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INFORMED CONSENT: SOME PROBLEMS REVISITED

Arthur J. Shartsis*

I. INTRODUCTION

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. (Cardozo, J.)¹

When one says the first word on a controversial subject, he should not delude himself into thinking that he will have an opportunity to say the last. (Hubert W. Smith, M.D., LL.B.)²

It is no longer disputed that the physician has a duty to inform his patient of the nature of the treatment proposed by the physician and the risks involved in that treatment. Because of this required disclosure the patient is better able to "determine what shall be done with his own body"³ by making an informed decision whether or not to undergo treatment. Yet, both the law and medicine are far from the "last say"⁴ concerning certain particularly difficult problems which arise within the scope of the physician's communication to the patient and the patient's assent to treatment. In this process of communication and assent, which is commonly referred to as informed consent, serious abuses of the physician-patient fiduciary relationship⁵ can result if the physician knowingly withholds information from the patient, or, for some reason, if the patient's consent remains uninformed despite his receiving seemingly adequate information from the physician. For medico-legal⁶ and practical reasons there has been a tendency to avoid develop-

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¹ *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

² Smith, *Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick With Serious or Fatal Illness*, 19 TENN. L. REV. 349, 349 (1945-47) [hereinafter cited as Smith].

³ *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

⁴ Smith, *supra* note 2 and accompanying text.

⁵ See generally 2 D. LOUISELL & WILLIAMS, *MEDICAL MALPRACTICE* (1970) [hereinafter cited as LOUISELL & WILLIAMS].

⁶ Note, *Duty of Doctor to Inform Patient of Treatment: Battery or Negligence?*, 34 SO. CAL. L. REV. 217, 224-25 (1961).
"Decisions which discourage doctors from exercising their highly trained skills to better the human lot should be carefully considered. If the increasing trend of malpractice claims continues, the relation-

ing narrow or rigid rules for deciding issues involving informed consent.⁷ Nonetheless, most aspects of informed consent have been given ample consideration, and broad principles have evolved relating to the extent of the physician's duty and the content of his disclosure.

The general duty of the physician is to inform a patient effectively of all aspects of the treatment which the physician knows, or should know, will affect the patient's decision to undergo or abstain from treatment.⁸ Professor D. Louisell and Dr. H. Williams, state:

ship between doctor and patient might well become so strained that doctors will be reluctant to take chances which might save many lives."

See also, B. FICARRA, *SURGICAL AND ALLIED MALPRACTICE* 41 (1968), where the author states:

"The very concept of confidence is one of mutuality of giving and receiving and is not to be considered as a one-way street. The possibility of having a legal action brought against most physicians or surgeons is highly probable today. Thus the practicing doctor has accepted it as a definite occupational hazard. He fully realizes that the patient to whom he renders care of a major or minor nature may eventually bring him to court. When a physician is constantly under threats of legal actions, he inevitably arouses within himself a defensive instinct which by gradual attrition erodes his professional humanitarian and altruistic ambitions. As the noble assets of the medical profession are gradually eroded, it is the patient who loses the boundless benefits that can occur to him by the doctor who is unfettered by legal threats."

See generally Oppenheim, *Informed Consent to Medical Treatment*, 11 CLEV.-MAR. L. REV. 249 (1962) [hereinafter cited as Oppenheim].

⁷ Because of the unique nature of each case, involving potentially infinite combinations of ailments, possible treatments, and individual psychological and emotional components, the promulgation of rules is difficult in what has been considered the discretionary realm of the physician. See, e.g., Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 643 (1969) [hereinafter cited as Waltz & Scheuneman]:

"Because the physician's decision must be made in light of the condition and psychological disposition of a given patient in a particular case, it is meaningless to speak of a customary standard delineating the scope of a privilege to withhold risk information."

⁸ See generally C. STETLER & A. MORITZ, *DOCTOR AND PATIENT AND THE LAW* (1962); Karchmer, *Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug"*, 31 MO. L. REV. 29 (1966) [hereinafter cited as Karchmer]; Oppenheim, *supra* note 6, at 256; Plante, *An Analysis of "Informed Consent"*, 36 FORDHAM L. REV. 639, 653 (1968) [hereinafter cited as Plante]; Smith, *supra* note 2, at 352; Waltz, *supra* note 7; 34 SO. CAL. L. REV., *supra* note 6, at 223; Note, 109 U. PENN. L. REV. 768 (1961); Comment, 18 BAYLOR L. REV. 137 (1966); Comment, 4 DUQUESNE U. L. REV. 450, 451 (1966).

[W]here circumstances permit, the patient should be told (1) the diagnosis, (2) the general nature of the contemplated procedure, (3) the risks involved, (4) the prospects of success, (5) the prognosis if the procedure is not performed, and (6) alternative methods of treatment, if any.⁹

Proper disclosure does not mean exhaustive disclosure.¹⁰ There are exceptions which make disclosure requirements consonant with the daily realities of medical practice. Where risks ought to be common knowledge they need not be disclosed.¹¹ The physician is not required to continue to disclose risks which the patient knows because of previous experience with the treatment to be administered.¹² There is also a considerable body of both law¹³ and commentary¹⁴ supporting the principle that where an emergency exists the physician need not obtain the consent of the patient for operative procedures. Consent to a particular plan or treatment does not bind the physician to that exact plan:

The law does not insist that a surgeon shall perform every operation according to plans and specifications approved in advance by the patient, and carefully tucked away in his office-safe for courtroom purposes.¹⁵

Those aspects of informed consent which have not been given sufficient consideration relate to: 1) acceptable justifications for failure to disclose material risks; 2) whether the proper cause of action is in battery or negligence; and 3) problems arising from difficulties in the communication process between physician and patient.

⁹ LOUISELL & WILLIAMS, *supra* note 5, at 594.43-44.

¹⁰ See generally Karchmer, *supra* note 8; McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 *MINN. L. REV.* 381 (1957); McCoid, *The Care Required of Medical Practitioners*, 12 *VAND. L. REV.* 549 (1959); Oppenheim, *supra* note 6.

¹¹ Roberts v. Young, 369 Mich. 133, 119 N.W.2d 627 (1963); Starnes v. Taylor, 272 N.C. 386, 158 S.E.2d 339 (1968).

¹² Yeates v. Harms, 193 Kan. 320, 393 P.2d 982 (1964).

¹³ See generally Barnett v. Bachrach, 34 A.2d 626 (D.C. Mun. App. 1943); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Delahunt v. Finton, 244 Mich. 226, 221 N.W. 168 (1928); Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962); DiRosse v. Wein, 24 App. Div. 2d 510, 261 N.Y.S.2d 623 (2d Dept. 1965).

¹⁴ See generally Kelly, *The Physician, the Patient, and the Consent*, 8 *KAN. L. REV.* 405 (1960); Levin, *Consent to Medical Procedures*, 1963 *INS. L. J.* 711; McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, *supra* note 10; Plante, *supra* note 8, at 653; Powell, *Consent to Operative Procedures*, 21 *MD. L. REV.* 189, 202 (1961); Note, *Consent as a Prerequisite to a Surgical Operation*, 14 *CINN L. REV.* 161, 168 (1940); Note, 26 *MICH. L. REV.* 561, 562 (1928).

