenton State College*,¹⁶⁷ holding that the breach of medical standards is not a required element of the plaintiff's case, but conformity to standards is an affir-

160. Courts later interpreted legislation to require use of the malpractice model and to impose liability only when its elements are fulfilled. See *Shack v. Holland*, 89 Misc. 2d 78, 389 N.Y.S. 988 (1976).

161. 79 Misc. 2d 51, 359 N.Y.S.2d 432 (1974).

162. 47 A.D.2d 199, 366 N.Y.S.2d 163 (1975).

163. 36 Colo. App. 254, 540 P.2d 1118 (1975).

164. In *Mallet v. Pirkey*, 171 Colo. 271, 466 P.2d 466 (1970), the court formulated the hybrid response to a record in which the plaintiff alleged no warning whatsoever. The jurisdiction followed a subjective reliance element in *Stauffer v. Karabin*, 30 Colo. App. 357, 492 P.2d 862 (1971); but an objective materiality test was applied in *Hamilton v. Hardy*, 37 Colo. App. 375, 549 P.2d 1099 (1976). See also *Niblock v. United States*, 438 F.Supp. 383 (D. Colo. 1977).

165. 96 N.J. Super. 242, 232 A.2d 840 (1967).

166. 62 N.J. 267, 300 A.2d 563 (1973).

167. 162 N.J. Super. 142, 392 A.2d 600 (1978).

mative defense. Objective materiality, defined as any fact that might affect a patient's decision, is an element.

Finding a place for medical standards under a misrepresentation model is illustrated best by Washington cases that have struggled with how probative of materiality expert testimony may be.

At the outset Washington acknowledged that laymen can recognize their needs for disclosure¹⁶⁸ and that a jury can ascertain the standard of disclosure and apply it to a concrete case without expert testimony.¹⁶⁹ But the case recognized that a doctor is not liable for failing to advise of a rare risk not foreseeable by physicians; thus the question whether the doctor should have apprehended the existence of the risk often requires expert testimony. Shifting from the mental components of culpability (scienter, knowledge, and constructive knowledge) to the element of patient deliberation, the case offers an objective materiality rule in which expert testimony is relevant but not controlling. The relevancy of expert testimony utilized by the defense later evolved to an affirmative defense in *Miller v. Kennedy*.¹⁷⁰

Decided after *Watkins* and *Mason* but before *Miller* was *ZeBarth v. Swedish Hospital Medical Center*,¹⁷¹ which affirmed a large verdict for the plaintiff; however, in dicta *ZeBarth* retreats from misrepresentation to the malpractice model and distinguishes *Mason v. Ellsworth* as atypical.¹⁷² But closer inspection indicates that the court was not departing from the misrepresentation model. The opinion held that the standard is the prevailing medical judgment of the best disclosure for the patient. The court maintained that the standard is disclosure of such information as the medical community perceives that a patient of "ordinary understanding" needs to "balance the possible risks against the possible benefits."¹⁷³ The hypothetical ordinary patient's need for information to balance risk is the test. This conclusion contrasts with the pure malpractice model, in which the doctor balances the interests. The decision almost completely ignored the notion of a therapeutic privilege.¹⁷⁴ The main discussion of expert medical testimony occurred in the context of deliberation on the materiality of information to a

168. *Watkins v. Parpalce*, 2 Wash. App. 484, 469 P.2d 974 (1970).

169. *Mason v. Ellsworth*, 3 Wash. App. 298, 474 P.2d 909 (1970).

170. 11 Wash. App. 272, 522 P.2d 852 (1974).

171. 81 Wash. 2d 12, 499 P.2d 1 (1972).

172. Annot., *Necessity and Sufficiency of Expert Evidence to Establish Existence and Extent of Physician's Duty to Inform Patient of Risks of Proposed Treatment*, 52 A.L.R. 1067, 1078 (1973).

173. *Id.* at 1079.

174. *Id.* at 1077.

layman, not in an examination of therapeutics. In short, materiality is objective and usually requires testimony by doctors about how typical patients make decisions. Yet even this reference to medical experts was somewhat useless; the court remained disturbed by the fact that "the plaintiff did not categorically state that, had he known or been informed of the risks, he would not have accepted the treatment."¹⁷⁵ The court inferred the plaintiff's subjective reliance from his testimony. The final result requires both actual reliance (which is presumed or readily inferred) and objective materiality (which requires strict proof); an affirmative defense of objective immateriality is available. Unfortunately, the judges referred to subjective reliance as an issue of "proximate cause." Reliance may be viewed as cause-in-fact, but reliance has nothing to do with the notion of proximate cause, a misnomer for the limitation of liability.

