

MARSINGILL *v.* O'MALLEY: THE DUTY TO DISCLOSE BECOMES THE DUTY TO DIVINE

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ABSTRACT

In Marsingill v. O'Malley, the Alaska Supreme Court held that the physician's duty to disclose extends to situations in which a physician has not had an opportunity to examine a patient. This Comment argues that extending the physician's duty to disclose in this way places an unreasonable burden on physicians and that the Alaska Supreme Court was not justified in imposing this duty under the Marsingill facts. Further, the supreme court's rationale for choosing the reasonable patient standard over the reasonably prudent physician standard may be outdated. The reasonable patient standard is based on a fallacy of medical paternalism, is tainted by hindsight bias, and causes physicians to respond negatively in a manner that harms patients. Without legislative intervention, physicians will be forced to inconvenience patients or assume an unreasonable risk.

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INTRODUCTION

Consider the following legal practice scenario: One evening after work, you get a call from a client concerning a document she has just received regarding a matter for which you provided legal service. She provides little detail about the contents of the document, and she asks your advice. You point out the obvious: you cannot give her advice without having an opportunity to evaluate the document and you ask to see it. Your client apologizes for the late call and says she'll take a look at it again and get back to you but only if she thinks it needs your attention.

The next you hear from your client is when you are served with a complaint alleging that you have committed professional malpractice by failing to provide her with enough information to make an intelligent decision regarding her need for legal advice.

Now consider this lawyer-client hypothetical in the context of the physician-patient relationship. After *Marsingill v. O'Malley*,¹ a physician has a duty to disclose the material facts for her patient's decision about whether to seek professional services regardless of the physician's opportunity to evaluate the patient.² If the patient makes known to the physician that she has decided not to seek the physician's services, the

1. *Marsingill v. O'Malley (Marsingill II)*, 128 P.3d 151 (Alaska 2006); *Marsingill v. O'Malley (Marsingill I)*, 58 P.3d 495 (Alaska 2002). *Marsingill* was twice appealed to the Alaska Supreme Court. See discussion *infra* Part II.B.2.

2. See *Marsingill II*, 128 P.3d at 162.

physician has a duty to disclose the potential consequences of that decision. It is for the trier of fact to determine whether the physician provided sufficient information for the patient to make an informed decision about her need to seek the physician's services.³

Applying the duties of physicians in their relationships with patients after *Marsingill* to those of the lawyer in our hypothetical would require the lawyer to speculate about the contents of the unseen document, provide legal advice to the client without knowledge of its contents, and advise her of the consequences should the client fail to seek further counsel on the matter. Whether our lawyer provided sufficient information including material risks for an informed client decision will be for the trier of fact to determine.⁴

This Comment considers the doctrine of informed consent and more specifically the duty to disclose as it applies to physicians' care in Alaska following *Marsingill v. O'Malley*. Part I discusses the duty to disclose and informed consent law in Alaska prior to *Marsingill*. Part II begins with an explanation of the process by which physicians conduct patient evaluations. The balance of Part II discusses the procedural history of *Marsingill* and considers the *Marsingill* court's discussion of the duty to disclose and the standard to be used by a jury in assessing the adequacy of a physician's disclosure. Part III first considers the Alaska Supreme Court's discussion of the factors governing the duty to disclose and its selection of the "reasonable patient" standard. Part III then explores physician responses to the decision in *Marsingill I* and the implication of those responses for patient care. Part IV briefly discusses post-*Marsingill* case law and concludes with some final thoughts on this unique case.

I. THE DUTY TO DISCLOSE AND INFORMED CONSENT IN ALASKA PRE-MARSINGILL

The central case in modern informed consent jurisprudence is *Canterbury v. Spence*.⁵ In *Canterbury*, the surgeon characterized a scheduled spine operation to the patient's mother as "no more serious than any other operation" and failed to reveal that there was a 1% risk of

3. *Id.*

4. *Marsingill I*, 58 P.3d at 503 (quoting *Korman v. Mallin*, 858 P.2d 1145, 1149 (Alaska 1993)) (holding that material risks are risks that a physician knows or should know a reasonable person would likely consider significant to her decision).

5. 464 F.2d 772 (D.C. Cir. 1972).

paralysis attendant with the procedure.⁶ The patient developed paralysis and eventually filed suit.⁷ The *Canterbury* decision established the framework for Alaska's subsequent jurisprudence and stands for five propositions.

First, the fundamental right that every mentally competent adult patient decides the course of her own medical treatment requires physicians to obtain the patient's informed consent prior to performing treatments or procedures that have risks a patient would consider in deciding whether to undergo the treatment or procedure.⁸ Second, the scope of disclosure is shaped by the patient's material informational needs to make an informed decision, not medical custom.⁹ Third, the content of the disclosure is determined by what the physician knows or should know to be the informational needs of an ordinary, reasonable person in the patient's position.¹⁰ Fourth, there is no need to disclose risks which are already known to the patient such as the inherent risk of infection complicating surgery, risks of which persons of average sophistication are aware, or risks which are immaterial to the decision of whether to undergo the treatment.¹¹ Fifth, in failure to disclose cases, causality is determined objectively based on what an ordinarily prudent person in the patient's position would have decided if properly informed of all significant risks that are known or should be known by her physician.¹²

The Alaska Supreme Court first considered informed consent in the 1975 case *Poulin v. Zartman*.¹³ In *Poulin*, the discussion focused on the

6. *Id.* at 776-79. The patient was never advised of the risk and his mother actually signed the consent after surgery. The surgeon justified his non-disclosure to the patient maintaining that revealing the risk might deter his patient from undergoing needed surgery and that disclosure might produce adverse psychological reactions which could preclude the success of the operation. *Id.*

7. *Id.* at 778.