¹⁵ See Barnett v. Bachrach, 34 A.2d 626, 629 (D.C. Mun. App. 1943).

II. MAY INFORMATION EVER BE WITHHELD?

The major issue in this article is whether a physician may ever knowingly refrain from informing a mentally competent adult patient of a risk involved in a proposed treatment when the knowledge of the risk would be material¹⁶ to the patient's decision of whether to undergo that treatment. In nearly all of the cases¹⁷ and articles¹⁸ which deal with, or touch upon, informed consent, there is a general recognition that "a physician is privileged to withhold information on specific risks when disclosure would seem detrimental to his patient's well being."¹⁹ The grounds usually used to support such an exception are that the patient "might refuse neces-

¹⁶ There are two sets presently proposed to determine whether or not a fact would materially affect a patient's judgment. The prevalent test is stated by LOUISELL & WILLIAMS, *supra* note 5, at 594.50:

"The usual way of showing this is for the plaintiff to testify that if he had been told of the dangers he would not have consented to the procedure. If he does not so testify, and if this fact does not otherwise appear in the case, the element of proximate cause is absent and the defendant will prevail." (Footnotes omitted).

The problem with this test is that injured patients who cannot prove malpractice negligence or patients claiming damages for battery may be too readily inclined to allow present knowledge to influence their appraisal of past judgment. Johnson, *Medical Malpractice Doctrines of Res Ipsa Loquitur and Informed Consent*, 37 U. COLO. L. REV. 182, 185 (1965) [hereinafter cited as Johnson], writes:

"Generally speaking, it is safe to speculate that when a patient selects a physician and places confidence in him, the patient will submit to those procedures recommended by the doctor. But at the trial the patient-plaintiff will certainly testify that 'had I known of that risk, I would never, never have consented.' The jury may well agree."

The realities suggested by Johnson tend to minimize the value of the Louisell & Williams test. More recently, Waltz & Scheunemann, *supra* note 7, at 647, suggest what appears to be a preferable test:

"[t]he proper question is whether a reasonable person in the plaintiff's position would have withheld consent to a therapy had all material risks been disclosed."

¹⁷ See generally Patrick v. Sedwick, 391 P.2d 453 (Alaska 1964); Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957); Natanson v. Kline, 187 Kan. 186, 354 P.2d 670 (1960); Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965); Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962).

¹⁸ See generally LOUISELL & WILLIAMS, *supra* note 5; Johnson, *supra* note 16; Oppenheim, *supra* note 6; Smith, *supra* note 2; Smith, *Antecedent Grounds of Liability in Practice Surgery*, 14 ROCKY MT. L. REV. 233 (1942); Waltz & Scheuneman, *supra* note 7; 109 U. PENN. L. REV., *supra* note 8; Comment, *Informed Consent in Medical Malpractice*, 55 CAL. L. REV. 1396 (1967).

¹⁹ See Waltz & Scheuneman, *supra* note 7, at 641.

sary treatment,"²⁰ or that such information may cause unnecessary anxiety and hinder the success of the treatment.²¹ No articles have dealt in depth with the implications of this exception. A few cases have been decided in part on this basis.²² Such an exception cannot be justified.

Notwithstanding this area of contention, there are certain established situations in which a physician is neither required to inform the patient of the risks involved in a proposed treatment, nor is he required to obtain the consent of the patient. The law is clear that the consent of a minor²³ or a person who is *non compos mentis*²⁴ is meaningless and authority to proceed with treatment must come from a third party. Where an emergency exists the rules governing informed consent are generally held in abeyance.²⁵

As well as the established exceptions noted above, there are certain limitations to the extent of disclosure which the physician must make. He need not disclose every possible detail of the treatment and its potential risks. Many commentators express the opinion that reasonable disclosure does not mean a physician must inform the patient of all possible results no matter how remote.²⁶ Commentators also recognize that extremely detailed and technical explanations of all of the possibilities can have an adverse effect on any patient.²⁷ Professional medical practice often dictates which

²⁰ LOUISELL & WILLIAMS, *supra* note 5, at 594.46. This however, begs the conclusion that the treatment is "necessary," when it should be up to the patient to determine necessity in relation to his own body.

²¹ *Id.*

²² Patrick v. Sedwick, 391 P.2d 453 (Alaska 1964); Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970).

²³ See Bonner v. Moran, 126 F.2d 121 (D.C. Cir. 1941); Bowers v. Talmadge, 159 So. 2d 883 (Fla. App. 1963); Jackovach v. Yocom, 212 Iowa 914, 237 N.W. 444 (1931); Tabor v. Scobee, 254 S.W.2d 474 (Ky. App. 1952); Sharpe v. Pugh, 270 N.C. 598, 155 S.E.2d 108 (1967); Rogers v. Sells, 178 Okla. 103, 61 P.2d 1018 (1936); Kelly, *supra* note 14; Powell, *supra* note 14, at 207, 14 CINN. L. REV., *supra* note 14; 26 MICH. L. REV., *supra* note 14, at 565.

²⁴ See Farber v. Olkon, 40 Cal. 2d 503, 254 P.2d 520 (1953); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Kelly, *supra* note 14; Powell, *supra* note 14.

²⁵ See the sources cited at notes 13 and 14, *supra*.

²⁶ See generally Karchmer, *supra* note 8; McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, *supra* note 10; McCoid, *The Care Required of Medical Malpractice Practitioners*, *supra* note 10; Oppenheim, *supra* note 6.

²⁷ See generally Karchmer, *supra* note 8; McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, *supra* note 10; McCoid, *The Care Required of Medical Malpractice Practitioners*, *supra* note 10; Oppenheim, *supra* note 6.

facts or possibilities a physician need not disclose to even the most stable patient.²⁸ The physician's claim that his withholding of information was in accordance with normal standards of practice will be subject to expert testimony concerning both medical judgment in general²⁹ and the specific medical practice related to the particular type of treatment in issue.³⁰

The difficulty arises in deciding whether the physician may withhold information for other reasons. If so, what are those reasons and what is their justification? Before discussing this issue a basic distinction must be made. The problem of informed consent which will be dealt with in this portion of the article involves a physician who undertakes a treatment without disclosing a risk which would affect the patient's judgment about whether to undergo treatment, and that risk becomes actual damage during the course of treatment.³¹ This is a true informed consent problem. This must be distinguished from the situation in which the physician goes beyond the scope of the treatment which he originally described to the patient and in fact treats some other or additional part of the patient's body.³² This second type of problem is more aptly described as exceeding the scope of treatment and will be discussed in section III.

Once the physician ventures outside the well established exceptions to informed consent, he enters a major gray area of the law. May the physician knowingly withhold information concerning certain risks from the patient because, in his judgment, "the patient's mental and emotional condition was such that it would have been therapeutically unwise to inform him of the risk"?³³ Are there grounds for the physician to "prove the reasonableness of any lesser disclosure"³⁴ outside the well established exceptions? Such possibilities have been so frequently mentioned in passing without careful consideration that they ought to be put to rest. A few cases have held for a physician-defendant on such

²⁸ See generally *Dietze v. King*, 184 F.Supp. 944, 949 (E.D. Va. 1960); *Collins v. Meeker*, 198 Kan. 390, 396-97, 424 P.2d 488, 494-95 (1967); *Johnson*, *supra* note 16; *Oppenheim*, *supra* note 6, at 259, 260.