ZeBarth's poor reasoning about informed consent is attributable to the fact that malpractice in the administration of radiology treatment and the doctrine of *res ipsa loquitur* were the main issues on appeal. Also, the question of whether the plaintiff must produce expert testimony on an informed consent count was not presented; the plaintiff had produced testimony from two doctors who agreed that the risks in question are material to everyone who considers them and that it is good practice to reveal the risks. An "exception" to the need for expert testimony discussed by the opinion was also dicta. The exception is "manifest duty."¹⁷⁶ The court gives as an example of manifest duty the obligation to disclose the risks of spinal x-ray burns in the context of treatment for a non-malignant wart. This example actually illustrates objective materiality of the risk. The exception to the expert testimony requirement is yet another indication that the misrepresentation model primarily motivates *ZeBarth* and that proof of the medical standards of disclosure is not required. Rather, the court seeks cogent evidence, such as expert testimony, of objective materiality. The dissent called *ZeBarth* a "result decree." As such, the decision supports the consumer model found in the other Washington cases, coupled with an affirmative defense of qualified privilege.

A Washington court in 1972 used the consumer misrepresentation model in a case in which the skin condition of a patient of oriental background worsened after dermabrasion that had only a 50% chance of success in oriental patients.¹⁷⁷ The court stressed the patient's need to be aware of the risk and not the custom of disclosure

175. *Id.* at 1080.

176. *Id.* at 1076.

177. *Hunter v. Brown*, 4 Wash. App. 899, 484 P.2d 1162 (1971).

and withholding by doctors; the case does suggest that expert testimony may be relevant to the need-to-know elements (objective materiality) and may therefore be presented by either the plaintiff or defendant.¹⁷⁸ The Washington Supreme Court affirmed patterns of the misrepresentation model that included objective materiality in *Miller v. Kennedy*¹⁷⁹ and *Holt v. Nelson*.¹⁸⁰ The *Miller* case provides therapeutic privilege as an affirmative defense. Thus, an informed consent trial in Washington may begin as a deceit case but become a malpractice trial after the plaintiff rests.¹⁸¹

One implication of an affirmative defense is that if cogent evidence supporting it is introduced but not contradicted, the defendant is entitled to judgment, just as the plaintiff is entitled to judgment if he presents evidence to support all elements of his case and the defendant rests without contradicting this evidence. But sometimes courts declare that a jury is free to disregard a defendant's evidence of a medical custom to withhold information.¹⁸²

The language of *Sard v. Hardy*¹⁸³ resembles a skein of malpractice and misrepresentation, with medical standards as an affirmative defense. The court permitted the physician to introduce freely proof of medical standards of disclosure, but said if the standards are not conclusive, the jury may disregard them. The court called this evidentiary benefit a qualified, narrow privilege, but did not establish it as an affirmative defense. The opinion notes that the plaintiff's case often will require expert testimony about the existence and magnitude of risks and alternatives, as well as the detrimental effects of materialized risks, but his presentation need not contain expert testimony or other proof of professional standards of dis-

178. *Hunter v. Brown*, 81 Wash. 2d 465, 502 P.2d 1194 (1974).

179. 91 Wash. 2d 155, 588 P.2d 734 (1978).

180. 11 Wash. App. 230, 237, 523 P.2d 211, 216 (1974).

181. The *Miller* appellate court, in construing *ZeBarth*, reviewed the jury instructions and firmly settled on objective materiality, excusing proof of actual subjective reliance. The supreme court adopted the appellate view as its own.

182. A strong statement of jury power to disregard defense evidence of therapeutic need is *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977). Since most misrepresentation model jurisdictions invite or allow defense evidence of medical custom as relevant to an issue of therapeutic privilege, all partake of the hybrid model. This writer has labeled as hybrids only those states in which the tenor of the cases indicate that a therapeutic defense, supported by expert testimony and not rebutted or seriously impeached by expert testimony, would entitle the defendant to a directed verdict. This is the usual implication of an affirmative defense. However, no reported decision articulating this implication has been found, although several cases, like *Sard*, appear to articulate the contrary. Thus, despite frequent mention of privilege and defense, few cases are, properly speaking, hybrids.

183. 281 Md. 432, 379 A.2d 1014 (1977).

closure.¹⁸⁴ The meaning of the doctor's freedom to introduce proof of medical standards on the trial of the general issue is uncertain. The court posited a requirement of objective materiality, but confused it with actual subjective reliance by calling objective materiality a causal issue. The court may have suggested that the information reasonable patients need tends to influence what reasonable physicians provide. As a consequence, proof of the medical standards is probative of the needs of reasonable patients. Incidentally, the opinion specifically identifies as an element the actual or constructive knowledge (*scienter*) of the doctor.

The hybrid form retains much of the malpractice model. The main objections to the hybrid model are that professional biases may produce weak standards and that a lack of consensus may abrogate all standards, so that the medical profession is unregulated.¹⁸⁵ An additional practical objection is that the delegation of standards to a profession and a requirement that the plaintiff produce expert testimony about the standards renders all plaintiffs vulnerable to a conspiracy of silence. An extreme response to such objections is the fictional battery theory.

