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## INFORMED CONSENT IN WASHINGTON: EXPANDED SCOPE OF MATERIAL FACTS THAT THE PHYSICIAN MUST DISCLOSE TO HIS PATIENT

The doctrine of informed consent allows a patient to recover damages from a physician despite having received non-negligent medical diagnosis and treatment.<sup>1</sup> The frequent justification for the recovery is that a patient has the right to decide what is done to his body. Failing to obtain a patient's informed consent to a particular course of treatment makes a physician liable for injuries proximately resulting from that treatment. In Washington, the doctrine has grown swiftly<sup>2</sup> and has been heavily influenced by cases from other jurisdictions.<sup>3</sup> Although the doctrine's skeletal elements have been enacted into statute,<sup>4</sup> it remains the task of develop-

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1. Holt v. Nelson, 11 Wn. App. 230, 237, 523 P.2d 211, 216-17 (1974).

2. A cause of action based on an informed consent theory was not recognized in Washington until 1970. Watkins v. Parpala, 2 Wn. App. 484, 490-91, 469 P.2d 974, 978 (1970).

3. Three cases from other jurisdictions have been particularly influential in Washington's development of the doctrine: Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972).

4. R.C.W. § 7.70.050 (1979) provides:

(1) The following shall be necessary elements of proof that injury resulted from health care in a civil negligence case or arbitration involving the issue of the alleged breach of the duty to secure an informed consent by a patient or his representatives against a health care provider:

(a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;

(b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;

(c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;

(d) That the treatment in question proximately caused injury to the patient.

(2) Under the provisions of this section a fact is defined as or considered to be a material fact, if a reasonably prudent person in the position of the patient or his representative would attach significance to it deciding whether or not to submit to the proposed treatment.

(3) Material facts under the provisions of this section which must be established by expert testimony shall be either:

(a) The nature and character of the treatment proposed and administered;

(b) The anticipated results of the treatment proposed and administered;

(c) The recognized possible alternative forms of treatment; or

(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the recognized possible alternative forms of treatment, including nontreatment.

(4) If a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available, his consent to required treatment will be implied.

WASH. REV. CODE § 7.70.050 (1979).

ing case law to flesh out the rights, duties, powers, and liabilities<sup>5</sup> imposed by the informed consent legal relationship.

Part I of this comment charts the current contours of the doctrine<sup>6</sup> and traces the general pro-plaintiff shift which has developed since Washington recognized the tort a decade ago. The model used to illustrate this shift is a continuum, with the poles representing doctrinal and social policy choices favorable either to the plaintiff-patient or to the defendant-physician. Part II examines the expanded scope of the physician's duty to disclose material facts. This comment posits that the material facts which the physician must disclose to his patient are the risks involved in a proposed treatment, the alternatives to the proposed treatment, and any physical abnormalities discovered by the physician that may indicate danger to the patient. Finally, Part III considers the medical and legal implications occasioned by the pro-plaintiff shift of the doctrine and by the expanded scope of required disclosure. Special emphasis is placed on the prospect of recovering damages for a mistaken diagnosis under an informed consent theory.

This comment concludes that the recent rapid expansion of the informed consent doctrine threatens to upset the decisional balance between patient and physician established by traditional malpractice law. The decision whether that expansion is to be encouraged or discouraged should rest on carefully considered policy choices, not the recent trend of exploiting the doctrine's malleability by characterizing traditional malpractice claims in informed consent terms.

## I. THE DOCTRINE GENERALLY

### A. *The Rationale*

The physician's duty to refrain from treating the patient without first obtaining the patient's informed consent is grounded upon the liberal precept, "Over himself, over his own body and mind, the individual is sovereign."<sup>7</sup> This principle of patient sovereignty conflicts with the basic

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5. For definitions of rights, duties, powers, and liabilities, see Corbin, *Legal Analysis and Terminology*, 29 YALE L.J. 163, 163-70 (1919). See also note 11 and accompanying text *infra*.

6. Injuries to the mental health of patients by psychologists or psychiatrists occasioned by the failure to obtain the patient's informed consent to treatment are beyond the scope of this comment. Likewise, this comment does not consider emergency situations or patients who lack the mental capacity to consent to treatment. R.C.W. § 7.70.050(4) (1979) provides for implied consent to treatment in emergency situations. WASH. REV. CODE § 7.70.050(4) (1979).

7. J.S. MILL, ON LIBERTY 10 (A. Castell ed. 1947). An oft-cited alternative statement of the principle was made by Justice Cardozo: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Society of New York*

tenet of the Hippocratic tradition, "Doctor knows best."<sup>8</sup> Patient sovereignty and physician sovereignty may be represented by poles of a continuum to conceptualize the tension between the two principles. Neither pole accurately represents the relation imposed by law. For example, the prospect of patient recovery despite non-negligent medical decisions made by the physician precludes the possibility that the physician possesses decisional supremacy. Likewise, although opinions advert to the patient's "right" to make the "ultimate informed decision,"<sup>9</sup> final authority does not reside in the patient for two reasons. First, a patient cannot require a physician to administer a course of treatment opposed by the physician.<sup>10</sup> Second, the patient is rarely in a position to propose treatment. He consults a physician because he lacks the knowledge to diagnose or the ability to cure whatever malady has befallen him.

The term "informed consent" represents a complex legal relationship and demands careful definition.<sup>11</sup> Imposing a duty on the physician to disclose information prior to treating the patient establishes a correlative right of the patient to receive information material to the decision whether to undergo that treatment. Incident to that patient right is the power either to consent to or veto any proposed medical procedure. The physician is under a legal liability because the legal relationship between the physician and the patient depends on the patient's exercise of his power of choice.

Legal protection of the patient's right to receive information is prompted by the unequal informational status of the parties. The physician's special training makes him aware of facts unlikely to be known by the patient. Before the patient can exercise his power of choice in a meaningful way, this disparity in information germane to the patient's exercise

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Hosp., 211 N.Y. 125, 105 N.E. 92, 93 (1918), *overruled on other grounds*, Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S. 3 (1957).

8. See Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. Pitt. L. Rev. 137, 148 (1977).

9. See Judge Callow's approving quotation of Cobbs v. Grant, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972), in Miller v. Kennedy, 11 Wn. App. 272, 283, 522 P.2d 852, 861 (1974), *aff'd per curiam*, 85 Wn. 2d 151, 530 P.2d 334 (1975).

10. Individual sovereignty over mind and body also applies to the physician. For example, if a cancer patient rejected a proposed surgical procedure in favor of laetrile treatments, the physician would be under no duty to provide those treatments. Another example might involve a patient's choice of acupuncture to combat pain.

11. "The phrase 'informed consent' evokes . . . magic expectations. Its protagonists often convey that once kissed by the doctrine, frog-patients will become autonomous princes. . . ." Katz, *supra* note 8, at 137. The phrase requires painstaking definition before it can be discussed. *Id.* at 138.

of his power of choice must be minimized. Consequently, the duty to supply information to the patient has been imposed on the physician.<sup>12</sup>

Patient sovereignty, which represents the polar extreme of the sovereignty continuum, is often cited as the rationale behind informed consent. This rationale is inaccurate, since analysis indicates that the patient does not have the right<sup>13</sup> to decide what course his medical treatment will take. The patient has the power to consent to or veto a proposed medical procedure. The physician also has the power to refuse to administer a course of treatment that he opposes. Thus, agreement between the physician and the patient regarding the choice of medical procedure is a condition precedent to legally administered treatment.