²⁹ See *McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment*, *supra* note 10, at 434.

³⁰ *Roberts v. Wood*, 206 F. Supp. 579 (S.D. Ala. 1962); *Di Filippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961).

³¹ *E.g.*, *Natanson v. Kline*, 187 Kan. 186, 354 P.2d 670 (1960). *Wilson v. Scott*, 412 S.W.2d 299 (Tex. 1967).

³² *E.g.*, *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905).

³³ See *LOUISELL & WILLIAMS*, *supra* note 5, at 594.62.

³⁴ See 55 CAL. L. REV., *supra* note 18.

grounds,³⁵ and straight forward analysis reveals that these cases are not only weak in their use of precedent, but also lack any critical consideration of what the doctrine involves.

In *Patrick v. Sedwick* where a subtotal thyroidectomy was to be performed, Dr. Sydnam, the physician who advised the undertaking of surgery, "told the plaintiff that [a subtotal thyroidectomy] was nothing more than a tonsillectomy."³⁶ The patient met the operating physician, Dr. Sedwick, "for a few minutes in the operating room just prior to surgery."³⁷ In neither encounter with either physician was the patient-plaintiff told that the possibility of paralysis to vocal cords was one to five percent in all such operations performed regardless of the surgeon's care or technique. Dr. Sedwick's decision as to "(w)hether information concerning serious risks of surgery should be given or withheld . . . had been based upon his talks about the patient with Dr. Sydnam, the referring physician."³⁸ Dr. Sydnam's "notes indicated that the patient was a nervous and apprehensive person."³⁹ While the court did not make clear whether this was a specifically pleaded defense in the court below, it drew the conclusion that this was a sound basis for limited disclosure of risks stating:

There is good law in support of the argument made by the defendant in his brief . . . that doctors frequently tailor the extent of their preoperative warnings to the particular patient to avoid the unnecessary anxiety and apprehension which such appraisal might arouse in the mind of the patient.⁴⁰

In determining that physicians could "tailor the extent of their preoperative warnings,"⁴¹ the court made no attempt to distinguish between entirely withholding notice of material risks and giving a modest description of the possible results.

The court then cited three decisions in support of its position.⁴² A careful reading of those cases evidences the weak basis the *Patrick* court used as "good law"⁴³ to support the proposition that doctors may so tailor their preoperative warnings.

³⁵ *Patrick v. Sedwick*, 391 P.2d 453 (Alaska 1964); *Nishi v. Hartwell*, 52 Haw. 188, 473 P.2d 116 (1970).

³⁶ *Patrick v. Sedwick*, 391 P.2d 453, 458 (Alaska 1964).

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Roberts v. Wood*, 206 F. Supp. 579 (S.D. Ala. 1962); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P.2d 170, (1957); *Di Filippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961).

⁴³ *Patrick v. Sedwick*, 391 P.2d 453, 458 (Alaska 1964).

In *Roberts v. Wood*, the first case cited in *Patrick*, the court found that “[t]here is no evidence that [the physician] misrepresented the serious nature of the operation or failed to inform the patient of its attendant dangers.”⁴⁴ In *Salgo v. Leland Stanford Jr. University*, the second case cited, the California Supreme Court set out what has come to be one of the important modern statements of the duty of a physician to disclose facts “which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.”⁴⁵ The court simply did not deal with an allegation by the defendant physician that his limited disclosure had been on the grounds that the patient was unduly apprehensive.⁴⁶ The third case cited in *Patrick* was *Di Filippo v. Preston* where the defense of

⁴⁴ *Roberts v. Wood*, 206 F. Supp. 579, 583 (S.D. Ala. 1962). This case is perhaps the only solid basis for the holding in *Patrick v. Sedwick*, 391 P.2d 453 (Alaska 1964). In this case the patient submitted to a second subtotal thyroidectomy operation in five years (1954 and 1959). The physician told her that the second operation “would be similar to the one she had undergone in 1954.” *Roberts v. Wood*, *supra* at 583. The court noted that she was to undergo a gynecological operation and subtotal thyroidectomy at the same time during the 1959 operation, and in light of the patient’s emotional state as well as the fact that the patient had “previously experienced a thyroidectomy,” the court was “of the opinion the patient was properly advised of the seriousness of the operation.” *Id.* The plaintiff did not enter evidence that she was not aware of the risks from the previous treatment (*see generally* *Yeates v. Harms*, 193 Kan. 320, 393 P.2d 982 (1964), cited in note 12, *supra*, concerning knowledge from previous treatment), and the materiality of the risk was never dealt with. It is also not clear from the decision whether the defendant in *Roberts v. Woods* ever raised the same defense allowed in *Patrick v. Sedwick*, since the *Roberts v. Woods* court found “no evidence” of failure by the physician “to inform the patient of (the operation’s) attendant dangers.” 206 F. Supp. at 583.

⁴⁵ *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957)

⁴⁶ *Id.* *Salgo* is less in point than *Roberts v. Woods*, 206 F. Supp. 579 (S.D. Ala. 1962). Without dealing with the specific problem the court suggested, as many articles have done, that full disclosure “may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself.” 154 Cal. App. 2d at 578, 317 P.2d at 181. In supporting this general pronouncement, as well as the statement that “a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent,” *Id.*, the court cited *Hunt v. Bradshaw*, 242 N.C. 517, 88 S.E.2d 762 (1955); *Simone v. Sabo*, 37 Cal.2d 253, 231 P.2d 19 (1951); *Schloendorff v. Society of New York Hospital*, 21 N.Y. 125, 105 N.E. 92 (1914). None of these three cases either involved or mentioned withholding of disclosure by the physician in

withholding disclosure to assuage the patient's fears was also never raised.⁴⁷

In *Nishi v. Hartwell*, the plaintiff-patient, who was a dentist, was paralysed from the waist down during a thoracic aortography and subsequently died.⁴⁸ The purpose of the diagnostic procedure was to determine the existence of aneurysm, and involved an exposure of an artery in the inguinal region, followed by an injection of radio-opaque contrast medium through a catheter so that the aorta would be outlined under x-ray. The defendant-physicians did not disclose to the patient, Dr. Nishi, that paralysis and death were collateral hazards associated with the use of the chemical Urokon as the radio-opaque contrast medium. It was uncontradicted at trial that there was no disclosure of the risk associated with Urokon, and that the injury to Dr. Nishi occurred as a result of the use of Urokon in the thoracic aortography.⁴⁹ The suit was dismissed at the close of the plaintiff's case, because the plaintiff failed to come forward with independent expert testimony to prove a prime facie case of negligence.⁵⁰

order to keep from alarming an already apprehensive patient. It is interesting to note that Cardoza, in his often quoted *Schloendorff* decision, apparently dealing with the problem of apprehensive patients stated only that "[t]here may be cases where a patient ought not to be advised of a contemplated operation until shortly before the appointed hour." *Schloendorff v. Society of New York Hospital*, *supra* at 134, 105 N.E. at 95. The implication is quite strong that Cardozo felt that the patient should be advised under all circumstances, the timing of the disclosure notwithstanding.