The Fictional Battery Model

The last model of interest is fictional battery. Technical battery is actual battery, and the defendant must argue actual consent, which may be implied from the circumstances. The only exception is emergency treatment, in which the law itself implies consent.

Fictional battery is constructive battery. Liability may exist despite the doctor's precise description of the organs he will touch, the specific procedures to be used, and the tools and materials he will utilize. Liability may attach even if a patient laboring under no mental infirmity said expressly "I consent to that work with those instruments upon those organs by that method." The liability *non obstante* arises if the physician does not inform adequately of collateral risks.

Ohio is the one jurisdiction that has created the fictional battery tort to supplement a malpractice tort. In *Belcher v. Carter*¹⁸⁶ a doctor failed to warn the plaintiff of the risks of x-ray treatment. The plaintiff sued in one count that appeared to confuse negligence and battery. The trial court rejected the complaint and gave leave to plead in two counts. The plaintiff refused to amend his original com-

184. 281 Md. at 445, 379 A.2d at 1023-24.

185. *The T. J. Hooper*, 60 F.2d 737 (2d Cir. 1932).

186. 130 Ohio App. 2d 113, 234 N.E.2d 311 (1967).

plaint, and the judge dismissed the case without prejudice. The appellate court affirmed, announcing that the facts alleged would support simultaneously negligence and battery counts. The two theories should have been drafted separately, and the court gave the plaintiff one year in which to refile.

Later, a published trial court opinion reinforced *Belcher*. In *Congrove v. Holmes*,¹⁸⁷ the trial judge entered summary judgment for the plaintiff in a case in which the doctor admitted that he had not disclosed risks of a thyroidectomy. The opinion cites the famous technical battery cases of *Pratt, Mohr*, and *Schloendorff* as authority.¹⁸⁸ The opinion excerpts depositions and interrogatory answers in which the doctor voiced a therapeutic privilege defense, claiming his withholding information was in the patient's best interests. The court completely rejected the defense. The plaintiff tendered no affidavits of expert testimony and expressed only her subjective reliance on the physician's silence. The record established that vocal chord injury is a substantial risk of thyroidectomy and had occurred in the case. The court reasoned that specific proof of the magnitude of the risk is not required, and, even more strikingly, said that the element of causation may be reached on motion when the papers on file show that the plaintiff's injury falls within the scope of the substantial risks of the procedure. If *Congrove* is followed, plaintiffs in Ohio often will obtain judgment without expert testimony on any issue.

Fictional battery as distinguished from technical battery seeks to remedy loss caused by side effects and to enforce disclosure of the risks; actual battery attempts to compensate for the medical intrusion itself and to enforce disclosure of the doctor's contemplated procedures. Implied actual consent is irrelevant in fictional battery cases, because express consent usually is found. But the analogy has an innuendo: as a matter of policy, the courts should treat the absence of information as trespassory, *i.e.*, the nondisclosure should be treated as if the patient had not consented to the procedure.

Pennsylvania opinions sometimes analyze disclosure issues in terms of trespass; thus, these opinions lend support to the fictional battery theory.¹⁸⁹ The general approach of Pennsylvania law is to use the misrepresentation model with an element of objective materiality and to require expert testimony to establish risks, magnitude, and physical causation; but expert testimony is not needed to show medical customs of disclosure or to demonstrate

187. 37 Ohio Misc. 95, 308 N.E.2d 765 (1973).

188. 37 Ohio Misc. at 100, 308 N.E.2d at 768.

189. *Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 633 (1966).

materiality.¹⁹⁰ The cases label the claim as a trespass action, and one decision stipulates that the interest primarily protected is physical integrity.¹⁹¹

In *Gray v. Grunnagle*,¹⁹² the plaintiff filed counts of both trespass and negligence but withdrew the negligence count at trial. Following a jury verdict for the plaintiff, the trial court adjudged for the defendant notwithstanding the verdict. The reviewing court reversed on the rationale of the vitiation of consent, or fictional battery.¹⁹³ A malpractice rationale would have worked as well, because the plaintiff's evidence included expert testimony that the custom among doctors was to advise patients of risks, and this defendant did not.¹⁹⁴ An actual battery rationale also could be derived from the record because, according to the plaintiff, the defendant proposed exploratory surgery, after which the plaintiff was to decide whether to have corrective surgery; during the exploration, the defendant attempted to correct the condition he found and worsened the plaintiff's condition. There was a 10-15% chance of aggravating the condition even with skillful surgery, and the defendant had not disclosed this risk.