### B. *The Affirmative Duty of the Physician to Disclose Information*

In the past decade, a significant expansion of the physician's duty to disclose information to his patient has occurred. As late as 1972 the physician's duty to disclose information was governed by the reasonable physician standard.<sup>14</sup> Recent cases, however, impose the duty to disclose as a matter of law.<sup>15</sup> As a result, the evidentiary burden on plaintiffs to produce expert medical testimony has been eased.<sup>16</sup>

The original doctrinal and social policy choice—whether the failure of the physician to obtain his patient's informed consent embodied a battery<sup>17</sup> or negligence<sup>18</sup> theory—had largely been settled before Washington "imported" the doctrine. In *Watkins v. Parpala*,<sup>19</sup> the first Washing-

12. "The patient is entitled to rely upon the physician to tell him what he needs to know about the condition of his own body." *Miller v. Kennedy*, 11 Wn. App. 272, 282, 522 P.2d 852, 860 (1974).

13. See note 5 *supra*.

14. *ZeBarth v. Swedish Hosp. Medical Center*, 81 Wn. 2d 12, 29, 499 P.2d 1, 11 (1972).

15. See, e.g., *Miller v. Kennedy*, 11 Wn. App. 272, 290, 522 P.2d 852, 865 (1974).

16. Recalling the sovereignty continuum, the patient clearly would favor being relieved of the requirement of producing expert medical testimony concerning the standards of disclosure in the medical community. To the physician, disclosure was properly a question of medical judgment and could not be evaluated in the absence of an expert standard. Disclosure as a matter of law relieves the patient from the requirement of producing expert testimony regarding the standards of disclosure in the medical community, circumventing any "conspiracy of silence" among medical colleagues. R.C.W. § 7.70.050(3), however, lists facts that must be established by expert medical testimony in an informed consent action. Although the patient's expert medical testimony burden has been eased, procuring expert medical testimony generally remains mandatory for the plaintiff to recover. WASH. REV. CODE § 7.70.050(3) (1979).

17. An ineffective consent may be viewed as the equivalent of no consent at all; therefore, the physician's treatment constitutes an unpermitted touching, or battery. See *Berkey v. Anderson*, 1 Cal. App. 3d 790, 803, 82 Cal. Rptr. 67, 76-77 (1969).

18. The duty to disclose may also be viewed as part of the physician's duty of due care. W. PROSSER, *LAW OF TORTS* 165 (4th ed. 1971).

19. 2 Wn. App. 484, 469 P.2d 974 (1970).

ton case to recognize informed consent, the appellate court was persuaded to adopt the negligence framework primarily because of the unintentional nature of the physician's actions.<sup>20</sup>

The *Watkins* court also considered whether the physician's duty to obtain a patient's informed consent existed as a matter of law or depended upon the prevailing standards of the profession.<sup>21</sup> The court decided that the physician's duty to obtain his patient's informed consent could be established only by expert medical testimony regarding the medical community's standard of disclosure.<sup>22</sup>

Judicial reluctance to impose a duty to disclose information absent expert medical testimony is evident in the first Washington Supreme Court case to address the issue of informed consent, *ZeBarth v. Swedish Hospital Medical Center*.<sup>23</sup> In *ZeBarth*, the court upheld a jury instruction requiring physician disclosure defined in terms of what reasonable physicians in the same specialty would divulge in similar circumstances.<sup>24</sup>

When placed on the sovereignty continuum, both the *Watkins* and *ZeBarth* decisions represent doctrinal and social policy choices protecting the defendant-physician. Absent an egregious physician mistake or common knowledge of the medical procedure, the patient could not recover damages unless expert testimony established that the physician deviated from accepted medical standards.<sup>25</sup>

The current position, more favorable to the plaintiff-patient, was established in *Miller v. Kennedy*.<sup>26</sup> At issue was the validity of the trial court's instruction on informed consent. Precisely, plaintiff claimed that the instruction erroneously required him to establish that the defendant's con-

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20. *Id.* at 490-91, 469 P.2d at 978.

21. The issue before the court concerned the evidentiary requirements necessary to establish that a particular risk should have been disclosed to the patient. In *Watkins*, the plaintiff alleged that the defendant-dentist caused gum impression material to enter an air passage from the root canal to the sinus. After a jury verdict for defendant, the trial court granted plaintiff a new trial limited to damages. On appeal, the *Watkins* court held that an informed consent theory could not support the grant of a new trial limited to damages and reinstated the jury verdict for defendant-dentist. *Id.* at 492, 469 P.2d at 979.

22. "[W]hether or not a particular risk should be disclosed should have the same evidentiary requirements as any other act of malpractice." *Id.*

23. 81 Wn. 2d 12, 499 P.2d 1 (1972). The injury to the plaintiff was paralysis allegedly caused by an excessive initial dose of radiation received while undergoing treatment for Hodgkin's disease. *Id.* at 16, 499 P.2d at 5.

24. "This duty [to disclose], however, is limited to those disclosures which, according to the recognized medical standards of that specialty, should be given by a reasonable doctor . . . in the same or similar circumstances." *Id.* at 22-23 n.4, 499 P.2d at 8 n.4.

25. The *ZeBarth* court recognized that situations requiring departure from the general rule of expert testimony would arise. *See id.* at 23-24, 499 P.2d at 8-9.

26. 11 Wn. App. 272, 522 P.2d 852 (1974), *aff'd per curiam*, 85 Wn. 2d 151, 530 P.2d 334 (1975). The injury to plaintiff was the loss of a kidney as a result of the insertion of a biopsy needle at a point above the intended site. *Id.* at 274-75, 522 P.2d at 856.

duct violated the medical community's standard of disclosure.<sup>27</sup> The court of appeals stated that a standard established by physicians was irreconcilable with the patient's "right" to make the "ultimate informed decision."<sup>28</sup> Accordingly, the court held the instruction deficient for failing to indicate that the duty to disclose material facts existed as a matter of law.<sup>29</sup> The court reasoned that once expert testimony established that the medical procedure undertaken presented a risk to the patient, then it was no longer for medical custom to determine what information the physician should disclose.<sup>30</sup> The Washington Supreme Court affirmed *Miller* in a *per curiam* opinion that explicitly adopted both the reasoning and the result reached by the court of appeals.<sup>31</sup>

Current Washington doctrine, that the physician's duty of disclosure exists as a matter of law, is more favorable to the plaintiff-patient than earlier doctrine. The accompanying social policy choice, protecting the patient's power to consent to or veto a proposed medical procedure, is also patient-oriented. On the issue of the duty to disclose, therefore, the law has taken two pro-plaintiff steps. The first was recognizing the tort. The second was rejecting the requirement that plaintiff produce expert testimony to establish the duty.<sup>32</sup>

### C. *The Breach of the Physician's Duty to Disclose*

The physician breaches his duty when he fails to disclose a fact material to the exercise of the patient's power either to consent to or veto a proposed medical procedure. Labeling this duty to disclose information as "informed consent" has led to confusion.<sup>33</sup> Although the term sug-

27. *Id.* at 281, 522 P.2d at 859.