⁴⁷ See *Di Filippo v. Preston*, 53 Del. 539, 173 A.2d 333 (1961). In this case the defense was that "it was not a practice of surgeons in the Wilmington area to warn the patients of the possibility of resultant injury to the recurrent laryngeal nerves from a thyroidectomy." *Id.* at 550, 173 A.2d at 339. There was no defense raised of concern for an emotionally ill-prepared patient.

⁴⁸ *Nishi v. Hartwell*, 52 Haw. 188, 189, 473 P.2d 116, 118 (1970). The patient was originally the plaintiff, but after his death his wife maintained the suit on behalf of his estate and herself.

⁴⁹ *Id.*

⁵⁰ The plaintiff tried the case on a battery theory. Had battery been the appropriate form of action, expert testimony should have been irrelevant and the proper question should have been whether there was consent to the touching. As a result of this battery approach, the plaintiff apparently never prepared to come forth with expert witnesses to support the plaintiff's case. The only physicians appearing were the defendants, as adverse witnesses. The majority of the court gave weight to the physicians' testimony without going so far as to consider them the expert witnesses of the plaintiff. On the basis of the case as presented by the plaintiff without independent expert witnesses, the court upheld the dismissal after presentation of the

The court apparently had a number of grounds for its holding. Primary among these was the fact that the physicians felt that disclosure would further frighten Dr. Nishi, who was already anxious about his continually deteriorating health.⁵⁴ One of the physician-defendants testified that since Dr. Nishi was "a professional man . . . a dentist," he knew that with every injection "a hazard exists, so that it didn't seem necessary to tell this professional man, 'Now is it a hazard?' He knows it."⁵² The court discussed the fact that this diagnostic treatment was being undertaken to determine whether or not Dr. Nishi would have to go to Texas for surgery by a prominent surgeon. The prospect of avoiding the trip to Texas through the use of this diagnostic treatment "delighted" Dr. and Mrs. Nishi.⁵³ Finally, turning to the testimony of a second defendant-physician, the court noted that this defendant felt Urokon to be the only satisfactory chemical available, and that there was a minimal chance (two in 3,800) of death from its use.⁵⁴ In order to underscore this point, in the only footnote in the decision, the court cited authority which established that at least half of the surgeons in the United States used Urokon "despite the existence of other media considered by some to be less toxic," but which did not facilitate the best pos-

plaintiff's case. While the court was prepared to say that, "[t]he right of a plaintiff to relief does not depend upon his allegations or his theory of the case" (52 Haw. at 191, 473 P.2d at 119), it is clear that under the plaintiff's theory of battery it was to plaintiff's prejudice and detriment not to come forward with expert witnesses, whose appearance presumably would have at least gotten the case to the jury. The dissenting opinion of Abe, J. discusses this problem. See section III of this article for a discussion of the battery-negligence question.

⁵¹ *Id.* at 193, 473 P.2d at 120.

⁵² *Id.* This testimony, cited by the court, appears to give a second and independent reason for the court's decision, i.e., that the patient already knew the risks. Certainly the normal risks involved in routine injections do not include paralysis or death, but rather a small possibility of infection. Therefore, this testimony offered no grounds of defense whatsoever.

⁵³ *Id.* One wonders whether the "delight" of the patient actually resulted from the fact that his physicians had recommended a "fairly simple procedure" as a possible alternative to a trip to Texas for diagnosis or surgery. Had Dr. Nishi been told that the proposed treatment involved a risk of paralysis or death, no matter how slight, he might have elected to undertake such risks only at the hands of well-known heart specialists in Houston.

⁵⁴ *Id.* The court's position might have been stronger had they relied on this point alone. Remoteness of risk is an accepted basis for limiting disclosure. The issue would then become whether a risk as great as death or paralysis at these odds must be disclosed.

sible x-rays.⁵⁵ The clear implication of this footnote is that there existed other types of media which might have been used on Dr. Nishi if he had been in a position to make an intelligent choice.

On the basis of the foregoing facts, with the difficulties created by the battery-negligence confusion discussed in the dissenting opinion,⁵⁶ the court asserted that the evidence

brought defendants' omission to disclose clearly within the exception to the duty of full disclosure which excuses the withholding of information for therapeutic reasons. Under the showing made, we do not think that reasonable minds can differ on this point.⁵⁷

In light of the fact that Dr. Nishi had already endured a history of medical hardship, could have had a choice of different doctors or different chemicals, and was faced with a risk of extreme magnitude despite favorable odds, it may be that reasonable minds could certainly differ over whether or not Dr. Nishi should have been placed in a position to make these decisions by being fully apprised of the possible consequences of the proposed treatment.

A reading of the cases and articles in the area of informed consent reveals many ill-considered pronouncements along the lines of *Partick v. Sedwick* and *Nishi v. Hartwell*. The various implications of this exception to disclosure must therefore be examined.

At least seven results can occur when an overly emotional or unstable patient receives a full disclosure of the risks involved in a treatment which the physician recommends: (1) he may not be any more anxious or upset than he already is with the prospect of treatment; (2) he may submit to the treatment with no ill effects caused by increased anxiety; (3) he may submit to the treatment and suffer ill effects caused by increased anxiety; (4) he may refuse to submit to treatment, retaining the dangers or discomforts of his ailment, but having no ill effects from the anxiety; (5) he may refuse to submit to treatment and become worse as a result of the anxiety caused by the disclosure and subsequent decision not to undergo treatment; (6) he can postpone treatment until he feels capable of undergoing and coping with the possible risks involved; and (7) he can seek alternative treatment.

Cases and articles rarely distinguish between these potential outcomes and tend to limit their discussion of the potential impact of full disclosure to the vague possibility of creating "unnecessary anxiety and apprehension which such appraisal might

⁵⁵ *Id.*

⁵⁶ See note 50 *supra*.

⁵⁷ 52 Haw. at 195, 473 P.2d at 121.

arouse in the mind of the patient.”⁵⁸ This attitude assumes that there is no alternative to immediate treatment, and that anxiety will in fact result and will in fact be detrimental.⁵⁹ It also assumes that either possibility (3) or (5) will occur, and that either must be avoided. In effect, the possibility of two potentially harmful results occurring out of a total of seven potential results is justification for non-disclosure. There is also at work the assumption that since the probability of the undisclosed risk actually occurring is small, any apprehension or anxiety should be avoided and considered unnecessary. This, however, begs the question.

Protecting the patient from undesirable psychological side-effects appears to be morally defensible only where the patient would have undergone the treatment regardless of the risks.⁶⁰ The catch, however, is that the physician can never be sure that the patient would subject himself to those risks unless the patient himself is consulted. There is nothing morally defensible about inducing a human being to undergo something which he would not have voluntarily undergone had he known of the possible consequences. The result of inadequate disclosure is bound to be the same despite the physician's motive if the undisclosed risk becomes a post-treatment reality—the patient is likely to feel that he has been deprived of the right to make decisions about his own body, and a law suit may occur.

The physician, if he feels medically justified in withholding disclosure for any reason, can do little either to protect himself further or to comfort his patient. He may not attempt to quiet the patient's nerves by telling him “no danger can result” when in fact the physician knows danger can result from treatment.⁶¹ “Often ‘affirmative misstatement’ is but a synonym for ‘fraudulent misrepresentation.’”⁶² It is also well settled that the “physician must specifically and fully answer questions about risks put him

⁵⁸ *Patrick v. Sedwick*, 391 P.2d 453, 458 (Alaska 1964). See also *Williams v. Menehan*, 191 Kan. 6, 379 P.2d 292 (1963); *Karchmer*, *supra* note 8; *Oppenheim*, *supra* note 6; *Waltz & Scheuneman*, *supra* note 7, at 642.