A federal opinion applying Pennsylvania law, *Dunham v. Wright*,¹⁹⁵ reviewed the "imperfectly articulated" Pennsylvania Supreme Court opinion in *Gray* and, in effect, applied a consumer misrepresentation model. *Dunham* acknowledged the doctor's obligation to disclose alternatives, if any, and their risks. The opinion stated that Pennsylvania law denies a therapeutic privilege to withhold the information, but the court affirmed a judgment entered on a verdict for the defendant. The record showed that the defendant had advised the plaintiff's decedent of some risks, but not of the risk of death from thyroidectomy. The evidence, however, showed that alternative treatments had failed already and that the decedent was very ill. The trial court gave an objective materiality instruction which the reviewing court approved. The withheld information made no reasonable difference and, objectively considered, no real alternative existed. The plaintiff had offered no expert testimony to establish local medical standards of disclosure, and the defendant did not assert any need for such evidence.¹⁹⁶ The opinion merits

190. *Jeffries v. McCague*, 242 Pa. Super. Ct. 76, 363 A.2d 1167 (1976); *Cooper v. Roberts*, 220 Pa. Super. Ct. 260, 286 A.2d 647 (1971).

191. *Cooper v. Roberts*, 220 Pa. Super. Ct. 260, 286 A.2d 647 (1971).

192. 423 Pa. 194, 223 A.2d 663 (1966).

193. 423 Pa. at 206, 223 A.2d at 674.

194. 423 Pa. at 203, 223 A.2d at 672.

195. 423 F.2d 940 (3d Cir. 1970).

196. *Id.* at 945 n.9.

praise for ascertaining ambiguous state law with trespassory overtones and for discussing fulfillment and breach of duty instead of existence *vel non* of duty.¹⁹⁷

This trespassory construct has at least two ominous implications. One is punitive damages. The second is an award of damages for the intrusion itself. A third, less threatening, implication is the applicable statute of limitations. Otherwise, fictional battery resembles the deceit model or one of its variations and requires proof of actual subjective reliance but no proof of objective materiality.

Case law shows heightened judicial scrutiny of the withholding of information if alternatives exist and if the defendant chooses an unorthodox method.¹⁹⁸ An extreme example of the unorthodox is experimentation.

A special case of fictional battery is experimentation upon a naive subject. Even if a jurisdiction follows the malpractice model and if the legislature has restricted the availability of battery remedies in a medical context, the doctor who performs a novel or exploratory operation and discloses the procedure without explaining its experimental character commits a battery.¹⁹⁹

Another issue related to new procedures is that of novice surgeons. A Texas case, *Wilson v. Scott*,²⁰⁰ presents both issues. The plaintiff had lost hearing in his left ear after a stapedectomy with a vein graft to correct hearing impairment he suffered for twenty years. The defendant had explained that the operation was new, complex, and delicate, that it might not succeed, that the hearing of the plaintiff might deteriorate, and that the plaintiff might die in the surgery or lose his sense of taste.²⁰¹ But the parties bitterly disputed

197. *Ciccarone v. United States*, 350 F. Supp. 554 (E.D. Pa. 1972), represents a less satisfactory federal opinion. Plaintiff-veteran sued VA doctors. The court ruled for the defendants when the doctors discussed benefits and consequences of a meningitis test with plaintiff and his wife, but failed to give the percentage probabilities of risks. If rationalized as a case of unproven objective materiality or of substantial compliance with the obligation to warn (no breach), the case would be unexceptional in Pennsylvania. But the court says the facts strike a fair balance between the interest of the patient in information and the interest of doctors to practice medicine without "harassment." Doctrinally the statement is wrong in a misrepresentation jurisdiction and would be wrong even in a malpractice jurisdiction, where the interests balanced (information, therapy) are interests of the patient. The comment is unjudicious and completely unnecessary, since the alternate ground of limitations was an adequate ground for judgment.

198. 26 A.D.2d 693, 272 N.Y.S.2d 557 (1966) (involving a radical "spinal twist" operation).

199. *Gaston v. Hunter*, 121 Ariz. App. 33, 588 P.2d 236 (1978). *Contra*, *Karp v. Cooley*, 493 F.2d 408, 423-24 (5th Cir. 1974), *cert. denied*, 419 U.S. 845 (1974).

200. 412 S.W.2d 299 (Tex. 1967).

201. *Id.* at 301-02.

whether the defendant had also mentioned the 1% chance of total deafness in the left ear. The court consciously chose the malpractice model and rejected both the misrepresentation model and the hybrid model; the opinion implies an element of objective materiality but not subjective reliance.²⁰² The court found the scintilla of expert testimony the plaintiff needed to gain access to the jury in the cross examination of the defendant, when the doctor said "such warning is standard and I gave it."²⁰³ The plaintiff urged as a breach the admitted failure of the defendant to warn that this stapedectomy would be the first performed independently on a live patient; previously, the defendant had done stapedectomies on cadavers and in the course of special training had watched other surgeons. The court did not address the argument. The plaintiff had alleged that the surgery was an experiment and a battery. In dissent, three judges of the closely-divided court noted that of the three theories originally pleaded (battery, deceit, and negligence), only the first two were urged to the appellate court;²⁰⁴ thus, the majority could not adopt the negligence model and grant a new trial on a negligence theory.²⁰⁵ Arguing the negligence theory before the supreme court, the plaintiff's counsel conceded a broad therapeutic privilege to doctors, and the court tentatively agreed with him.²⁰⁶

The allegations of battery in *Gaston* and *Wilson* are likely to be repeated when surgery seems experimental. But, the battery in experimental settings will be fictional, since the patient unwittingly consents to the procedure; he actually is deceived. Yet in English-speaking legal systems, fictional actions are derived, in the growth of modern substantive law, from the fictional trespasses.