8. *Id.* at 780-83.

9. *Id.* at 786.

10. *Id.* at 787.

11. *Id.* at 788. Two additional exceptions to the rule of disclosure are the "emergency exception," where the harm from failure to treat is imminent and the patient is unable to give consent because of unconsciousness or incapacity, no relative is available to give consent, and the harm posed by no treatment outweighs any harm posed by the treatment, and the "therapeutic exception," where disclosure poses such harm to the physical or mental well-being of the patient that it may foreclose a rational decision, complicate or hinder treatment, or cause psychological damage to the patient. *Id.* at 788-89.

12. *Id.* at 791.

13. 542 P.2d 251, 275 (Alaska 1975) (overruled on other grounds by *State v. Alex*, 646 P.2d 203 (Alaska 1982)). In one earlier case, *Patrick v. Sedwick*, 391 P.2d 453, 458 (Alaska 1964), the supreme court limited its analysis of informed

Canterbury principle: there must be a demonstrated causal link between the breach of the duty to disclose and the patient's treatment choice in order to recover for "lack of informed consent."¹⁴

In *Poulin*, the plaintiff's daughter was born premature and required the administration of high oxygen concentrations.¹⁵ The child survived but was disabled and blinded by a condition called retrolental fibroplasia (RLF).¹⁶ Poulin alleged, *inter alia*, a breach of the duty to disclose the availability of an alternative method of oxygen therapy for treatment of his child's respiratory distress that would have lowered her risk of sustaining RLF.¹⁷ Omission of this disclosure was material because the alternative method of administration reportedly reduced the risk of RLF.¹⁸

The supreme court did not reach the "difficult and complex" question of the scope of disclosure because the record failed to document that, had Poulin known about the alternative, he would have declined the oxygen administration employed by Dr. Zartman.¹⁹ Therefore, no causal link between the failure to disclose and the treatment chosen was established.²⁰

The next year, the Alaska Legislature codified portions of the common law doctrine of informed consent in section 09.55.556 of the Alaska Statutes.²¹ The statute established three requirements. First, to avoid liability, a health care provider must disclose the common risks and reasonable alternatives to proposed treatments or procedures.²² Second, a claimant has to prove by a preponderance of the evidence that the provider failed to make the required disclosure and, but for the failure to disclose, the claimant would not have consented to the

consent to what risks the physician must disclose and concluded that "good law" stood for the proposition that a physician need not detail all of the hazards of an operation and that physicians retain discretion to tailor the revealed details to avoid "unnecessary anxiety and apprehension" on the part of the patient.

14. *See Patrick*, 391 P.2d at 458 (holding that plaintiff must establish that, but for the physician's failure to disclose, the patient would have chosen the undisclosed treatment or course of care over the course of care that was chosen).

15. *Poulin*, 542 P.2d at 256.

16. *Id.* RLF is an eye condition that causes blindness. One cause of RLF is administration of high concentrations of oxygen to newborns. *Id.*

17. *Id.* at 255-58.

18. *Id.* at 275. The alternative method is called "titration." *Id.*

19. *Id.*; *cf. Patrick*, 391 P.2d at 458 (finding no causal link between physician's failure to disclose risks of procedure and patient's decision to undergo procedure).

20. *Poulin*, 542 P.2d at 275.

21. ALASKA STAT. § 09.55.556 (2006).

22. ALASKA STAT. § 09.55.556(a) (2006).

proposed treatment or procedure.²³ Third, the statute spells out certain available defenses to the failure to obtain informed consent: (1) the risk not disclosed is too commonly known or too remote to require disclosure, (2) the patient stated to the provider that regardless of the risk of the proposed treatment or procedure, she would undergo it and did not want to be informed, (3) consent by or on behalf of the patient was impossible, and (4) the therapeutic exception, where the health care provider reasonably believed that full disclosure would have a substantially adverse effect on the patient's condition.²⁴ Notably absent is any delineation of the standard by which the adequacy of disclosure will be measured.

In the 1993 case *Korman v. Mallin*,²⁵ the Alaska Supreme Court took on the issue it side-stepped in *Poulin*: the scope of disclosure required by the doctrine of informed consent.²⁶ In *Korman*, the plaintiff alleged medical negligence and lack of informed consent following a reduction mammoplasty procedure²⁷ which resulted in "broad, wide, and painful" scars.²⁸ Reversing the trial court's grant of summary judgment for Dr. Mallin, the Alaska Supreme Court remanded for trial, noting the absence of a statutory standard to judge the adequacy of disclosure and adopting what it called the "modern view": the reasonable patient standard espoused by *Canterbury* and other state courts.²⁹ In explaining its holding, the Alaska Supreme Court relied on its understanding of the physician-patient relationship: "The physician-patient relationship is one of trust. . . . A physician therefore undertakes, not only to treat a patient physically, but also to respond fully to a patient's inquiry about his treatment, i.e., to tell the patient everything that a reasonable person would want to know about the treatment."³⁰

Under the reasonable patient standard, the physician must disclose risks which are material to a reasonable patient's decision regarding treatment.³¹ The court described the two-step process of determining

23. *Id.*

24. ALASKA STAT. §§ 09.55.556(b)1-4 (2006).

25. 858 P.2d 1145 (Alaska 1993).