⁵⁹ It is this author's belief that the true and basic feeling of such authors is that the patient will not defer to the physician's judgment that he ought to undergo the proposed treatment. This deference to and belief in the “doctor knows best” theory entirely overlooks the realities of the *Cardozo maxim* quoted at the opening of this paper.

⁶⁰ See generally *Plante*, *supra* note 8.

⁶¹ See *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962).

⁶² *LOUISELL & WILLIAMS*, *supra* note 5, at 549.64. See also *Natanson v. Kine*, 186 Kan. 393, 350 P.2d 1093 (1960).

by the patient,"⁶³ even if he does not want to fully inform the patient. A physician operating in a manner specifically prohibited by the patient will probably be liable for a battery⁶⁴ in most cases.⁶⁵ Thus, a physician may not fraudulently mislead the patient, must answer all questions regarding the proposed treatment, and cannot treat a patient against the patient's will. It appears that those patients who may be subjected to less than full disclosure by their doctors are those individuals who fail either to ask the proper questions⁶⁶ or have such a limited knowledge of the proposed treatment that they cannot anticipate which part of their body to protect through timely protest. Adequate disclosure to an individual who the doctor feels should not be either deterred from treatment by fear, or weakened by anxiety, must not depend upon a random request to know the risks. The situation should never be such that "[o]nly if the patient asks, should full disclosure be made."⁶⁷ Nor should doctors be compelled to be silent to questions by the patient or fear making encouraging remarks.

Beyond the unnecessary strains which limited disclosure puts upon the physician-patient relationship there are other sound grounds for not allowing a physician to proceed with a treatment without full disclosure. First, if the physician gives less than full disclosure, the patient will be submitting to treatment unaware of the risks of the particular treatment. Second, since physicians in various areas of medicine may only be held to the professional standards of their school of technique,⁶⁸ treatment for the same medical problem by a physician with a different medically accepted approach might involve different risks which the patient might be willing to undergo. The patient may seek out other physicians only after learning of the risks from the first physician. Third, the anxiety

⁶³ LOUISELL & WILLIAMS, *supra* note 5, at 594.63.

⁶⁴ See McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, *supra* note 10, at 403. See also *Bennan v. Parsonnet*, 83 N.J.L. 20, 25, 83 A. 948, 950 (1912).

⁶⁵ Waltz & Scheuneman, *supra* note 7, at 648, discuss a possible exception to operative procedures undertaken in the face of specific prohibition: "[W]here death is substantially certain and the proposed therapy has an extremely high probability of success . . . [t]here is authority that the physician can proceed with treatment in such a situation even in the face of adamant refusal of consent by the patient."

⁶⁶ An interesting consideration arises when one attempts to determine what type of question may compel full disclosure by the physician. Can the patient simply ask the physician "what are the risks" or must he be more specific.

⁶⁷ LOUISELL & WILLIAMS, *supra* note 5, at 594.54.

⁶⁸ *Kaplan v. Haines*, 96 N.J. Super. 242, 257, 232 A.2d 840, 848 (1967).

sensed by the physician who intends to withhold full disclosure may result from a lack of confidence by the patient in that same physician. For example, a patient may feel quite comfortable going to a family doctor for regular check-ups and yet not feel comfortable undergoing a major operation by that same doctor. Thus, the anxiety a physician senses when talking with the patient about that physician performing major treatment may be the very thing which keeps the physician from full disclosure. It would be ironic for a patient who does not have full confidence in his doctor for major treatment (although perhaps for minor treatments and check-ups) to be subject to precisely that which the patient would reject because of the relationship.

The intricacies of this last example suggest an extreme situation, but consultation with more than one physician and exposure to various approaches toward treatment of the same problem may go a long way to relieve the tensions a doctor perceives. In fact, a doctor who feels he cannot disclose various risks of treatment for certain reasons should direct the patient, who already knows his medical problem, to visit another physician, preferably of another medically accepted approach in the same field. Not only will this relieve the physician from making a singular judgment with regard to the patient's ability to cope with the risks, but it may offer the patient an alternative treatment with greater or lesser risks, or at least increase the patient's confidence in the physician so that the ultimate disclosure will not produce the expected anxiety.⁶⁹ Since the need for treatment will, in most cases, be confirmed in the patient's mind, he is then more adequately prepared to weigh the risks of treatment against the risks of foregoing treatment. If chances are to be taken, it is the patient's right to decide which chances they will be.

Some commentators⁷⁰ have suggested that the problems inherent in withholding disclosure from anxiety ridden patients can be

⁶⁹ The existence of more than one medically accepted approach to the same ailment may at first confuse the patient and increase his anxiety; this is a reality which must be accepted. The occasional possibility of selecting among treatments with different risks has obvious advantages for the patient, as does the opportunity to consult with two physicians. For example, in *Nishi v. Hartwell*, 52 Haw. 188, 473 P.2d 116 (1970), the patient could have had the choice between different radio-opaque contrast media to be used in a thoracic aortography to determine the existence of aneurysm. The alternatives involved different risks and different benefits in that case.

⁷⁰ See LOUISELL & WILLIAMS, *supra* note 5, at 594.47; Smith, *supra* note 14; Smith, *supra* note 2; Note, *Physician and Patient: Some Problems of Consent*, 2 WASHBURN L.J. 158, 170 (1962).

avoided by consulting with or obtaining consent from close relatives of the patient. This frequently mentioned solution to the problem of limited disclosure lacks a sound basis in both present law and policy. This erroneous idea must also be put to rest, for our law rightfully does not provide for such a possibility.

Unless an individual is either a minor⁷¹ or *non compos mentis*⁷² or unless a guardianship or power of attorney has been legally granted, no individual may act for another individual without his specific consent. Thus, unless family members are specifically given power by the patient or the court to consent to treatment based on facts not to be told to the patient, they cannot do so. Some articles⁷³ and cases⁷⁴ have recognized this.

The only case which has even suggested that such a power of consent without legal authorization exists is *Lester v. Aetna Casualty & Surety Co.*,⁷⁵ which held:

⁷¹ See the sources cited at note 23, *supra*.

⁷² See the sources cited at note 24, *supra*.

⁷³ See generally LOUISELL & WILLIAMS, *supra* note 5, at 594.64 (at 594.64 Louissell and Williams put into correct light the statement they make at 594.47, *supra* note 60); Kelly, *supra* note 14; Powell, *supra* note 14, at 216; 14 CINN. L. REV., *supra* note 14, at 170.

⁷⁴ See generally *Bang v. Charles T. Miller Hospital*, 251 Minn. 427, 88 N.W.2d 186 (1958) (recognizing the necessity of legal authorization for another party to make decisions); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905) (even where a family physician was requested to be present at the operation by the patient, the court would not imply power for the physician to consent for the patient).