FORMS OF ACTION AND GRAPHIC METHODS

Lawyers who read literally the practice statutes that abolish the traditional forms of action and who believe that those statutes are fully effective appreciate neither legal history nor current legal and social trends. A literal reliance upon practice statutes overlooks the use of analogy in the evolution of both doctrine and policy and the usefulness of forms to formulate advice to clients, to prepare cases, and to predict judicial decisions. For those reasons, Professor F.W. Maitland recommended the continuing study of common law forms and of the process by which antecedents evolved into new forms. In

202. *Id.*

203. *Id.* at 303.

204. *Id.* at 304-05.

205. *Id.* For a more extreme example of waiver of an error in trial court rulings on informed consent, see *Lester v. Aetna Cas. & Surety Co.*, 240 F.2d 676 (5th Cir. 1957).

206. 412 S.W.2d at 301.

Forms of Action at Common Law,²⁰⁷ he employed a branching line diagram to describe the evolution of forms and to illustrate the splintering of trespass, the foremost English writ, into the abundance of remedies which order the freedom of men and women in the English-speaking world.

Understanding how Maitland would describe the tort of failure to obtain informed consent requires consideration of that great bifurcation when case split from trespass and redivided into deceit, negligence, and other forms. Now those subbranches are reconverging and coinciding, bending back toward the main trunk of trespass itself. Statutes also contribute in varying degrees to model building.

STATUTES

Twenty-three states have so-called informed consent statutes.²⁰⁸ A number of categories exist. One group functions as "rules of evidence" laws,²⁰⁹ specifying the force and effect of items like written forms. The laws in the second group are "substantive laws,"²¹⁰ specifying the elements of claims and defenses. For example, they may fully or partially preempt the standards question by specifying the information a physician must disclose. The Washington statute is both evidentiary and substantive. The laws of Florida, Maine, New York, North Carolina, and Rhode Island have a variety of mostly procedural contents that make them hard to classify.

Besides these twenty-three states, five states have statutes about consent but not informed consent.²¹¹

207. F. MAITLAND, *EQUITY AND FORMS OF ACTION AT COMMON LAW—TWO COURSES OF LECTURES* 348 (A. Chaytor & W. Whittaker eds. 1909).

208. See ALASKA STAT. § 09.55.556 (Supp. 1977); DEL. CODE ANN. tit. 18, § 6852 (1976); FLA. STAT. ANN. § 768.132 (Supp. 1975); IDAHO CODE § 39-4304 (Supp. 1976); IOWA CODE ANN. § 147.137 (Supp. 1977); KY. REV. STAT. ANN. § 304.40-320 (Supp. 1976); ME. REV. STAT. ANN. tit. 24, § 2905 (1977); NEB. REV. STAT. § 44-2816 (Supp. 1976); NEV. REV. STAT. § 41A.100 (1975); N.H. REV. STAT. ANN. §§ 507-C:1 & 507-C:2; N.Y. [PUB HEALTH] LAW § 3805-d (McKinney 1976); N.C. GEN. STAT. § 90-21.11 (Supp. 1976); OHIO REV. CODE ANN. § 2317.54 (Supp. 1977); OR. REV. STAT. § 677.097; PA. STAT. ANN. tit. 40, § 1301.103 (Purdon 1977); R.I. GEN. LAWS § 9-19-32 (Supp. 1976); TENN. CODE ANN. § 23-3414 (Supp. 1976); UTAH CODE ANN. § 78-14-5 (1977); VT. STAT. ANN. tit. 12, § 1908 (1977); WASH. REV. CODE ANN. § 7.70.050 (Supp. 1976); WYO. STAT. § 33-340.14 (1976).

209. The states comprising the group are Idaho, Iowa, Nevada and Ohio.

210. The second group of states is Alaska, Delaware, Hawaii, Kentucky, Nebraska, New Hampshire, Oregon, Pennsylvania, Tennessee, Texas, Utah, and Vermont. The Texas statute delegates standard formulation to a disclosure panel whose rules become similar to legislated standards or matters of law:

211. ARK. STAT. ANN. § 82-363 (1976); GA. CODE ANN. § 88-2908 (1976); LA. R.S. 40:1299.40 (Supp. 1975 & 1976); MISS. CODE ANN. § 41-41-3 (1972); MO. ANN. STAT. § 431.061 (Vernon).