28. *Id.* at 283, 522 P.2d at 860-61 (quoting with approval *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972)).

29. *Id.* at 290, 522 P.2d at 865. Interestingly, the court found that neither the jury instruction proposed by plaintiff nor the one given by the trial court required the jury to measure the duty to inform by a standard established by expert testimony. *Id.* at 290 n.11, 522 P.2d at 864-65 n.11. Apparently the trial court instruction was erroneous due to developments in the law subsequent to the trial. See Brief for Appellant 30-32, *Miller v. Kennedy*, 11 Wn. App. 272, 522 P.2d 852 (1974), *Miller*, 11 Wn. App. at 290, 522 P.2d at 865 (holding).

30. "Once it has been established by expert medical testimony that a risk existed . . . it is not for the medical profession to establish a criteria [sic] for the dissemination of information to the patient based upon what doctors feel the patient should be told." *Miller*, 11 Wn. App. at 285-86, 522 P.2d at 862.

31. The supreme court opinion stated: "We can add nothing constructive to the well considered opinion of [the] court [of appeals] and, accordingly, approve and adopt the reasoning thereof." *Miller v. Kennedy*, 85 Wn. 2d 152, 530 P.2d 334 (1975).

32. Expert medical testimony generally remains mandatory for plaintiff to recover, however. See note 16 *supra*.

33. The informed consent label has been called "an obvious misnomer." *ZeBarth*, 81 Wn. 2d at 23, 499 P.2d at 8.

gests both informational and consensual elements, the consent component has received scant attention from either courts or commentators.<sup>34</sup> Instead, the emphasis has been on the information the physician either withheld or disclosed, with relatively little scrutiny of the patient's subjective comprehension of that information. Thus, the tort is better understood when defined in terms of the physician's duty to disclose material facts.

The Washington cases have all involved what may be termed a substantive breach of the duty to disclose.<sup>35</sup> The physician either withheld information material to the exercise of the patient's power to decide,<sup>36</sup> or the undisclosed information was found immaterial.<sup>37</sup> Whether the physician has breached his duty to disclose, therefore, turns almost exclusively on whether any undisclosed information was "material" to the patient's exercise of his power of choice. The rapid expansion of Washington's view of materiality in this context is the focus of Part II.

### *D. Proximate Cause—The Requirement of Altered Conduct*

A successful suit under informed consent theory requires some causal connection between the undisclosed material fact and the injury to the patient.<sup>38</sup> The mere fact that an undisclosed risk materialized has generally been found insufficient to establish causation unless the informed patient would have avoided the injury by foregoing the treatment.<sup>39</sup> If disclosure would not have altered the patient's conduct and thus prevented the injury, then there is no causation. The role of proximate cause in the doctrine of informed consent, therefore, is to insure that recovery cannot be obtained for injuries unconnected to the physician's breach of his duty to disclose.<sup>40</sup> Washington's expanded scope of required disclosure, how-

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34. Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. L. Rev. 628, 643-46 (1969).

35. No Washington case has considered the possibility of a procedural breach of the duty to disclose. Such a breach would occur if the physician disclosed information in terms incomprehensible to the layman. Although the potential for a pro-plaintiff shift based upon a procedural breach of the physician's duty to disclose information exists, no such shift has occurred. *See generally* WASH. REV. CODE § 7.70.060(1) (1979) (description of material facts in written consent form must be in language the patient could reasonably be expected to understand).

36. *See, e.g.*, *Hunter v. Brown*, 81 Wn. 2d 465, 468, 502 P.2d 1194, 1196 (1972) (need for disclosure of only a 50% chance of success in a dermabrasion procedure held too clear to require expert testimony).

37. *See, e.g.*, *Mason v. Ellsworth*, 3 Wn. App. 298, 313-14, 474 P.2d 909, 919-20 (1970) (.75% risk of perforation of the esophagus in an esophagoscopy held not a reasonably foreseeable risk, therefore no duty to disclose).

38. Waltz & Scheuneman, *supra* note 34, at 646.

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

40. "An unrevealed risk that should have been made known must materialize, for otherwise the omission, however unpardonable, is legally without consequence. Occurrence of the risk must be harmful to the patient, for negligence unrelated to injury is nonactionable." *Id.* (footnote omitted).



ever, may allow recovery for failing to disclose facts that are tenuously connected with the reasonable patient's choice to forego treatment and thus avoid injury.<sup>41</sup>

Altered conduct has generally been the test for establishing causation. Traditionally, the more difficult question has been whether an objective or subjective standard should be used to decide whether the patient would have consented if he had been given all the material facts.<sup>42</sup> Under an objective test, the jury must decide whether the reasonable person, if apprised of the undisclosed information, would have consented to the proposed medical procedure.<sup>43</sup> A subjective test, on the other hand, requires that the jury decide whether this particular patient would have consented to the proposed treatment if fully informed.<sup>44</sup>

The analysis favoring an objective standard was elucidated best in *Canterbury v. Spence*,<sup>45</sup> a federal circuit court of appeals decision. The *Canterbury* court reasoned that the causal link was present when, and only when, disclosure of the withheld information would have resulted in a decision by the reasonably prudent patient to forego the proposed treatment.<sup>46</sup> The court rejected a subjective test because that test focuses on the injured patient's response to the hypothetical question: "Would you have consented if apprised of all the facts?" The subjective test puts the physician at the mercy of the patient's hindsight and bitterness.<sup>47</sup> Accordingly, the court concluded that an objective test would ease fact-finding and better assure "truth as its product."<sup>48</sup> Washington explicitly adopted the objective test in *Miller v. Kennedy*.<sup>49</sup>

The objective test of causation is inconsistent with the rationale of patient sovereignty because it deprives the patient of some portion of his decisional power.<sup>50</sup> True sovereignty over his own body<sup>51</sup> would allow a

41. See Part II-B *infra*.

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

43. *Id.*

44. See *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676, 690 (1972).

45. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). The injury to plaintiff in *Canterbury* was paralysis, allegedly resulting from exploratory surgery to determine the nature of plaintiff's back discomforts. Testimony indicated that the procedure, a laminectomy, presented a statistical risk of a 1% chance of paralysis. *Id.* at 778. At issue was the propriety of a directed verdict in favor of the defendant-physician. The court found the directed verdict improper, deciding that whether the physician should have disclosed the risk of paralysis to the patient was a question for the jury. *Id.* at 795.

46. *Id.* at 790-91. *Accord*, *Holt v. Nelson*, 11 Wn. App. 230, 236, 523 P.2d 211, 216 (1974).

47. 464 F.2d at 790-91.

48. *Id.* at 791. After an injury has occurred, the physician is also subject to the plaintiff-patient's self interest regarding anticipated recovery in a lawsuit.

49. 11 Wn. App. at 289-90, 522 P.2d at 864.