⁷⁵ *Lester v. Aetna Casualty & Surety Co.*, 240 F.2d 676, (5th Cir. 1957). The precise facts of this case are not clear from the Fifth Circuit opinion. Apparently the appellant (plaintiff below) went to a psychiatrist who administered shock therapy, and the appellant sustained some harm as a result. According to the circuit court the appellant did not object to or question this procedure. Appellant appealed on the ground of deprivation of due process and took exception, *inter alia*, to "that part of the charge relating to consent and in which the court (below) has said the jury may find that the full disclosure of the wife may stand in lieu of disclosure to the husband." *Id.* at 676 n.1. (In this author's opinion such an instruction should be improper). Appellant also asserted that the court below erred in not giving the following instruction: "That even if plaintiff was incompetent (by reason of insanity or otherwise) his wife could not contract for him, in the absence of interdiction, and second, appointment and qualification as curatrix." *Id.* at 611 n.2. From the circuit court opinion it appears that the appellant had consented in some part and that his wife also consented in some way. While the court may have found simply that the jury determined that the appellant had given adequate consent, they instead handed down their overly broad and unsupported holding quoted in the text which accompanies note 76, *infra*.

Assuming, as we must in support of the verdict and judgment, that the plaintiff's condition was such as to require neuro-psychiatric treatment and, in the judgment of his physician and his wife, to make it unsafe and unwise to require him to undergo the strain and shock of discussing and considering the possible, though not probable, hazards involved in, and making a decision as to, whether in view thereof the electro-convulsive or electro-shock treatments prescribed for, should be administered to, him; that, in the judgment of his physician and his family it was desirable, indeed necessary that they be administered; and that his wife, being advised of and fully comprehending the situation, added to his consent already given her consent to the administration of the treatments, *we are bound to hold that if further consent than that already given by plaintiff to their administration was needed, the wife could and did give sufficient legal consent*, and that giving the complained of charge and refusing the requested charges was not prejudicial error. Any other conclusion would, we think, be contrary not only to human experience and sound reason but to the teachings of our cases of *Wall v. Brim*, 5 Cir., 138 F.2d 478 and the cases cited in it.⁷⁶

This statement regarding a wife's power to consent for a husband who is legally sane is as incorrect as it is lengthy.

In *Wall v. Brim*,⁷⁷ the case relied upon to support this unfounded thesis, the doctor at no time asserted that he withheld information of material risks because of the psychological condition of the patient. No consent was ever given by the patient's husband. In fact, the court remanded the case for retrial because:

[t]he issue, as to whether the defendant in proceeding with the operation as he did after discovering its true character, without advising plaintiff of its nature and securing her consent to it, committed a trespass upon her or a breach of his obligation to exercise the care and skill required of him, was not developed and tried out as it should have been.⁷⁸

Wall v. Brim in no way supports the unsound holding in *Lester v. Aetna Casualty & Surety Co.* The cases cited in *Wall* only speak to the necessity of an informed consent.⁷⁹

⁷⁶ *Id.* at 679 (Emphasis added).

⁷⁷ *Wall v. Brim*, 138 F.2d 478 (5th cir. 1943). In this case the defendant doctor, while in the course of an operation on a cyst behind plaintiff's ear, for which he had consent, discovered that the cyst was far larger than he had originally told the plaintiff. Without advising plaintiff, who was conscious during the operation, of the increased seriousness of dealing with the larger cyst, he proceeded to expand his operation. Plaintiff suffered severe permanent facial nerve damage as a result.

⁷⁸ *Id.* at 481.

⁷⁹ *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905) (physician may not operate beyond the scope of the consent); *Bennan v. Parsonnet*, 83 N.J.L. 20, 83 A. 948 (1912) (a surgeon may not perform an operation different in kind from that consented to, or with different risks).

There is no foundation for allowing an individual without legal power to make decisions affecting another's life; and there are sound social considerations which militate against such a policy. Suppose the physician obtains consent from a close relative of the patient. In a properly performed operation the patient sustains some damage which is precisely of the nature about which he would have been warned through full disclosure. He sues the physician. The physician-defendant produces the consent of the close relative as a defense of his limited disclosure to the patient. Assuming that some limited disclosure is valid, the physician would still have to prove that in his sound medical judgment the patient-plaintiff should not have been told of the risk. The physician's burden is precisely the same whether or not a relative is involved—he must justify his lesser disclosure to the patient.⁸⁰ Whether or not he must disclose information to the patient cannot depend on the random existence of a close relative. If it can, how close must that relative be? It would also be unacceptable for a physician to go from relative to relative to find someone to consent and thereby protect himself in his decision to withhold information of material risks from the patient. The doctor should never be deluded into believing that a relative's consent diminishes his burden to prove validity of a lesser disclosure to the patient.

There may, however, be some sound reasons for conferring with and obtaining consent from relatives despite their lack of legal capacity. First, should the patient die, such consent might act as some form of estoppel against consenting relatives in a wrongful death action. More important, assuming that there can be a valid ground for non-disclosure, such conference with and consent from close relatives might be evidence that the physician did everything possible to learn about the patient, and drew upon the family's opinions of the patient's psychological and emotional state of being. This might bolster the physician's presentation of the basis for his decision not to make full disclosure.

For those who theorize that non-disclosure may be rectified by family consent, there is a further alternative. Assuming that the family has its authority in part by virtue of its closeness to the patient, why then should not the decision regarding treatment be made by bringing the family and the patient together to make the decision? Affording the family power to consent must assume generally that the patient would most likely be pleased with and rely upon their judgment. The family should therefore be utilized

⁸⁰ See 55 CAL. L. REV., *supra* note 18.

by the physician to deal with the patient and to help him to make an informed decision about the operation.

There appear to be no devices or practices available to the physician to enable him to limit his disclosure of information to the patient and still meet the requirements of informed consent. In fact, there are no sound grounds for allowing a physician to proceed with a treatment with less than full disclosure, notwithstanding the well established exceptions. The involvement of the family, as well as the consultation with two different physicians as already noted, should help to diminish the patient's anxiety, increase his understanding of the need for the operation, and generally do away with the situation in which non-disclosure might be thought to be warranted. Ultimately, the patient may never consent, despite the number and identity of individuals involved. That is his right. The law has not yet, using either sound analysis or sound precedent, promulgated a rule to the contrary.

III. BATTERY OR NEGLIGENCE?

At present confusion remains as to whether the doctor is liable for battery or negligence when harm occurs during treatment and the patient was not forewarned of that possibility. The characterization of the cause of action as either battery or negligence gives rise to significantly different ways in which the case ought to be tried in court. Sound analysis will show that the cause of action is properly negligence and not battery.

In a law suit based upon lack of informed consent a patient sues a physician for damages because either the patient did not consent to the treatment or the physician did not inform him of the risks. The patient is not required to allege that the physician was negligent in administering the treatment.⁸¹ To state a claim for which there may be relief, the patient need only show that some undisclosed risk of which he should have been forewarned did in fact result in damage to his body or that he did not consent to the treatment undertaken.⁸²

The courts have tended to be unclear in defining the nature of the plaintiff's cause of action.⁸³ The confusion in the courts arises

⁸¹ *Perry v. Hodgson*, 168 Ga. 678, 148 S.E. 659 (1929); *Tabor v. Scobee*, 254 S.W.2d 474 (Ky. App. 1952); *Franklyn v. Peabody*, 249 Mich. 363, 228 N.W. 681 (1930).