26. *Id.* at 1146.

27. Reduction mammoplasty is a surgical procedure in which the size of large breasts is reduced by excision of the excess tissue.

28. *Korman*, 858 P.2d at 1148.

29. *Id.* at 1148-49, 1151; *see also* *Hondroulis v. Schuhmaker*, 553 So.2d 398, 412 (La. 1988).

30. *Korman*, 858 P.2d at 1149 (quoting *Pedersen v. Zielski*, 822 P.2d 903, 909 (Alaska 1991)).

31. *Id.* (citing *Hondroulis*, 553 So.2d at 411); *see also* *Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir. 1972).

materiality under the reasonable patient standard.³² First, some expert testimony is necessary because only a qualified expert can judge what risks exist and the probability of their occurrence.³³ Second, the trier of fact must decide whether the probability of that harm occurring is a risk which a reasonable person would contemplate when deciding on treatment.³⁴ Expert testimony is not required for the second step of the process.³⁵

The *Korman* court discussed situations when a physician did not have to disclose the harm under the circumstances outlined in *Canterbury*.³⁶ The court described the right to exclude risks that are so obvious as to “justify presumption of such knowledge.”³⁷ Although the *Korman* court determined that Dr. Mallin satisfied his obligation to disclose inherent risks in the procedure, the supreme court decided that summary judgment was improvidently granted because the record was silent on whether the disclosure included the likelihood of painful, unsightly scarring or the increased risk of such scarring because *Korman* was a tobacco smoker.³⁸

In summary, *Korman* set the standard for breach of the duty to disclose as the reasonable patient standard described in *Canterbury*. The rationale for imposing this “modern view” is in part based on the principle of respect for personal autonomy. It is also founded on the fiduciary-like nature of the physician-patient relationship, where the patient’s reliance on the physician for health and treatment creates a duty to respond fully to a patient’s inquiries.³⁹

32. *Korman*, 858 P.2d at 1149.

33. *Id.* (citing *Hondroulis*, 553 So.2d at 412).

34. *Id.*

35. *Id.*

36. *Id.* at 1149–50 (citing *Canterbury*, 464 F.2d at 788–89).

37. *Korman*, 858 P.2d at 1150 (citing *Sard v. Hardy*, 379 A.2d 1014, 1022–23 (Md. 1977)).

38. *Id.* at 1147, 1150–51. *Korman* maintained that Dr. Mallin had not explained to her that her tobacco smoking would increase her risk of scarring. *Korman* admitted to reading in the surgery consent form that she signed that all complications of which she had been advised of verbally or in writing were increased by 50% because she smoked. *Id.*

39. See *Pedersen v. Zielski*, 822 P.2d 903, 909 (Alaska 1991).

II. UNRAVELING MARSINGILL

A. Medical Decision Making or Evaluation⁴⁰

A physician's typical approach to a patient begins with soliciting the patient's history and conducting a physical examination. The length of the history and the comprehensiveness of the physical examination vary depending upon the acuity, severity, and complexity of the patient's illness. At the conclusion of this initial process, a differential diagnosis is formulated. The differential diagnosis is a compilation, usually unwritten at this stage of an evaluation, of the disease entities that should be considered given the patient's history and the findings of the physical examination. Often, additional diagnostic procedures like laboratory tests and x-rays help narrow the differential diagnosis by eliminating some possibilities.

Treatment recommendations typically *follow* this evaluative process except where, by virtue of historical specificity, evaluation and diagnosis can be made based on history alone. However, when a patient's telephone call presents symptoms and signs that are non-specific or numerous and there is no opportunity to perform a physical examination, the physician will be unable to perform an adequate evaluation over the phone. Any response to inquiry about treatment recommendations at this point is speculative and most likely to be directed at symptomatic relief rather than definitive therapy.⁴¹ Further evaluation is necessary to develop a reasonable differential diagnosis. Although a condition's severity and frequency of occurrence play a role in prioritizing the differential diagnosis, it would be improper and hazardous to exclude possible diagnoses until continued evaluation justifies their exclusion.⁴²

In assessing a patient who has called for advice over the telephone, a physician may have nothing more than the patient's recitation of a few non-specific symptoms on which to base the initial evaluation. Speculation about various diagnoses is unlikely to be helpful to the

40. This section is based on the author's 35 years of clinical practice as a physician. The book *Medical Decision Making* utilizes a similar approach to medical decision making and evaluation. See HAL SOX ET AL., *MEDICAL DECISION MAKING* (1988).

41. One form of "treatment" at this stage might include aspirin for a high fever or for certain forms of pain.

42. A common pitfall for the inexperienced practitioner is to seize upon a diagnosis that seems most likely or most serious and halt the evaluative process at that point. As the evaluation progresses, considering additional history, doing a directed or specialized physical examination, or performing additional tests may be warranted. Evaluation is most often an ongoing process.

patient and may be misleading. All a physician can offer is information the patient already knows. Patients may be in the best position to decide based on their own personal experience what should be their next course of action.