50. Katz, *supra* note 8, at 163-64.

51. See notes 7 and 28 *supra* (a patient has the "right" to make the ultimate decision). See also *Canterbury*, 464 F.2d at 780.

patient to veto a proposed course of treatment even if his veto was based on an unreasonable factor; therefore, if disclosure would have prompted an unreasonable decision to veto treatment, the failure to disclose could still be viewed as an actionable wrong.<sup>52</sup>

Nonetheless, in R.C.W. § 7.70.050, the Washington legislature adopted the *Miller* and *Canterbury* objective test for causation in informed consent actions. An element of plaintiff's suit is proof that a reasonably prudent person in the patient's circumstances would not have consented to the treatment if informed of the omitted material facts.<sup>53</sup>

In terms of the sovereignty continuum, the issue of proximate cause represents plaintiff's most difficult doctrinal hurdle. The test for causation, while virtually ignored in Washington's early cases,<sup>54</sup> coalesced in a pro-defendant form and remains so.

## II. THE EXPANDED SCOPE OF MATERIAL FACTS THAT THE PHYSICIAN MUST DISCLOSE

### A. *Material Facts: From Whose Perspective?*

While the case law has suggested that the physician is required to make "full"<sup>55</sup> or "complete"<sup>56</sup> disclosure, he is actually required to disclose much less. In Washington, the physician has a duty to disclose facts material<sup>57</sup> to the exercise of the patient's power of choice. The issue then becomes from whose perspective materiality is defined.

Determining materiality from the physician's perspective is illustrated by *ZeBarth*.<sup>58</sup> The *ZeBarth* court found a fact material if a reasonable physician would disclose that fact to his patient.<sup>59</sup> The court applied the traditional malpractice requirement that the plaintiff establish, by expert medical testimony, a departure from medical custom. Thus, the duty to

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52. See Goldstein, *For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent, and the Plea Bargain*, 84 *YALE L.J.* 683, 691 (1975).

53. WASH. REV. CODE § 7.70.050(1)(c) (1979).

54. For example, the jury instruction approved in *ZeBarth* omitted any mention of proof of altered conduct. It merely stated: "If therapy is administered without valid consent, it renders those responsible for such administration liable for any damages proximately resulting therefrom." *ZeBarth*, 81 Wn. 2d at 22-23 n.4, 499 P.2d at 8 n.4.

55. "[I]n discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent." *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P.2d 170, 181 (1957) (emphasis added).

56. "If . . . the patient inquires concerning any or all risks, then complete disclosure on the part of the physician is required." *Mason v. Ellsworth*, 3 Wn. App. 298, 313, 474 P.2d 909, 919 (1970) (emphasis added).

57. "The doctor has a duty to disclose the material risks as a matter of law." *Miller*, 11 Wn. App. at 284-85, 522 P.2d at 862 (footnote omitted).

58. See notes 23-24 and accompanying text *supra*.

59. *ZeBarth*, 81 Wn. 2d at 29, 499 P.2d at 11.

inform, the proof of the duty, and the scope of the duty were all governed by the standard of the medical profession.

Materiality from the patient's perspective was first enunciated in *Canterbury*<sup>60</sup> and later adopted by the Washington courts.<sup>61</sup> The *Canterbury* court reasoned that a physician's performance could be evaluated by either a special (*i.e.*, medical) or general (*i.e.*, reasonable person) standard, depending on whether expert medical judgment was required. The physician would be presumed to be governed by the general standard unless the special standard was triggered by the exercise of expert judgment.<sup>62</sup> Since the physician initially possesses the medical information, he must determine the scope of disclosure.<sup>63</sup> The *Canterbury* court, however, did not believe that this initial decision required expert judgment. They concluded that in this setting the physician was to be judged by the general standard of reasonableness.<sup>64</sup> The court determined that the patient's "right" to decide demanded that the scope of disclosure be defined by the patient's need for the information.<sup>65</sup>

This "need to know" also formed the basis of the *Miller* court's formulation of the scope of disclosure. The *Miller* test was: "Would the patient as a human being consider this item in choosing his or her course of treatment?"<sup>66</sup> The failure of the *Miller* court to restrict the patient's informational needs to reasonable limits was rectified by R.C.W. § 7.70.050, which renders a fact material "if a reasonably prudent person in the position of the patient or his representative would attach significance to it [in] deciding whether or not to submit to the proposed treatment."<sup>67</sup> This test is consistent with the objective test of causation; it also circumscribes the patient's power to choose.<sup>68</sup>

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60. 464 F.2d 772 (D.C. Cir. 1972). It is difficult to overstate the impact of the *Canterbury* decision on Washington law. Much of the current doctrine, on this and other issues, is traceable to *Canterbury*.

61. *Miller*, 11 Wn. App. at 285-88, 522 P.2d at 862-64.

62. *Canterbury*, 464 F.2d at 785.

63. *Id.* at 787. Under the *Canterbury* court's reasoning, it is possible to argue that the physician generally should be evaluated by a special, medical standard, established by expert testimony. In discussing the scope of disclosure required of the physician, the court stated: "[The physician] cannot know with complete exactitude what the patient would consider important to his decision, but on the basis of his medical training and experience he can sense how the average, reasonable patient expectably would react [in deciding what information he should disclose to his patient]." *Id.* (footnote omitted). Since this initial decision involves expert judgment, arguably the application of the special, medical standard should have been triggered.

64. "Whenever nondisclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of the facts." *Id.* at 788.

65. *Id.* at 786-87.

66. *Miller*, 11 Wn. App. at 282-83, 522 P.2d at 860.

67. WASH. REV. CODE § 7.70.050(2) (1979).

68. See notes 50-52 and accompanying text *supra*.

## Informed Consent in Washington

### B. *The Elements of Material Facts*

Currently in Washington, the physician's duty to disclose material facts is comprised of three elements. First, the physician has a duty to disclose material risks inherent in a proposed treatment. Second, the physician has a duty to disclose alternative courses of treatment, including no action, and their attendant risks. Third, the physician has a duty to disclose the existence of a potentially dangerous physical abnormality and the diagnostic steps, including tests, available to ascertain the significance of that abnormality.

#### 1. *Risk disclosure*

The severity and probability of risks in a proposed medical procedure are the clearest examples of material facts that the physician must disclose. The nexus between risk disclosure and the effective exercise of the patient's power of choice provided both the rationale and the initial impetus for the development of the doctrine. Washington's early cases are couched in risk disclosure language.<sup>69</sup> Since the reasonable patient would want to know the dangers inherent in any medical procedure, early cases justified the informed consent doctrine as protecting the patient from suffering the consequences of encountering unknown risks.<sup>70</sup>

*Hunter v. Brown*<sup>71</sup> provides an excellent illustration. The physician failed to disclose both that the treatment's probability of success was only fifty percent and that the risk of aggravating the plaintiff's condition was greater for persons of the patient's racial group.<sup>72</sup> The Washington Supreme Court held that the need for disclosure was so obvious that expert testimony was unnecessary.<sup>73</sup>

On the issue of proximate cause, therefore, a risk disclosure fact pat-

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69. *E.g.*, *Hunter v. Brown*, 81 Wn. 2d 465, 502 P.2d 1194 (1972) (need for disclosure of 50% risk of failure in dermabrasion procedure held too obvious to require expert medical testimony); *Mason v. Ellsworth*, 3 Wn. App. 298, 474 P.2d 909 (1970) (.75% risk of perforation of the esophagus in an esophagoscopy held not foreseeable).