OTHER FORMS AND OTHER PROFESSIONS

Medicine is the most fertile field for the growth of the informed consent doctrine, because medical side effects can be dramatic and the profession's tradition of withholding information about even serious matters is striking and stubborn. But the informed consent doctrine occasionally appears in other fields, in which its development is more limited.

Giving advice about legal consequences (predicting the legal behavior of judges, tax collectors, and other officials) is a main aspect of the practice of law. Lawyers sometimes are obligated to volunteer information or to initiate discussion about consequences with clients who have not requested that information. These obligations are defined by professional standards of skill.²¹² Most opinions do not concern "side effects," but the failure of the main objective of the action. Conversely, some side effects (*e.g.*, tax consequences of a transaction undertaken for reasons other than tax avoidance) can occur in law. The cases imply that if a dispute about informed consent to a side effect risk exists, the courts generally follow a malpractice model. If overtones of another tort are found in cases of withheld legal advice, the actions resemble conversion or wrongful detention of the choice which "ultimately" belongs to the client.²¹³

Though informed consent cases are infrequent in the field of education, one notable decision is *Thomas v. Chicago Board of Education*.²¹⁴ The plaintiff alleged that his coach and the school board had failed to warn him of the risks of spinal injury from tackling opposing players in football competition on artificial turf.²¹⁵ The trial court dismissed that count, and the appellate court did not even discuss it, affirming the lower court's judgment for the defendants. The context and allegations suggest that counsel for the plaintiff relied on a consumer misrepresentation model.

ETHICAL JURISPRUDENCE

The different legal models reflect competing virtues identified by the moralists. Joseph Fletcher²¹⁶ acknowledges that caring and honesty appear to conflict but argues that concern usually implies honesty; thus the instances of genuine conflict are infrequent. He notes that medical codes give little attention to the problem of

212. R. MALLIN & V. LEVIT, *LEGAL MALPRACTICE* 311-14 (1977).

213. *Id.* at 312-13.

214. 60 Ill. App. 3d 729, 377 N.E.2d 55 (1978).

215. 60 Ill. App. 3d at 732, 377 N.E.2d at 57.

216. J. FLETCHER, *MORALS AND MEDICINE* 34-64 (1954).

honest communication to patients. Standards are hard to find, but Fletcher cites persuasive writings by physicians who disclose that the growth of benevolent lying hurts both the doctor and the patient.

Fletcher argues that outright dishonesty and half-truths are indistinguishable in a relationship of trust and provides four reasons why both are wrong. The first reason is the human and moral status of the patient. Nondisclosure of diagnosis and alternatives to the patient disregards his capacities for moral choice and reasoning and dehumanizes him. Fletcher gives pastoral examples in which the receipt of bad news has given patients opportunities for courage, reason, and truly inspiring human action. A second reason is the preservation of the confidence itself. A patient is hurt when he finds that a doctor has not confided in him. A third reason is self-determination. Fletcher considers the action of nondisclosure to be usurpation, and he admonishes physicians to refuse responsibilities which are not theirs. His fourth rationale employs the concept of intellectual property, suggesting conversion or invasion. Fletcher concludes that the withheld facts belong to the patient and are valuable because patients want them. Though he discusses diagnostic findings, his argument is equally applicable to risks of treatment. The election among alternatives is the patient's; the physician must not steal the patient's vote.

Fletcher purports to be neither strict nor lax about honesty. But he strongly favors complete disclosure. However, he concedes too readily that children and incompetent patients do not possess a claim to full disclosure and defends lying by psychologists because therapy sometimes depends on it. He contradicts his moral urgings by expressing as a mitigating factor the view that psychiatric statements are less well-established and more opinionated than other medical statements. This position is contrary to his observation that accuracy and veracity are different and that to discuss the uncertainty of facts when the issue is morality misleads. When the facts are uncertain, doctors should be most forthright. Honesty in expressing opinions should be equivalent to that in reporting concrete facts. In fields other than psychiatry, Fletcher recognizes only a small therapeutic reservation.

Like Fletcher, Sissela Bok²¹⁷ properly distinguishes between truth and truthfulness and insists that deception may occur through silence; she focuses her inquiry on lying in a narrower sense.²¹⁸ She

217. S. BOK, *LYING: MORAL CHOICE IN PUBLIC AND PRIVATE LIFE* (1978).

218. *Id.* at 6-16.

restricts the use of deception as "therapy"²¹⁹ and attacks typical justifications physicians give for deception.²²⁰ Bok agrees with Fletcher that unhappy information may produce good moral and medical results in patients, scientifically demolishing the paternalistic argument that ignorance is best. She cites research data that 80% of affected patients keenly want to know unsatisfactory findings and collateral risks. These data corroborate the kind of pastoral and anecdotal reports that Fletcher had mentioned a quarter century earlier. Bok forcefully insists that the impossibility of scientific precision is no excuse for intentional falsehood.