B. Analysis of *Marsingill v. O'Malley*

1. *Facts.* In October 1994, Dr. James O'Malley performed surgery on Vicki Marsingill to remove staples placed in her stomach by another surgeon to facilitate weight loss.⁴³ By January 1995, Marsingill had recovered from her October surgery and was able to return to work.⁴⁴

During her evening meal on February 14, 1995, Marsingill suffered a sudden illness characterized by pain, nausea, and inability to eat.⁴⁵ Her pain worsened over several hours and eventually her daughter called Dr. O'Malley on the telephone.⁴⁶ Dr. O'Malley first spoke with Marsingill's daughter and then to Marsingill herself.⁴⁷ Marsingill and her daughter reported that Marsingill's symptoms included nausea, abdominal distention, pain, inability to burp or pass gas, and that her stomach was "hard as a rock."⁴⁸

Dr. O'Malley advised Marsingill that he was unable to evaluate her over the phone and "if she felt bad enough to call him at night" she should go to the emergency room (ER) for an evaluation.⁴⁹ Dr. O'Malley repeated several times that he could not evaluate her over the phone and offered to meet Marsingill at the ER to expedite her admission.⁵⁰ When asked what would happen at the ER, Dr. O'Malley informed Marsingill that the evaluation would include x-rays and *probably* placement of a nasogastric tube, a device inserted through the nose and used to evacuate stomach contents.⁵¹ Dr. O'Malley knew that Marsingill, based on her experience, strongly disliked these tubes.⁵²

After several minutes of conversation, Marsingill told Dr. O'Malley she was feeling better and, after hanging up the phone, told her

43. *Marsingill I*, 58 P.3d 495, 497 (Alaska 2002).

44. *Id.*

45. *Id.*

46. Appellee's Brief at 3, *Marsingill II*, 128 P.3d 151 (Alaska 2006) (No. 3AN-95-9909 CI).

47. *Marsingill I*, 58 P.3d at 497.

48. *Id.*

49. *Id.*

50. *Id.*; Appellee's Brief, *supra* note 46, at 6-7 (testimony of Dr. O'Malley and Elizabeth Belgarde, who overheard O'Malley's half of the conversation).

51. *Marsingill I*, 58 P.3d at 497.

52. *Id.* at 497-98.

daughter she would “tough it out for awhile.”⁵³ Dr. O’Malley’s undisputed testimony was that he again told her that “he believed she should go to the ER and in any case, if symptoms worsened, she should call him again or directly proceed to the ER.”⁵⁴ Marsingill’s daughter left shortly thereafter, believing that Marsingill’s condition did not require her to stay.⁵⁵

Two to three hours later, Marsingill was found unconscious on the floor in respiratory distress. Paramedics took Marsingill to the hospital where surgery revealed the presence of an intestinal volvulus⁵⁶ causing intestinal obstruction and vascular compromise of the bowel.⁵⁷ During the night Marsingill suffered a neurological event that left her with brain damage characterized by memory loss and partial paralysis.⁵⁸

2. *Procedural History.* Marsingill filed suit against Dr. O’Malley asserting four claims, including breach of informed consent: Marsingill alleged that Dr. O’Malley gave her insufficient information during their phone conversation to allow her to make an intelligent decision about whether to meet him at the ER for an evaluation. The jury found for Dr. O’Malley on each of the four claims. Marsingill appealed on the informed consent claim.⁵⁹ Marsingill maintained that the trial court applied the wrong standard for deciding whether Dr. O’Malley had given her adequate information to make an intelligent decision about going to the ER during their telephone conversation.

The Alaska Supreme Court agreed with Marsingill. The court held in *Marsingill I* that the jury should have been instructed to use the reasonable patient standard of care, not the trial court’s reasonable professional standard of care, to determine whether Dr. O’Malley had given Marsingill sufficient information during the phone call to make an intelligent decision about seeking further evaluation.⁶⁰ The court, in its analysis, declared that the duty to disclose extends not only to patients

53. *Id.* at 498.

54. Appellee’s Brief, *supra* note 46, at 6.

55. *Id.* at 5–6.

56. Volvulus is a rare condition in which the intestine abnormally rotates inside the abdominal cavity. It may cause obstruction of the bowel, cut off the blood supply to the bowel or both. J. E. SCHMIDT, ATTORNEYS’ DICTIONARY OF MEDICINE AND WORD FINDER V-103 (1992).

57. Appellee’s Brief, *supra* note 46, at 7.

58. *Id.*; see also Appellant’s Opening Brief at 2, *Marsingill II*, 128 P.3d 151 (Alaska 2006) (No. 3AN-95-9909 CI) (claiming that as the result of her brain damage, Marsingill has no memory of the phone call).

59. *Marsingill I*, 58 P.3d 495, 495 (Alaska 2002). Marsingill also appealed the claim that O’Malley lacked skill and knowledge in general surgery and as a consequence gave her incompetent advice. *Id.*

60. *Id.* at 505.

for whom treatment has been recommended but also to patients who are seeking treatment.⁶¹ The court considered Dr. O'Malley's recommendation that Marsingill meet him at the ER for an evaluation as a recommendation for treatment.⁶² The court apparently drew this conclusion because during the telephone conversation Dr. O'Malley speculated that a nasogastric tube, a device often employed to relieve symptoms of abdominal distention, would *probably* be inserted.⁶³

The trial court's judgment was vacated and "the case [was remanded] for a new trial on Marsingill's claim for breach of the duty to provide enough information to allow her to make an intelligent treatment choice."⁶⁴ The jury on retrial was to "be instructed to decide the claim from the standpoint of a reasonable patient."⁶⁵

At retrial, the jury again found for Dr. O'Malley. Marsingill again appealed claiming, *inter alia*, that the trial court's jury instruction describing the physician's duty as a duty to provide "material information" to enable a reasonable patient to make an informed and intelligent decision misstated the law by excluding the word "all" before "material."⁶⁶ Marsingill also appealed the admission of testimony by Dr. O'Malley's experts concerning the standard of care for disclosures on the grounds that "their views were not directly relevant to what a reasonable patient would want to know" and that such testimony was inadmissible because the physician expert witnesses were not experts on what a reasonable patient would want to know.⁶⁷

In *Marsingill II*, the Alaska Supreme Court rejected her contention that the word "all" before the word "material" was necessary to define the standard.⁶⁸ The court noted that the term "material information" was defined in the jury instructions as including any information that a reasonable patient would find significant.⁶⁹ Accordingly, the court stated that "[r]eading the instructions as a whole, then, it seems unlikely that a reasonable juror would have concluded that Dr. O'Malley met his duty

61. *Id.* at 504.