70. "[T]he very purpose of the disclosure rule is to protect the patient against the consequences which, if known, he would have avoided by foregoing the treatment." *Canterbury*, 464 F.2d at 790 (footnote omitted).

71. 81 Wn. 2d 465, 502 P.2d 1194 (1972). The issue was whether the trial court erred in granting defendant-physician's motion for a directed verdict based on plaintiff's failure to introduce evidence of a medical standard of disclosure. *Id.* at 467, 502 P.2d at 1196.

72. Plaintiff, an Oriental woman, consulted defendant-physician regarding hyperpigmentation and facial scars. The physician recommended dermabrasion, a process akin to sandpapering the skin. After a painful and embarrassing recovery period, plaintiff's condition became worse. *Id.* at 466, 502 P.2d at 1195.

73. *Id.* at 468, 502 P.2d at 1196. The decision was pre-*Miller*. See notes 26–32 and accompanying text *supra*, for a discussion of the requirement of expert medical testimony in informed consent actions in Washington.

tern involves only one "link" in the causal chain. The reasonable patient would not have consented to the treatment, and thus would have avoided injury, if apprised of the undisclosed risk.

## 2. *Alternative disclosure*

In one sense, only a minimal expansion of the disclosure duty is required to include feasible, alternative medical procedures. A meaningful exercise of a power of choice certainly envisions consideration of alternatives. The expansive nature of imposing on the physician a duty to disclose alternatives, however, is apparent for two reasons. First, due to the patient-oriented standard of materiality,<sup>74</sup> the physician is under a duty to disclose alternative treatments or tests that the physician may regard as unacceptable and may be unwilling to administer. Second, the disclosure of alternatives adds another potential link in the causal chain.

The duty to disclose alternatives that the physician regards as undesirable for the patient was established in *Archer v. Galbraith*.<sup>75</sup> The injury occurred incident to the removal of a portion of plaintiff's thyroid gland due to the presence of a "cold nodule," which had malignant tendencies.<sup>76</sup> Evidence indicated that the course of treatment undertaken was medically preferred, although alternatives with substantially greater risks were available.<sup>77</sup> Plaintiff's physicians both testified that they regarded surgery as the only proper course of treatment for the plaintiff's condition.<sup>78</sup> The court held that it was for the jury to decide the feasibility of the alternatives.<sup>79</sup> Despite testimony indicating that the course of treatment followed was the prudent one, the court decided that an opportunity to choose an alternative treatment should have been given to the patient.<sup>80</sup>

The second expansive aspect of alternative disclosure relates to causa-

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74. See Part II—A *supra*.

75. 18 Wn. App. 369, 567 P.2d 1155 (1977). At issue was the propriety of two trial court instructions given prior to a jury verdict for defendant-physician. The first instruction withdrew from the jury's consideration plaintiff's claim that the physician failed to disclose an alternative method of treatment. The second instruction described the physician's duty of disclosure in terms substantially identical to plaintiff's proposed instruction, but omitted any mention of a duty to disclose alternative courses of treatment. *Id.* at 374–76, 567 P.2d at 1159–60.

76. *Id.* at 370, 567 P.2d at 1157. As a result of the operation, plaintiff's voice was reduced to a hoarse whisper and she experienced difficulty swallowing liquids and regaining her breath after exertion. *Id.* at 370–71, 567 P.2d at 1157.

77. Both a needle biopsy and observation coupled with drug therapy were available options. If the cold nodule had proved malignant, either option would have been dangerous for the patient. *Id.* at 372–74, 567 P.2d at 1157–59.

78. *Id.* at 371, 373–74, 567 P.2d at 1157, 1158.

79. *Id.* at 379, 567 P.2d at 1161.

80. "While it may be that the testimony as a whole indicated that the prudent course of action was to remove the nodule surgically, this decision was not a decision to be made by the physician but by the patient." *Id.* at 378, 567 P.2d at 1161.

tion. In *Holt v. Nelson*,<sup>81</sup> the issue was the propriety of the trial court's granting plaintiff's motion for a new trial after a jury verdict for defendant-physician. Plaintiff's motion was prompted by the failure of the trial court to give plaintiff's requested jury instruction on informed consent.<sup>82</sup> The appellate court upheld the decision to grant a new trial for plaintiff on all issues.<sup>83</sup> The court reasoned that the omitted portion of plaintiff's jury instruction<sup>84</sup> adequately stated plaintiff's claim: if the alternative of a caesarean delivery and the comparative risks between a vaginal and a caesarean delivery had been disclosed, then the plaintiff would have elected the alternative treatment and thus avoided injury to her child.<sup>85</sup>

As *Holt* indicates, requiring alternative disclosure may add another link in the causal chain. If the alternative of no treatment is unavailable, then the patient must prove more than that she, or the reasonable person, would not have consented to the proposed treatment if fully informed. Under the *Holt* fact pattern, two correct choices by the patient must be proven prior to concluding that the failure to disclose the information caused the injury to the child. First, the plaintiff must prove that a fully informed reasonable patient would have vetoed the proposed delivery procedure. Second, the plaintiff must prove that the reasonable patient would have chosen the "proper" delivery procedure.<sup>86</sup> Only then may the undisclosed information be said to have caused the injury to the child.

### 3. Abnormality disclosure

In the recent case of *Gates v. Jensen*,<sup>87</sup> the Washington Supreme Court added a third element, abnormality disclosure,<sup>88</sup> to the scope of material

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81. 11 Wn. App. 230, 523 P.2d 211 (1974). In *Holt*, an expectant mother experienced painless bleeding five weeks before the expected birth. The symptoms indicated placenta previa, which was confirmed seven weeks later. At that point the physician attempted to induce labor, but was unsuccessful. After signs of poor fetal heart tones, a caesarean section was commenced. The child was born a spastic quadriplegic. *Id.* at 231-32, 523 P.2d at 214.

82. *Id.* at 232, 523 P.2d at 214.

83. *Id.* at 243-44, 523 P.2d at 220.

84. The omitted portion of plaintiff's instruction was somewhat cryptic concerning the issue of informed consent. It stated: "In failing to obtain the informed consent of the parents in electing to induce labor and attempt a vaginal delivery in the face of circumstances making a Caesarean Section the proper alternative." *Id.* at 233, 523 P.2d at 215. The court held that the instruction would have properly presented the issue of informed consent to the jury. *Id.* at 242, 523 P.2d at 219.

85. *Id.* at 242, 523 P.2d at 219. Note that the court implicitly adopted the subjective test of causation in characterizing plaintiff's claim.

86. Note the implicit assumption that a physician could have been found who would have consented to administer the "proper" medical alternative. See note 10 *supra*.

87. 92 Wn. 2d 246, 595 P.2d 919 (1979).