⁸² W. PROSSER, *HANDBOOK OF THE LAW OF TORTS*, 104-05 (4th ed. 1971) [hereinafter cited as PROSSER].

⁸³ See generally 34 So. CAL. L. REV., *supra* note 6.

over whether the cause of action is properly battery or negligence. This confusion gives rise to more than an academic discussion of legal niceties. A careful definition of the cause of action will help to guide the courts in determining whether or not expert witnesses are necessary and to what issues they should testify. A clearer definition will also enable the judge to sharpen his instructions to the jury both as to what alleged breaches the jury should consider and the type or damages it may award.

Until 1960 malpractice cases based on lack of consent had been decided on the theory of battery.⁸⁴ The essence of battery is an unconsented touching.⁸⁵ Thus a patient who has not been informed of certain risks has not consented to touches involving those risks, and if one of the risks manifests itself in a harm, he claims damage under the theory of battery. The courts, however, have confused the issue by using battery.

The proper inquiry in a case based on battery is whether or not the patient did consent and was informed. This is a question of fact for which expert witnesses are not necessary.⁸⁶ The courts, however, have tended to allow expert witnesses to testify and in this way bring into issue whether or not the physician was exercising sound professional judgment in limiting his disclosure.⁸⁷ In a traditional battery case the question is whether or not the party consented to the touching; the attenuating circumstances of the intent of the defendant or the professional judgment of the defendant should not enter into consideration.

A battery theory is often applied to the situation in which the physician carries his treatment or operative procedure substantially beyond the original plan or to a different part of the body.⁸⁸ This is not an informed consent situation in which undisclosed risks are involved. Here an undisclosed treatment is involved, and the result is more aptly described as exceeding the scope of the original treatment. There is no consent whatsoever to this touching. Battery is perfectly applicable to this form of malpractice.⁸⁹

⁸⁴ *Id.*

⁸⁵ PROSSER, *supra* note 82, at 36.

⁸⁶ Natanson v. Kline, 187 Kan. 186, 189, 354 P.2d 670, 673 (1960).

⁸⁷ Di Filippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961); Williams v. Menahan, 191 Kan. 6, 379 P.2d 292 (1963); Roberts v. Young, 369 Mich. 133, 119 N.W.2d 627 (1963); Hunt v. Bradshaw, 242 N.C. 517, 88 S.E.2d 762 (1955); LOUISELL & WILLIAMS, *supra* note 5, at 594.48.

⁸⁸ *E.g.*, Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905).

⁸⁹ PROSSER, *supra* note 82, at 104.

The primary difficulty with using the battery theory is this. In the situation in which a physician withholds information concerning risks involved in a treatment and in which the patient gives consent to that treatment (without knowledge of such risks), there is a consent to the touching—that is, a consent to the treatment as the patient understands it. In essence, the plaintiff-patient would not be able to argue that he did not consent to the treatment (since he did), but would have to argue that he did not consent to a treatment which included the risks to which he was subjected. The focus therefore is not so much on the patient's lack of consent as it is on whether the physician misinformed or misrepresented by omission or otherwise the nature of the treatment to which the patient was subjected. The jury, therefore, in reality will not be deciding liability on grounds of whether there was consent but rather on whether or not the defendant was justified in doing what he did—that is, whether his omission or misrepresentation was sufficiently material to change the nature of the treatment as understood by the plaintiff, thus invalidating the consent, or whether the plaintiff would have nonetheless undergone the treatment had he known the risks. If the jury finds for the defendant and must use a battery theory, it can only do so by applying some form of constructive consent by the plaintiff to undertaking the risks in issue. It cannot find "implied consent" since there are no acts of any kind by the plaintiff which give grounds for implying that he consented to something he knew nothing of.⁹⁰ There is no basis at law for "constructive consent" to battery, and the entire unnecessary fiction can be avoided by relying on negligence.

Negligence theory provides a more adequate and flexible tool for working in this sensitive area. The negligence alleged would be the physician's failure to disclose or failure to effectively communicate with the patient. Expert testimony would properly be admitted to address questions concerning the treating physician's judgment, the generally acceptable professional practice for the treatment in issue, and even the psychological and emotional condition of the patient. Marcus L. Plante, in an article entitled "An Analysis of Informed Consent,"⁹¹ deals with the advantages of using a negligence theory. He maintains that:

[W]hen the basis of the case is medical negligence as opposed to battery, the physician has a much wider range of discretion and the elements weighed in evaluating his conduct are more numerous. These authorities warrant the conclusion that when a physician

⁹⁰ *Id.* at 102.

⁹¹ Plante, *supra* note 8.

tells a patient what he proposes to do, he has a strict duty to explain the nature and character of the procedure in terms that the patient can understand, but that when the physician is considering whether he should disclose collateral hazards to the patient he may take into account things other than the plain use of language. This conclusion has important implications in subsequent litigation. A physician sued in battery has relatively little "elbow room" in which to establish a defense. A physician sued for medical negligence in failing to disclose hazards has many more possibilities on which to base a defense under the circumstances that existed.⁹²

As a negligence issue the physician-plaintiff can also attempt to prove that the patient would have nonetheless undergone the operation. By doing so the physician-defendant proves that his withholding of disclosure was not the proximate cause of the injury.⁹³ Such proof that a patient would have consented anyway should be a *non sequitur* in a battery allegation since the issue is whether the patient in fact consented. Because a patient-plaintiff will invariably testify that if he had known of the risk he would never have undergone the treatment,⁹⁴ the proper question to put to the jury should be: "Would a reasonable person in the plaintiff's position have undergone the treatment had he known of the material risks involved?"⁹⁵ The patient-plaintiff may testify that there was some other treatment with other risks which he would have undergone, but this too is for the jury to consider. If there are alternative methods of treatment, each involving different risks, the jury is free to decide that the patient might well have elected a different treatment or no treatment at all. If the jury decides that the patient would have undergone a different treatment without the same risks or would not have undergone treatment at all, then the physician will be liable for the damages incurred.

Negligence is also more realistically adapted to the award of damages. The award is a straightforward compensation for the harm suffered.⁹⁶ In contrast, if battery were to be used, there should be the possibility of an award for actual, nominal and punitive damages.⁹⁷ The actual damages would be the same as those awarded in a finding of negligence. Nominal damages are those awarded for the mere showing of battery, even if no actual damage or harm

⁹² *Id.* at 656.

⁹³ See PROSSER, *supra* note 82, at 238-39.

⁹⁴ Johnson, *supra* note 16, at 185.

⁹⁵ Waltz & Scheuneman, *supra* note 7, at 647. This test is discussed at note 22, *supra*.

⁹⁶ PROSSER, *supra* note 82, at 143.

⁹⁷ *Id.* at 35.

exists.⁹⁸ Punitive damages are awarded when the jury finds the battery to be an especially egregious act.⁹⁹ There is no history of nominal and punitive damage awards in informed consent cases. The sensitive nature of the physician-patient relationship and the universal presumption of good faith on the part of the physician have militated against such awards. The concept of battery therefore is an inaccurate device for appraising the realities of harm to the plaintiff under an alleged breach of informed consent.