62. *Id.*

63. *Id.* at 497. A nasogastric tube is a soft, hollow tube introduced through the patient's nose and advanced to the stomach. It is frequently used diagnostically for x-ray contrast studies in the evaluation of abdominal pain and for the purpose of relieving distention of the intestinal tract.

64. *Id.* at 505.

65. *Id.*

66. *Marsingill II*, 128 P.3d 151, 155 (Alaska 2006).

67. *Id.*

68. *Id.* at 162.

69. *Id.*

to disclose 'material information' despite neglecting to disclose matters that Marsingill would have deemed to be significant."⁷⁰

The court also observed that under the negligence standard governing failure-to-disclose claims, physician expert testimony on the amount and kind of information that patients generally want was relevant to whether Dr. O'Malley gave Marsingill the information a reasonable patient would want to know and to show what a reasonable physician is likely to think a patient might want to know.⁷¹ The court vacated the judgment of the trial court and remanded on an issue unrelated to informed consent.⁷²

3. *Discussion of the Court's Analysis on Imposition of the Duty to Disclose and on the Relevant Standard to Apply.* The Alaska Supreme Court imposed a duty to disclose upon Dr. O'Malley based upon the American Medical Association's (AMA) Code of Medical Ethics (CME) Section 8.08, the ethical policy governing informed consent drafted by the AMA as a source of policy guidance for practicing physicians.⁷³ The court observed that because all of the experts and Dr. O'Malley accepted the premise that AMA CME Section 8.08 applied in Marsingill's case, a determination of whether Alaska's Informed Consent Statute⁷⁴ would have independently encompassed the duty to disclose was unnecessary.⁷⁵ Based on this analysis, however, the supreme court and Dr. O'Malley and his experts had different understandings of the meaning of Section 8.08.

The supreme court characterized the scope of disclosure mandated by AMA CME Section 8.08 as providing that "[t]he patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice."⁷⁶ But this is only the first

70. *Id.*

71. *Id.* at 159.

72. *Id.* at 164 (remanding for reconsideration of the amount of attorneys' fees awarded).

73. See COUNCIL ON ETHICS AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS § 8.08 (American Medical Association Press 2004) (1847). Although the Council on Ethical and Judicial Affairs has the authority to acquit, admonish, censure, or place on probation the accused physician or suspend her from AMA membership, unlike a state bar association, the AMA is not in a position to take action against a member's license to practice her profession. Only about one third of U.S. physicians hold membership in the AMA. Roger Bybee, *The Doctors' Revolt*, THE AMERICAN PROSPECT, July 1, 2008, http://www.prospect.org/cs/articles?article=the_doctors_revolt.

74. ALASKA STAT. § 09.55.556 (2006).

75. *Marsingill I*, 58 P.3d 495, 505 (Alaska 2002).

76. *Id.* at 499.

sentence of a multi-sentence paragraph, which continues in pertinent part:

The patient should make his or her own determination about treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.⁷⁷

When read as a whole, it is apparent the AMA⁷⁸ is discussing treatment and therapeutic situations, both of which, because of the diagnosis process discussed in Part II.A, logically follow an evaluation.

That AMA CME Section 8.08 can be read as covering the broader duty to disclose that the court imposed in *Marsingill I*, namely a duty to disclose *before* a physician has had an opportunity to perform an evaluation, is not evident on its face. Furthermore, nothing in the court's language satisfactorily explains why this should be the case. Although the court describes as "uncontradicted" the evidence that Dr. O'Malley told Marsingill to go to the ER for treatment, the statement of the facts indicates Dr. O'Malley urged her to go for an evaluation.⁷⁹ The court apparently fails to distinguish between a recommendation for evaluation and one for treatment.

Finally, perhaps recognizing that AMA CME Section 8.08 is intended to apply to treatment recommendations, the court mischaracterizes Dr. O'Malley's recommendation for an evaluation at the ER as the equivalent of a treatment recommendation to do nothing in the face of threatening symptoms.⁸⁰ Using the duty to disclose as a framework, the court considers Dr. O'Malley's acquiescence to Marsingill's decision not to seek evaluation as the equivalent of a treatment recommendation.⁸¹ Ultimately, however, physicians must always acquiesce to patients' decisions about treatment and evaluation

77. See AMA CODE OF MEDICAL ETHICS, *supra* note 73.

78. See also *Marsingill I*, 58 P.3d at 504 (Dr. O'Malley's understanding is the same as the AMA's, that the "factual predicate for the . . . duty to disclose, i.e., a recommended treatment or procedure, is totally absent.").