88. The expansion of material facts which the physician must disclose to include physical abnormalities—and, more importantly, the steps available to determine the significance of those abnormalities—largely prompted this comment. Consequently, *Gates* is discussed at some length.

facts that the physician must disclose. Two criticisms may be advanced against the expansion of materiality to include abnormalities. First, the court indicated that their new rule had already been established. By way of precedent, however, the court relied solely on an unjustified dictum in *Miller*, which in turn was supported only by a narrower dictum in *Canterbury*.<sup>89</sup> Second, abnormality disclosure extends the causal chain too far, allowing recovery for failure to disclose facts that, if disclosed, would be unlikely to prevent injury to the plaintiff.<sup>90</sup>

In *Gates*, the issue was "whether the doctrine of informed consent requires a physician to inform a patient of a bodily abnormality discovered during a routine examination and of diagnostic procedures which may be taken to determine the significance of that abnormality."<sup>91</sup> Plaintiff had consulted defendant-ophthalmologist complaining of blurring and of gaps in her vision. The physician administered the mandatory<sup>92</sup> eye pressure test for glaucoma, and obtained a borderline test reading that he did not disclose to the patient.<sup>93</sup> The physician then examined plaintiff's eyes and made a diagnosis that plaintiff did not have glaucoma.<sup>94</sup> He failed to disclose, however, that plaintiff's age and eye condition indicated a higher risk of glaucoma and that two additional "simple, inexpensive, and risk free"<sup>95</sup> tests existed to determine the significance of the initial borderline

89. See notes 102-04 and accompanying text *infra*.

90. A third criticism, the prospect of altering the rule against patient recovery for a physician's failure to diagnose or a mistaken diagnosis, is discussed in Part III-A *infra*.

91. 92 Wn. 2d at 247, 595 P.2d at 921 (emphasis added).

92. In *Helling v. Carey*, 83 Wn. 2d 514, 514 P.2d 981 (1974), the Washington Supreme Court found defendant-ophthalmologist negligent as a matter of law for failing to administer the same pressure test.

93. When the patient in *Gates* inquired about the pressure test, which involved placing a metal instrument directly on the eye, the physician informed her that everything was fine, that he had checked for glaucoma and that she was altogether "too young." Brief for Appellants at 6. *Gates v. Jensen*, 20 Wn. App. 81, 579 P.2d 374 (1978), *rev'd*, 92 Wn. 2d 246, 595 P.2d 919 (1979). Actually, plaintiff was 54 years old and severely myopic, which doubled her chances of getting glaucoma. 92 Wn. 2d at 247, 595 P.2d at 921.

94. The jury initially found that the defendant had made a non-negligent diagnosis. They were given an instruction stating: "An ophthalmologist has a duty to perform whatever diagnostic procedures are necessary, according to the standards of his specialty, and to inform himself as to the facts or circumstances indicating the presence or absence of eye disease in his patient." *Gates v. Jensen*, 20 Wn. App. 81, 87, 579 P.2d 374, 377-78. The Washington Supreme Court reversed for failure to give an instruction that reasonable prudence might require a standard higher than that practiced by reasonable ophthalmologists. 92 Wn. 2d at 251-54, 595 P.2d at 923-24.

95. These additional tests were dilating the patient's eyes (to gain a better view of the optic nerve discs) and a visual field exam (to determine loss in field of vision). *Gates*, 92 Wn. 2d at 248, 595 P.2d at 921.

"Risk free" was the *Gates* court's characterization. *Id.* Cf. *Helling v. Carey*, 83 Wn. 2d 514, 519 P.2d 981 (1974) (court characterized the same pressure test given to the patient in *Gates* as "simple" and "inexpensive," with no judgment factor involved, and concluded that administering the test would "no doubt" reveal the evidence of glaucoma. *Id.* at 518, 519 P.2d at 983).

reading. Two years later, after repeated<sup>96</sup> visits to the defendant-clinic, plaintiff was functionally blind.<sup>97</sup>

Conflicting evidence was offered on whether the standards of ophthalmologists required administration of the additional tests.<sup>98</sup> The supreme court held that it was for the jury to decide whether the reasonably prudent person would regard the borderline test reading, the increased statistical risk of glaucoma, and the alternative diagnostic tests as facts material to the plaintiff's choice of a diagnostic procedure.<sup>99</sup> The court stated that the physician's duty of disclosure arises as soon as he is aware of an abnormality which might indicate danger to the patient.<sup>100</sup> The court reasoned that to require less would be to deprive the patient of her power of choice.<sup>101</sup>

*Gates* is significant for several reasons. First, the duty to disclose arises when the physician encounters an abnormality. Second, a physician's duty to disclose may arise before he has made a diagnosis or has recommended a course of treatment. Third, tests that might lead to the discovery of disease are deemed material facts. Fourth, it is no defense that the physician has taken steps within the standard of his profession to satisfy himself that his patient suffers from no disease.

*Gates'* requirement of abnormality disclosure is subject to criticism because it elevated to a holding a dictum in *Miller*, which itself had broadened considerably a prior dictum in *Canterbury*. The *Canterbury* court had stated that a physician, if the exigencies of due care demanded, might be required to alert the patient to an abnormal condition.<sup>102</sup> *Miller* metamorphosed this statement into a flat contention that due care demanded disclosure of abnormalities.<sup>103</sup> *Gates* cited *Miller* as holding that a physician has a fiduciary duty to inform a patient of all abnormalities encoun-

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96. Plaintiff revisited the defendant-clinic 12 times. 92 Wn. 2d at 248, 595 P.2d at 921.

97. *Id.* at 249, 595 P.2d at 922.

98. Compare the differing statements of the experts who testified at trial concerning the standard of the profession regarding dilating the patient's eyes when viewing the discs to see if they exhibit the exacerbated "cupping" characteristic of glaucoma. Brief for Appellant at 21-35, *Gates v. Jensen*, 20 Wn. App. 81, 579 P.2d 374 (1978), *rev'd*, 92 Wn. 2d 246, 595 P.2d 919 (1979).

Defendants maintained that plaintiff's vision loss was attributable to a stroke, or series of strokes, termed ischemic optic neuropathy (ION). ION cannot be diagnosed or anticipated. *See* Brief for Respondents at 10-16, *Gates v. Jensen*, 20 Wn. App. 81, 579 P.2d 374 (1978), *rev'd*, 92 Wn. 2d 246, 595 P.2d 919 (1979). *See also* Brief for Respondents at 7-9, *Gates v. Jensen*, 92 Wn. 2d 246, 595 P.2d 919 (1979).

99. 92 Wn. 2d at 250-51, 595 P.2d at 923.

100. *Id.* at 251, 595 P.2d at 923.

101. *Id.*

102. "Due care may require a physician perceiving symptoms of bodily abnormality to alert the patient to the condition." 464 F.2d at 781 (emphasis added) (footnote omitted).

103. "Due care requires the physician to alert the patient to abnormalities in his body." 11 Wn. App. at 282, 522 P.2d at 860, *citing Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972).



tered.<sup>104</sup> This development makes it unclear whether the *Gates* court wanted to establish the rule requiring disclosure of abnormalities or merely compensate a sympathetic plaintiff.

Second, *Gates* failed to consider fully the requirement of altered conduct as proof of causation. The causal chain must be extended significantly under *Gates* to establish the required proof that the plaintiff would not have been injured but for the defendant's failure to disclose. The plaintiff in *Gates* must prove that: (1) if the physician would have disclosed the abnormality and the alternative diagnostic tests; (2) if the patient would have vetoed the physician's proposed test and consented to the alternative tests; (3) if the physician would have consented to administer the alternative tests; (4) if those tests would have indicated glaucoma; and (5) if the condition would have been treated successfully, then the patient would have avoided the injury.<sup>105</sup> At some point, the causal connection between the breach of the duty to disclose and the resulting injury becomes too speculative. The causal connection in *Gates* approaches, if not exceeds, the limit to which the law should extend its protection.