Unlike Fletcher, Bok is disinclined to suspend principles for the treatment of children and incompetents. She notes the corrosive effect of lying on character and argues that implying the consent of an incompetent man by reasoning from the perspective of a reasonable man is deficient.²²¹ Bok argues powerfully in favor of truthfulness and extends the presumption favoring honesty more widely than Fletcher.

If these moralists were judges confronting a *de novo* issue in their courts, Bok and Fletcher would adopt a misrepresentation model requiring a moderate to weak element of objective materiality and affording doctors a narrow affirmative defense of therapeutic privilege. Thus, Bok, Fletcher, and other sources they cite adopt principles used by the courts in Colorado, the District of Columbia, Florida, Kansas, New Jersey, and Washington.

CONCLUSIONS

Models and Law-Making

Reviewing courts should seek to fashion good law, giving appropriate weight to the policy of stability. This duty implies that they should proceed cautiously, evolutionally, and by analogy. Courts should draw freely upon a number of prior forms, but should acknowledge their use of analogies and respond when the bar criticizes weak analogies. The judiciary should treat informed consent disputes as neither completely *sui generis* nor entirely predetermined by other classes of torts. Courts must implement the intent of the legislature if a statute exists defining the elements of an informed consent action. A fair and clearly defined tort would require the plaintiff to prove the elements enumerated below.

219. *Id.* at 221-26.

220. *Id.* at 226-38.

221. *Id.* at 218.

Elements. To be able to recover, the plaintiff should have to plead and prove:

1. The risks of treatment and the existence of alternatives;
2. The general frequency or incidence of the risks of the various alternatives;
3. That occurrence of the risk is not unprecedented, that competent doctors know the risks, and that the plaintiff actually did not know the undisclosed risks or alternatives;
4. That the physician did not tell the plaintiff of some risks or alternatives;
5. That to a reasonable person with the plaintiff's condition, the undisclosed risks or alternatives are decisive factors in foregoing, postponing, or replacing the treatment;
6. That if the information had been disclosed, the plaintiff would have foregone, postponed, or replaced the treatment;
7. That an undisclosed risk materialized in the plaintiff and worsened his condition;
8. That the worsening exceeds the deterioration of the plaintiff's condition that would have occurred had the treatment been postponed, cancelled, or modified;
9. The monetary value of the difference between the incremental worsening and the deterioration avoided.

Scientific proof. Courts should require scientific proof by expert testimony of elements 1, 2, 3, 7 and 8 if those elements are contested. A doctor should be permitted to express an opinion on the actions of the "prudent patient," based on his observation of the behavior of patients (element 5).

Affirmative defense. The law should excuse nondisclosure if the defendant pleads and proves any one of the following facts or circumstances:

1. *Limitations.* The plaintiff filed suit after the time permitted by malpractice, negligence, or personal injury limitation statutes.
2. *Common knowledge.* The risk would have been known by an ordinarily prudent and knowledgeable person with the patient's condition.
3. *Emergency.* The condition of the patient would worsen severely during the delay in treatment caused by taking time to inform, causing the probability of success in treatment to decline greatly.
4. *Incompetent patient.* The patient is an infant younger than 14 years of age or is so mentally infirm that his testamentary capacity is insufficient, and the physician informed the parent or the principal caretaker of plaintiff of the risks.
5. *Medical practice.* Minimally competent doctors who value pa-

tient self-determination would nevertheless not disclose the risks or alternatives under the circumstances. (The source of standards is that segment of the medical community that values opportunities for choice by patients. In some communities this source may be co-extensive with the whole profession.)

Other forms. Courts should reserve the actual battery remedies for cases of a true absence of consent to touch, but should not use the tort of battery to adjudicate cases involving collateral risks and effects. Courts should imply readily actual consent from the circumstances in most medical cases. Courts usually should decide even those instances in which a physician affirmatively lies to a patient as a part of the new tort, not as classical deceit, since those lies usually will lack the element of malice.

Damages. The courts should adopt the Waltz-Inbau calculus of compensatory damages. Absent actual battery or an extraordinary lie to the patient, courts never should award punitive damages in "informed consent" cases. In situations of actual lying, the courts should require clear and convincing proof of an intent to hurt or embarrass the plaintiff, in addition to evidence of the knowledge of falsity. The possibility of recovery may seem rare. But the elevated burden of proof is essential to balance honesty and freedom against a practical rule that deters perjury and greed. The significance of lawyering consists in advancing transcendent goals in a domain of imperfect compliance, or of promoting justice in the world of practical affairs. Informed consent cases manifest that importance.

THEORY OF THE TORT (FORM OF ACTION)

IMPLICATIONS OF THEORY

1. Right (Interest Protected)

2. Correlative Duty of M.D.

3. Source of Standard of Disclosure

4. Element of Decision by Patient

TECHNICAL BATTERY MODEL

Bodily integrity and self-determination.