79. See *id.* at 497.

80. See *id.*

81. *Id.* at 504.

or risk doing violence to patient autonomy, protected throughout informed consent jurisprudence.⁸²

With respect to what standard should apply, the court decided that the issues of concern in *Marsingill* were “precisely” the issues that *Korman* describes as within the fact-finding powers that the reasonable patient standard leaves to lay jurors.⁸³ On remand, the reasonable patient standard governed the breach of duty to disclose claim.⁸⁴

Based on *Korman*, the duty to disclose should be governed by the reasonable patient standard in the context of recommendations for treatment. Since the court found that under the *Marsingill I* facts, Dr. O’Malley’s recommendation to seek an evaluation at the ER was really a recommendation for treatment, the reasonable patient standard should apply. Had the court more reasonably found Dr. O’Malley’s recommendation to seek evaluation not a “treatment recommendation,” it is unknown whether *Korman* would have been sufficient foundation for the court to invoke the duty to disclose.⁸⁵ The court instead chose a new source of law for the duty to disclose, AMA Section 8.08, and declared the reasonable patient standard from Alaska common law correct.⁸⁶

Although courts recently have been reluctant to allow the medical profession to set the standard for disclosure out of fear that professional protectionism or paternalism would govern the disclosure, there is reason to believe that the reasonably prudent physician standard would result in the degree of disclosure the courts have contemplated since *Canterbury*.

III. CRITIQUE OF *MARSINGILL I*

There are two aspects of note to the court’s analysis in *Marsingill I*: (1) the factors a court should consider in resolving the competing

82. See *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914) (finding physician civilly liable for performing a surgery where the patient had consented to an exam under ether anesthesia but testified that she had notified her physician, a hospital employee, that there was to be no operation); see also *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

83. *Marsingill I*, 58 P.3d at 505.

84. *Id.*

85. *Korman v. Mallin*, 858 P.2d 1145, 1146 (Alaska 1993); see also *Pedersen v. Zielski*, 822 P.2d 903, 909 (Alaska 1991) (holding that physician had a duty to disclose the fact that procedures used during patient’s operation were a cause of patient’s paralysis). *Pedersen*, however, addressed a physician’s comments regarding an adverse outcome from surgery rather than disclosure in a pre-treatment scenario. *Id.*

86. *Marsingill I*, 58 P.3d at 505.

interests relevant to the duty to disclose, and (2) courts' preferences for the reasonable patient standard in this setting.

Few would disagree that our courts have an obligation to refine and develop the common law. Changes in the common law should be the result of thorough and careful analysis, thoughtfully revealed in the court's opinion. The court should not confine its discussion to ideas that only support its eventual conclusion. The integrity of the courts is bolstered when the issues have been thoroughly evaluated and discussed.

A. The *Marsingill* Court Was Unjustified in Imposing a Duty to Disclose Under the Facts of the Case

In *Korman*, the Alaska Supreme Court relied primarily on the rationales expressed in *Hondroulis* and *Canterbury*.⁸⁷ The reason for imposing the duty accepted by the Alaska Supreme Court is that the patient has a right to determine what is done to her body, and this right can only be properly exercised when the patient is informed and in a position to make an intelligent decision.⁸⁸ Further, because patients rely nearly exclusively on their physicians for information, it is necessary to impose the duty to disclose to ensure the patient receives the information she needs to make her decision.⁸⁹ Implicit, but necessary to the imposition of the duty under this rationale, is the assumption that the physician can advise the patient of the relevant information necessary to make an intelligent decision.

Under the facts of *Marsingill*, Dr. O'Malley was not in a position to exercise his judgment for the benefit of his patient because he had not had an opportunity to evaluate Marsingill. After a physician has had an opportunity to evaluate her patient, the particularized information disparity between the usual patient and her physician is realized and warrants the imposition of the duty to disclose. In *Canterbury*, Dr. Spence had evaluated Canterbury's condition and was prepared to render a recommendation of proposed treatment.⁹⁰ Similarly, in *Hondroulis*, the operating surgeon had an opportunity to evaluate his patient's condition prior to advising surgery.⁹¹ This was not so in

87. See *Korman*, 858 P.2d at 1149 (quoting *Hondroulis v. Schuhmaker*, 553 So.2d 398, 414-15 (La. 1988)).

88. *Id.*

89. *Id.*

90. *Canterbury v. Spence*, 464 F.2d 772, 776-77 (D.C. Cir. 1972).

91. See also *Truman v. Thomas*, 611 P.2d 902 (Cal. 1980) (imposing upon physicians the duty to advise patients of the consequences of declining a

Marsingill. Dr. O'Malley was not speaking from the position of a physician who had an opportunity to evaluate the patient and advise any treatment. The *Marsingill* court failed to recognize or consider this important distinction between *Marsingill* and the cases it relied upon.

A second difference is the increased availability of health information for patients from sources other than their physicians. Physicians are no longer patients' exclusive source of information, which was true at the time of *Canterbury*, *Hondroulis*, and *Pedersen*. As of 2006, approximately 113 million adults have searched for health information and half of those indicated the information they received influenced their health care.⁹² The search engine Google is itself capable of *diagnosing* a number of diseases with accurate data input.⁹³ The time when physicians were the sole source of health information has passed. While physicians usually know more about disease and treatment than patients, until the opportunity to evaluate a patient has been afforded, the particularized disclosure necessary to provide the meaningful information *Canterbury* contemplates cannot be delivered. Only when the physician possesses specific, meaningful information that the patient needs to make an intelligent decision does the rationale of *Canterbury* make sense.