The tendency in informed consent cases has been to discuss the sorts of considerations raised in this discussion. Such considerations traditionally should not enter into a battery action. Negligence, on the other hand, properly allows a broader scope of inquiry in assessing precisely what the physician is liable for, if he is liable at all.

IV. PROBLEMS OF COMMUNICATION

There remains the problem of the physician who attempts to disclose all material risks to his patient, but for some reason is unsuccessful in his communication. The patient's consent is therefore meaningless.

Consent . . . connotes the dual elements of awareness and assent. To establish consent to a risk, it must be shown both that the patient was aware of the risk and that he assented to encounter it.¹⁰⁰

The rule is well established that "if the consent is not 'informed' consent it is not consent at all."¹⁰¹ It is clear, then, that the communication to the patient must enable the patient to make an intelligent decision concerning the proposed medical treatment. The problem which has not yet been studied is the nature of the physician's dilemma when he is aware that the consent is uninformed and therefore meaningless. The following discussion is by no means exhaustive; it is intended to open further consideration of this difficult area. The problem does not only involve the patient's inability to understand the descriptions given to him by the physician, but it also encompasses the language and approach used by the physician. The explanation given to the patient by the physician, often with a

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ Waltz & Scheuneman, *supra* note 7, at 643.

¹⁰¹ Note, *Physician and Patient: Some Problems of Consent*, 2 WASHBURN L. J. 153, 165 (1962); see *Natanson v. Kline*, 187 Kan. 186, 354 P.2d 170 (1960); *Corn v. French*, 71 Nev. 280, 289 P.2d 173 (1955); *Wilson v. Scott*, 412 S.W.2d 299 (Tex. 1967).

thought to making the risks as palatable as possible, must nonetheless be sufficient adequate and clear to allow satisfactory understanding of what exactly is involved. This suggests that a physician may not tailor his remarks too much, nor remain silent about any material risks.¹⁰² To do so might result in nullifying the legal effect of any consent the patient might give.¹⁰³

"[T]o be able to consent the patient must be able to comprehend the seriousness of his condition, the nature of the proposed treatment or operation, the expected results, and possible consequences thereof."¹⁰⁴ If these elements are lacking, the assent to treatment by the patient may not be an informed consent. If the patient lacks the intelligence to understand the treatment or risks, the physician is faced with a communications and education problem. If the patient has diminished mental capacity or is insane, there is nothing the physician can do to guarantee an informed consent except to have a guardian appointed.

There is a burden on the physician to determine the state of the patient's capacity to understand and therefore the nature of his consent. Walt and Scheuneman maintain that "[t]he proper question is whether a reasonable man would conclude from the patient's behavior that he was aware of the risk and that he manifested a willingness to encounter it."¹⁰⁵ It may seem unduly burdensome to bind the physician not only to decide what and how to disclose, but also whether the patient understood and consented to the treatment and its attendant risks. However, the physician is the only party in a position to carry out such appraisals.

The physician's burden is not that great, however. Waltz and Scheuneman's formulation¹⁰⁶ should lead to the conclusion that the physician is not expected to analyze the patient's behaviour with the skill of a psychologist but may only be held to the standard of a reasonable man. Experts therefore will not testify as to the ways in which the physician should have recognized certain behavior on the part of the patient which an expert in human behavior and psychology would have determined to be lack of understanding or lack of consent.

Problems of both informing and consenting may be mitigated through the use of practices already discussed in this article. In-

¹⁰² See generally the sources at notes 61 and 62, *supra*.

¹⁰³ NATHAN, *MEDICAL NEGLIGENCE* 158 (1957).

¹⁰⁴ POWELL, *supra* note 14, at 208.

¹⁰⁵ WALTZ & SCHEUNEMAN, *supra* note 7, at 645.

¹⁰⁶ *Id.*

volvement of a second physician as well as members of the patient's family in both the disclosure of information and the establishing of informed consent can offer the physician a great deal of protection.

While this article has been primarily concerned with inadequate disclosure there remains the occasionally expressed fear that "telling the patient too much might be worse than telling him too little."¹⁰⁷ Such arguments concerning disclosure of "too much" information lack the requisite focus to be meaningful. Legally, there are no grounds to hold a physician liable for psychological or physical damage which might result from a good faith representation of risks involved in a particular medical treatment. No court has in any way intimated such an undesirable idea.¹⁰⁸ Telling the patient "too much" about his impending treatment might be harmful if the physician indulges in describing to the patient in overly imaginative, descriptive and elaborate detail all of the aspects of his treatment. There could possibly be an undesired emotional impact on the patient. No physician, however, is required to do this. The physician need only disclose the risks and the nature of the treatment; he need not describe his technique and procedure in detail. Disclosure of material risks is not to be construed as disclosure of all conceivable risks.¹⁰⁹ The physician need disclose only enough to enable the patient to make an intelligent decision about undergoing treatment. In essence, the professional judgment and experience of the physician must guide him in the extent of his disclosure beyond that minimum which informs the patient of the risks.

V. CONCLUSION

It is difficult to argue against the hypothetical example of a highly skilled physician deciding that his very emotionally sensitive patient would be needlessly bothered and possibly harmed by a discussion of the five percent possibility of a certain risk. Our traditional tendency has been to defer to the professional. Yet it is unfair to both parties to allow this sort of situation to continue. The physician faced with numerous technical decisions in a gen-

¹⁰⁷ Levin, *supra* note 14, at 717.

¹⁰⁸ While there are no cases holding that a physician can be liable for distress caused by accurate good faith representations, there is the somewhat bizarre case of *Ferrara v. Galluchio*, 5 N.Y.2d 16, 152 N.E.2d 249, 176 N.Y.S.2d 996 (1958), in which a physician who had caused X-ray burns was held liable for the mental anxiety ("cancer-phobia") suffered by the patient after the patient was later told by another physician that cancer might develop in the area of the burns.

¹⁰⁹ See the sources cited at note 26 *supra*.

erally overburdened practice is rarely a psychologist and should not be required to make such appraisals—the patient should not be deprived of his right to decide what should be done to his own body.

It is doubtful whether the point of view here presented, which would compel greater disclosure by physicians, will find favor among the members of the medical profession. Yet the arguments presented here are the inevitable conclusion of a reading of the Cardozo maxim¹¹⁰ in light of modern social trends. With increasingly widespread higher education the presence of more than one physician in most communities and a decline in the *in loco parentis* deference to professionals, individuals are less willing to allow decisions to be made by others which are of central concern to their own lives.

The medical profession stands to benefit from more clearly established requirements of disclosure which shift the burden of decision-making to the patient. In defense of less rigid requirements of disclosure by the physician, one commentator observed that “a surgeon cannot operate if one hand holds *Gray's Anatomy* and the other hand holds *Corpus Juris*.”¹¹¹ The practice of leaving broad discretion with the physician in determining what to disclose can only increase the need to clutch on to *Corpus Juris*. The multiple judgment involving first whether the patient is sufficiently psychologically prepared, and second what abridgement of disclosure is warranted by the patient's state of mind presents a difficult medico-legal decision. A full disclosure of material risks along with the involvement of the patient's family and at least one other physician can only help relieve the burden of legal worries from an already overburdened physician.

¹¹⁰ See the text accompanying note 1 *supra*.

¹¹¹ Levin, *supra* note 14, at 720.