Not to touch w/o permission. General advice to patient what M.D. will do when he lays on hands.

Rules of law about unconscionable touching, the courts.

Express consent or actual consent implied in fact.

PROFESSIONAL NEGLIGENCE MODEL

Balance of interests in good care and self-determination. Emphasis on good care.

Use skill in giving and withholding information about risks and alternatives.

Medical community and its practices.

Jurisdictions divided between objective materiality and subjective reliance.

IMPLICATIONS OF THEORY	TECHNICAL BATTERY MODEL	PROFESSIONAL NEGLIGENCE MODEL
5. Medical Expert Testimony		
a. Fact and Magnitude of Risks	Not even relevant.	Required
b. Existence of Alternatives	Not even relevant.	Required
c. Scierter (knowledge, constr. knowl., should know, etc.)	Not even relevant.	Required
d. Causation-in-Fact	Not even relevant.	Required
e. Materiality or Reliance (patient decisional element)	Not even relevant.	Sometimes required where objec. mat. is Element (e.g., Ill.).
f. Adequacy of Disclosure (breach of standard of disclosure)	Not even relevant.	Required
6. Medical Justifications or privileges		
a. Emergency	Available	Available
b. Incapacity	Available	Available
c. Therapeutics	Not available	Available
7. Other Justification Defenses		
a. Patient Request	Not relevant	Available
b. Common Knowledge	Not relevant to this theory.	Available
c. Implied Consent	Available and usually found in medical cases.	Not Relevant
8. Compensatory Damages		
a. Intrusion <i>per se</i>	Awardable and presumed.	Not awardable
b. Waltz-Inbau Credit to Defendant	Applicability questionable.	Should be applicable but not recognized explicitly.
9. Punitive Damages	Awardable	Not awardable
10. Common Law Genesis	Battery is an old tort.	Case
11. Jurisdictions Recognizing	Recognized everywhere. New torts have not abolished battery. New tort remedies cumulative with battery.	All but Ga.
12. Comment	Not to be forgotten.	Consumer model states will <i>a fortiori</i> give relief when the proof by plaintiff fulfills this model.

THEORY OF THE TORT (FORM OF ACTION)

IMPLICATIONS OF THEORY	CONSUMER FRAUD MODEL	FICTIONAL BATTERY MODEL
1. Right (Interest Protected)	Balance of Interests (good care, choice). Emphasis on info., choice, self-determination.	Self-determination and bodily integrity; emphasis on self-determination.
2. Correlative Duty of M.D.	Inform Patient fully, in all but extreme circumstances, about risks and alternatives.	To give the patient exquisite instructions about risks and alternatives.
3. Source of Standard of Disclosure	Community at large (objective) or the particular patient (subjective).	The patient himself
4. Element of Decision by Patient	Jurisdictions divided between objective mat., actual subj. reliance. Maybe both obj. mat. and subj. reliance in some jurisdictions (e.g., Ill., Wash., and Mass.).	Subjective reliance
5. Medical Expert Testimony		
a. Fact and Magnitude of Risks	Required in most cases.	Required
b. Existence of Alternatives	Required in most cases.	Required
c. <i>Scienter</i> (knowl., constr. knowl., should know of M.D.)	Required in most cases.	Required
d. Causation in Fact (materialization of the risk)	Required in most cases.	Required
e. Materiality or Reliance Element (patient decision element)	Relevant to object. mater. but not required. Not relevant when subj. reliance is the element.	Not required, not even relevant, given subj. reliance element.
f. Adequacy of Disclosure (breach or not of standard of disclosure).	Not required in P.F. case of Pl.	Expert testimony not required.
6. Medical Justifications or Privileges		
a. Emergency	Available	Available
b. Incapacity	Available	Available
c. Therapeutics	Affirmative defense in some jurisdictions (e.g., Colo., Wash., Kan., D.C., N.J.).	Not available
7. Other Justification Defenses		
a. Patient Request	Available	Available
b. Common Knowledge	Available	Available
c. Implied Consent	Not relevant	Not available

IMPLICATIONS OF THEORY	CONSUMER FRAUD MODEL	FICTIONAL BATTERY MODEL
8. Compensatory Damages		
a. Intrusion <i>per se</i>	Apparently not compensable.	Awardable
b. Waltz-Inbau Credit to Defendant	Arguably applicable but not recognized explicitly.	Arguably available
9. Punitive Damages	Not available absent specific intent to deceive.	Arguably awardable
10. Common Law Genesis	Tort of deceit; case, not trespass.	Trespass, not case.
11. Jurisdictions Recognizing	Cal., La., Mass., Md., Or., Pa., R.I., Vt., Wis. Hybrids: Colo., Wash., Kan., D.C., N.J., Fla.	Ohio, maybe Pa.
12. Comment	The boundary between this and the malpractice model is blurred in the American cases. Local variations abound.	An extreme theory.