B. The Justification for Choosing the "Reasonable Patient" Over One of the Professional Standards May No Longer Be Valid

1. *Medical Paternalism*. In *Korman*, the Alaska Supreme Court rejected professional standards for whether the physician had met his duty to disclose enough information for a patient to make an informed decision.⁹⁴ Preferring the "modern trend" of case law, the *Korman* court adopted the reasonable patient standard proposed by *Canterbury* and

recommended procedure, where the physician had an opportunity to evaluate the patient).

92. See Susannah Fox, *Online Health Search 2006* (Pew Internet & Am. Life Project, Washington, D.C.), October 29, 2006, at i-iii, available at http://www.pewinternet.org/pdfs/PIP_Online_Health_2006.pdf (last visited May 8, 2007). The 2006 report reveals that 80% of American adult internet users have searched for information on at least one of seventeen health topics; every day, eight million users search health topics; and approximately one half of respondents' most recent health search sessions had some impact on how they care for themselves or others. *Id.*

93. Hangwi Tang and Jennifer Ng, *Googling for a Diagnosis – Use of Google As a Diagnostic Aid: Internet Based Study*, 333 BRIT. MED. J. 1143, 1143-45 (2006), available at <http://www.bmj.com/cgi/content/full/333/7579/1143> (last visited May 10, 2007).

94. *Korman v. Mallin*, 858 P.2d 1145, 1149 (Alaska 1993).

articulated by *Hondroulis*.⁹⁵ The court was concerned that both professional standards (those of medical custom and the reasonably prudent physician) arrogate the judgment of adequate disclosure to physicians and fail to adequately protect the patient's interests.⁹⁶

One origin of the concern that physicians might choose not to disclose or to disclose inadequately is medical paternalism, identifiable within the profession dating to the time of Hippocrates. Hippocrates recommended "conceal[ing] most things from the patient while you are attending to him . . . reveal[ing] nothing of the patient's future or present condition."⁹⁷ Hippocrates believed that a physician's primary concern was the patient's well-being and that the patient's well-being was threatened by the delivery of bad news.⁹⁸ Paternalistic behavior was appropriate if it contributed to patient well-being. Although the rationale of *Canterbury* is strongly anti-paternalistic, even *Canterbury* permits an exception to disclosure where "risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view."⁹⁹

Interestingly, there is empirical evidence that paternalism within the medical profession was rapidly waning before the decision in *Canterbury* in 1972. For example, the *Hondroulis* court cited a 1968 surgical text that stated, "[a] physician's standards require him to inform the patient of 'everything pertinent both to his condition and to the probable course of his treatment which he is capable of understanding intellectually and able to accept emotionally . . .'"¹⁰⁰ There were other indicia that physicians were embracing the concept that patients should be informed fully about their health and care before the decision in *Canterbury*. A 1961 survey revealed the paternalistic position that 90% of physicians preferred not to tell cancer patients their diagnoses; by 1976, 97% of physicians surveyed preferred to disclose a diagnosis of cancer.¹⁰¹ This complete transformation in physicians' attitude towards

95. *Id.* (citing *Hondroulis v. Schuhmacher*, 553 So.2d 398, 411 (La. 1989); *Canterbury v. Spence*, 464 F.2d at 786-87.

96. *Id.*

97. Hippocrates, DECORUM 297 (W. Jones trans., Harvard University Press 1967).

98. *Id.*

99. *Canterbury*, 464 F.2d at 789.

100. *Hondroulis*, 553 So.2d at 416 (quoting Laufman, *Surgical Judgment*, in CHRISTOPHER'S TEXTBOOK OF SURGERY 1459, 1461 (9th ed., L. Davis 1968).

101. Christine Laine & Frank Davidoff, *Patient-Centered Medicine: A Professional Evolution*, 275 JAMA 152, 152-153 (1996).

disclosure took place in about the same time that it took courts to hear *Canterbury* and issue an opinion in the case.¹⁰²

The reality is that courts may be unsuited to addressing policy problems in a rapidly changing profession like medicine because of the length of time it takes to resolve cases. Crafting legal measures to combat paternalism when it is already a breach of the standard of care to fail to disclose is a belt and suspender approach where such redundancy is unnecessary. At worst, such behavior on the part of courts risks unconsidered and unintended consequences.

2. *The Objective Reasonable Patient Standard Is Tainted by Irremediable Hindsight Bias.* Hindsight bias is the inclination to see events that have occurred as more predictable than they were before they took place; it has a high probability of affecting the outcome of qualitative jury decisions like those in duty to disclose cases.¹⁰³ The *Canterbury* court employed the objective, reasonable patient standard because it was in concert with the usual negligence doctrine and, the court reasoned, the liability for failure to disclose should be in foresight, not hindsight.¹⁰⁴ However, no case explains how a jury is to fairly decide and combat its unavoidable hindsight bias about what a reasonable patient at the time of the disclosure would have wanted to know, given that an adverse outcome is known and an unrevealed risk has come to pass. Although various solutions for combating hindsight bias have been proposed, none has proved successful. In fact, once a person is put into the position of vulnerability to hindsight bias, no effective remedial response has been found.¹⁰⁵

3. *Negative Behavioral Responses to Imposing the Duty to Disclose Based on the Facts of Marsingill I.* There are several possible behavioral responses of physicians to the rule of *Marsingill I* on the duty to disclose. First, some physicians will, as the court decision requires, speculate on a

102. See *Canterbury*, 464 F.2d at 777. More than 13 years elapsed between *Canterbury*'s surgery and Judge Robinson's decision in the case. *Id.*

103. See Gregory N. Mandel, *Patently Non-Obovious: Empirical Demonstration That the Hindsight Bias Renders Patient Decisions Irrational*, 67 OHIO ST. L.J. 1391, 1403 (2006) (citing Jay J.J. Christensen-Szalanski and Cynthia Fobian Wilham, *The Hindsight Bias: A Meta-Analysis*, 48 ORGANIZATIONAL BEHAV. & HUM. DECISION PROCESSES 147, 150-51 (1991) (giving a meta-analysis of over 120 hindsight bias studies)).