### III. IMPLICATIONS

The doctrine of informed consent in Washington has undergone a marked pro-plaintiff shift since the physician's duty to disclose information was first recognized in 1970. Specifically, the physician is now responsible for disclosing abnormalities he discovers regardless of the steps he takes to ascertain the significance of those abnormalities and regardless of whether these steps are in full compliance with the standards of his

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104. "[*Miller*] held that a physician has a fiduciary duty to inform a patient of abnormalities in his or her body." 92 Wn. 2d at 250, 595 P.2d at 922, citing *Miller v. Kennedy*, 11 Wn. App. 272, 282, 522 P.2d 852 (1974), *aff'd*, 85 Wn. 2d 151, 530 P.2d 334 (1975).

Furthermore, the court cited *Betesch v. United States*, 400 F. Supp. 238 (D.D.C. 1974), for the proposition that the duty of disclosure arises whenever the physician becomes aware of an abnormality. *Betesch* concerned the failure of physicians conducting a pre-induction physical examination to inform a potential inductee that he was rejected from the armed forces on the basis of an abnormal x-ray. By the time plaintiff learned of the existence of the tumor which the x-ray evidenced, the disease had progressed to the incurable stage. While informed consent theories were not discussed, the district court held that the physicians under contract to the United States failed to exercise the care, skill, and diligence generally exercised by physicians in the locality. *Id.* at 247. The *Betesch* court was evaluating the physician's performance by a different standard. In that case a standard of disclosure did exist and the physicians fell below it.

In postulating a similar situation, the Minnesota Supreme Court stated: "Failure to disclose a risk that would have been disclosed under accepted medical practice thus should be a sufficient, but not a necessary, condition of [informed consent] liability." *Cornfeldt v. Tongen*, 262 N.W.2d 684, 702 (Minn. 1977).

105. It was not clear that the plaintiff's glaucomatous condition at the time of trial had, in fact, been the cause of her injury. See note 98 *supra*.

medical specialty.<sup>106</sup> The pro-plaintiff shift in the doctrine of informed consent has two significant implications. The most serious is the possibility that informed consent doctrine will supplant traditional malpractice doctrine. In particular, informed consent doctrine represents a vehicle for altering the rule against recovery for a non-negligent mistaken diagnosis<sup>107</sup> or a non-negligent failure to diagnose.<sup>108</sup> This potential alteration represents a major shift in the decisional balance between physicians and their patients struck by traditional tort law. Second, whether or not this alteration materializes, previous pro-plaintiff shifts in the doctrine are likely to encourage physicians to adopt overly defensive postures to protect themselves from liability, resulting in a misallocation of medical resources.

*A. Overlap with Traditional Malpractice Doctrine—Recovery for Mistaken Diagnosis?*

In the malpractice area, Washington adheres to the position that the physician does not insure the return to health of his patient.<sup>109</sup> A bad result, standing alone, does not create an inference of fault.<sup>110</sup> The inexact nature of medical science and human fallibility make the prospect of errors in diagnosis or a failure to diagnose inevitable.<sup>111</sup> If the physician exercises the skill and judgment of a member in good standing within his profession, these mistakes have been held nonactionable.<sup>112</sup>

The case of *Keogan v. Holy Family Hospital*<sup>113</sup> illustrates the potential of the informed consent doctrine to alter these rules. Plaintiff's theory was that defendant-physician had a duty to disclose the existence of alter-

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106. See Part II-B-3 *supra*.

107. See notes 109-12 and accompanying text *infra*.

108. *Id.*

109. *Miller*, 11 Wn. App. at 280, 522 P.2d at 859.

110. See *Teig v. St. John's Hosp.*, 63 Wn. 2d 369, 375, 387 P.2d 527, 531 (1963).

111. "[Medicine] is not an exact science, and even the very best of [doctors] can be wrong in diagnosis or procedure. The question, however, is not whether a physician has made a mistake; rather, the question is whether he was negligent." *Hoven v. Kelble*, 79 Wis. 2d 444, 256 N.W.2d 379, 385 (1977), quoting *Francois v. Mokrohisky*, 67 Wis. 2d 196, 226 N.W.2d 470, 472 (1975).

112. *E.g.*, *Crouch v. Wyckoff*, 6 Wn. 2d 273, 282-83, 107 P.2d 339, 343 (1940).

113. 22 Wn. App. 366, 589 P.2d 310 [hereinafter cited as *Keogan I*], *aff'd on rehearing*, 24 Wn. App. 583, 601 P.2d 1303 (1979) [hereinafter cited as *Keogan II*], *petition for review granted*, 93 Wn. 2d 1006, 612 P.2d \_\_\_\_ (1980).

In *Keogan*, a 37-year-old attorney consulted the physician complaining of chest pains. He was given a resting electrocardiogram and a cardiac enzyme test. The results of the cardiac enzyme test were "slightly abnormal." *Keogan I*, 22 Wn. App. at 367, 589 P.2d at 312. These tests were repeated during a second visit a short time later. A week after this second visit the attorney died of a heart attack. *Id.* at 367-68, 589 P.2d at 311-12. The issue on appeal was whether the trial court erred in refusing to give plaintiff's requested jury instruction on informed consent. *Id.* at 367, 589 P.2d at 311.

native diagnostic tests.<sup>114</sup> The court of appeals held that the duty to inform had not yet arisen, because the physician had not recommended a diagnostic or treatment procedure presenting a risk to the decedent.<sup>115</sup> *Keogan* is in clear conflict with the holding in *Gates*. Under *Gates*, the duty to disclose material alternatives arises as soon as the physician is aware of an abnormality.<sup>116</sup> Undisclosed alternative tests existed in *Keogan*, and reasonable minds might differ on whether knowledge of these tests was material to the exercise of the patient's power to consent to the tests that were given.

The court of appeals reconsidered their decision in *Keogan* after *Gates* was decided,<sup>117</sup> and again concluded that the physician's duty to disclose had not yet arisen.<sup>118</sup> The court distinguished *Gates* on its facts, citing the simple, risk free nature of the alternative tests in *Gates* and the relative ease of diagnosing glaucoma in comparison with heart disease.<sup>119</sup>

It is possible to reconcile *Keogan* with *Gates* and reach the same result as the court of appeals. Applying the *Gates* reasoning, the physician in *Keogan* had a duty to disclose the steps available to ascertain the significance of the patient's symptoms and the cardiac enzyme test results as soon as he became aware of these abnormalities. The existence of alternative diagnostic tests is material to the decision whether to consent to those tests that were given. Consequently, the failure to disclose the existence of those tests was a breach of the physician's duty. To conclude, however, that this breach of duty *caused* the heart attack and death of the patient is highly problematic. The choice of an alternative test by the decedent, the diagnosis of heart trouble, the amenability of the problem discovered to treatment, and the subsequent avoidance of injury represent a highly attenuated line of causation.

Characterizing the events which led to the plaintiff's death as a breach of the physician's duty to disclose material facts clouds the basis of the claim: a failure to diagnose heart trouble. The rationale supporting the rule against recovery for a non-negligent failure to diagnose continues to be valid. A physician cannot diagnose every disease and cannot cure every disease diagnosed.<sup>120</sup> If the rule is to be maintained, then a decision,

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114. The specific tests that the plaintiff alleged should have been disclosed were nitroglycerin, a stress (treadmill) EKG, and an angiogram. *Keogan I*, 22 Wn. App. at 370, 589 P.2d at 313.

115. *Id.* at 370, 589 P.2d at 312.

116. In *Keogan*, the abnormality triggering the disclosure duty was the chest pain that the plaintiff reported to the physician during his first visit. *Id.* at 368, 589 P.2d at 311-12. Alternatively, the "slightly abnormal" cardiac enzyme test results might trigger the duty to disclose the procedures available to ascertain the significance of that abnormality. *Id.* at 368-70, 589 P.2d at 311-13.

117. *Keogan II*, 24 Wn. App. 583, 601 P.2d 1303.

118. *Id.* at 584-85, 601 P.2d at 1304.

119. *Id.* at 584-86, 601 P.2d at 1304-05.

120. See note 111 *supra*.

as a matter of law, that the failure to disclose the existence of diagnostic tests did not cause the injury is warranted. A contrary result presumes that the patient, in the exercise of his power of choice, can correct the reasonable errors of his physician. This assumption is faulty. Holding a physician liable for a reasonable failure to diagnose is to adopt this faulty assumption and to abandon the negligence standard.<sup>121</sup> The inexact nature of medical science will remain no matter whom the law regards as the sovereign decision maker. As long as duty is defined in terms of behavior imposed by law, the physician ought not be held responsible for an injury which adherence to the standard of behavior imposed is unlikely to prevent.

### B. *Misallocation of Medical Resources*

The overall pro-plaintiff shift in the informed consent doctrine is a clear message from the courts to physicians to alter their professional disclosure practices. Whether this message is heeded or not, certain effects on professional conduct may be anticipated. Encouragement of defensive medicine<sup>122</sup> and an expanded role for written consent forms seem likely.

Commentators have speculated about a trend toward defensive medicine in connection with the malpractice "crisis" generally.<sup>123</sup> This trend, if it exists, can only be exacerbated by the growth of informed consent along its current lines. The spectre of liability for a failure to diagnose may tempt the physician to adopt excessively defensive practices. The use of duplicative tests, for example, is a direct outgrowth of the denigration of expert medical judgment. The physician is not encouraged to rely on his best judgment if his non-negligent decision, should he err, will not be a defense in a lawsuit.

Physicians may seek to avail themselves of the procedural advantages afforded by written patient consent forms.<sup>124</sup> If such a form is procured,

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121. One commentator has argued persuasively that informed consent is merely a stepping stone to strict liability in medicine. Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51, 57-58 (1977).

The Wisconsin Supreme Court recently refused to adopt a strict liability standard for the delivery of medical services, stating that "the consequences . . . cannot be predicted with sufficient clarity to permit the step to be taken." *Hoven v. Kelble*, 79 Wis. 2d 444, 256 N.W.2d 379, 393 (1977).

122. "Defensive medicine [consists] of medically unjustified care provided by the physician for the purpose of reducing the possibility of a malpractice suit . . . ." Project, *The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 942. The Project labeled this practice as "positive" defensive medicine. "Negative" defensive medicine was defined as a reluctance to undertake activities which have a high risk of resulting in malpractice litigation. *Id.* at 942 n.6.

123. *Id.*

124. This legal advantage may be the primary incentive for physicians to procure written consent forms. Clinical studies have concluded that written consent forms do not fulfill the purpose of promoting patient participation in medical decisionmaking. See, e.g., Cassileth, Zupkis, Sulton-Smith

then the patient has the burden of rebutting by the preponderance of the evidence the presumption that his consent was valid. R.C.W. § 7.70.-060<sup>125</sup> provides that a consent form signed by the patient or a responsible relative will be presumed valid if it contains the following information: a description, in layman's terms,<sup>126</sup> of the nature and character of the proposed treatment, including its risks, possible complications, alternatives, and expected results. According to the statute, the patient also may elect not to be informed of anything.<sup>127</sup>

Due to the extensive list of matters to be disclosed, and the possibility of judicial construction sympathetic to the injured patient, preprinted forms will suffice on rare occasions. Increased reliance on written forms will result in an increase in the amount of time a physician spends on "negotiating" these forms, and on additional record keeping burdens.<sup>128</sup>

The net result of these defensive practices—additional tests and written consent forms—is greater cost to the public for medical care and greater demands on physicians' time. Since medical resources, particularly time, are finite, a misallocation of medical resources is another consequence of the pro-plaintiff shift in the informed consent doctrine.

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& March, *Informed Consent—Why Are its Goals Imperfectly Realized?*, 302 NEW ENGLAND J. OF MED. 896 (1980).

125. R.C.W. § 7.70.060 states that:

If a patient while legally competent, or his representative if he is not competent, signs a consent form which sets forth the following, the signed consent form shall constitute prima facie evidence that the patient gave his informed consent to the treatment administered and the patient has the burden of rebutting this by a preponderance of the evidence:

(1) A description, in language the patient could reasonably be expected to understand, of:

- (a) The nature and character of the proposed treatment;
- (b) The anticipated results of the proposed treatment;
- (c) The recognized possible alternative forms of treatment; and

(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including nontreatment;

(2) Or as an alternative, a statement that the patient elects not to be informed of the elements set forth in subsection (1) of this section.

Failure to use a form shall not be admissible as evidence of failure to obtain informed consent.

WASH. REV. CODE § 7.70.060 (1979).

126. The goal of comprehensible written forms may be imperfectly realized. A study of surgical consent forms used at five medical centers in the Los Angeles area concluded that the readability of the forms was equivalent to material intended for upper-division undergraduate or graduate students. Grundner, *On the Readability of Surgical Consent Forms*, 302 NEW ENGLAND J. OF MED. 900 (1980). See also note 35 *supra*.

127. WASH. REV. CODE § 7.70.060(2) (1979).

128. Higher administrative costs, more directly related to malpractice litigation than defensive medicine, also affect the cost of health care. See *generally* Project, *supra* note 122, at 942-43.

#### IV. CONCLUSION

The past decade in Washington has seen both the judicial adoption and the expansion of the informed consent doctrine governing the physician-patient relationship. The development of the doctrine is particularly notable for its pro-plaintiff shift and for its increasing overlap with traditional medical malpractice. Most significantly, with the recent decision in *Gates v. Jensen*, the Washington Supreme Court has extended the scope of material facts that the physician must disclose to include both physical abnormalities the physician discovers and the steps available to ascertain the significance of those abnormalities. Imposing a duty to disclose the existence of diagnostic tests may allow patient recovery, despite an attenuated line of causation, for a non-negligent mistaken diagnosis by the physician. Furthermore, the extension of the doctrine threatens to upset the decisional balance established by medical malpractice law between physicians and patients, and encourages the practice of defensive medicine with its attendant misallocation of medical resources.

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