104. *Canterbury*, 464 F.2d at 787.

105. See Mandel, *supra* note 103, at 1402-03 (citing David A. Schkade & Lynda M. Kilbourne, *Expectation-Outcome Consistency and Hindsight Bias*, 49 ORGANIZATIONAL BEHAV. & HUM. DECISION PROCESSES 105, 108 (1991) (noting that once an outcome is known it becomes difficult to accurately reconstruct a previous state of mind)).

diagnosis based on the information provided by the patient regardless of its adequacy. This will likely be confusing and perhaps even misleading to patients. For example, the symptoms reported by Vicki Marsingill—abdominal pain and distention, nausea, and inability to burp or defecate—are not exclusive to intestinal obstruction. The Internet health information site WebMD Symptom Checker identifies at least 20 other conditions, both minor and serious, that share those symptoms and that a physician would have to consider and reveal if material to the patient's decision about what to do.¹⁰⁶ Dr. O'Malley himself, as well as at least one of his experts, posed several additional conditions as relevant diagnostic considerations.¹⁰⁷

Considering the number of potentially material facts to reveal, it is likely that physicians could only give speculative, summary advice such as "it could be very serious, it might be relatively trivial, and because I can't tell over the telephone, you should come in for an evaluation." How an answer like this is an improvement over the advice that was given, with respect to patient autonomy, the court leaves unexplained. The material information the patient needs is that an evaluation is necessary; exactly what Dr. O'Malley told Marsingill. The fact that two civil juries found for Dr. O'Malley—under the reasonably prudent physician standard in the first trial¹⁰⁸ and under the reasonable patient standard in the second trial¹⁰⁹—supports the conclusion that telling the patient she needed an evaluation was sufficient material information.

Undoubtedly, some physicians will continue to respond as Dr. O'Malley did: they will candidly relay that they are not in a position to draw diagnostic conclusions and suggest an evaluation. Although the juries in *Marsingill* found for Dr. O'Malley on the duty to disclose, there

106. Web MD, Symptom Checker, <http://symptoms.webmd.com/symptom-checker> (last visited May 7, 2007). Vicki Marsingill's symptoms: abdominal pain and distention, nausea, and inability to burp or defecate were entered into the program "Symptom Checker" along with some additional factors from the case history. A 46 year-old female patient with Marsingill's symptoms could have, as revealed in order of appearance by Symptom Checker: constipation, gas pains, gastroenteritis, diverticulitis, intestinal ileus, irritable bowel syndrome, intestinal obstruction, general and post-surgical adhesions, endometriosis, muscle strain, food poisoning, gallstones, giardiasis, helicobacter pylori infection, narcotic abuse, polycystic kidney disease, porphyria, indigestion, Budd-Chiari syndrome, and panic attack. Additional past medical history not presented in the court record may have allowed exclusion of some of these diagnostic considerations.

107. Appellee's Brief, *supra* note 46, at 14; *see also Marsingill I*, 58 P.3d 495, 499 (Alaska 2002). Other considerations included pancreatitis, acute ulcer, and slipped Nissen-fundoplication. *Id.*

108. *Marsingill I*, 58 P.3d at 497, 505.

109. *Marsingill II*, 128 P.3d 151, 155 (Alaska 2006).

is no assurance that other juries will do so under similar facts. Speculatively, the *Marsingill* juries recognized that physicians must have an opportunity to evaluate a patient prior to providing medical care, that the general risks and benefits of obtaining or refusing medical care or evaluation are well within the realm of the common knowledge of a reasonable patient. The jury presumably also recognized that those general risks and benefits required no disclosure beyond stating the obvious: "Without an opportunity to evaluate, I can't recommend a course of treatment." Since there is no assurance that all juries will respond as the *Marsingill* juries did in finding for Dr. O'Malley, these physicians are simply assuming the added liability the court has imposed.

Finally, other physicians have not been so sanguine in their response to *Marsingill*. After the decision in *Marsingill I*, considerable concern within the medical community prompted a change in physicians' practices.¹¹⁰ Some physicians simply declined to answer their patients' calls after hours, typically by having a phone message or answering service directing patients to go to the ER where an evaluation by the ER physician would precede any contact with the patient's primary physician.¹¹¹ The consequences of this change include substantial patient inconvenience, a general increase in the cost of care as a result of ER evaluation, and depersonalization of the delivery of health care. Where a rule imposes inconvenience and expense on all patients in an attempt to preserve an additional claim for an occasional patient, the rule becomes controversial. This is particularly so when there is already a mechanism in place, namely the negligence action that views the duty to disclose under an ordinarily prudent physician standard. When the professional standard to provide full disclosure to patients about their diseases, prognosis, and prospective treatments, affords a cause of action, imposing a more expensive theoretical rationale questioned by empirical studies is problematic and unjustified.

110. Tanya Albert, *Alaska Physician Wins Case on Ignored Medical Advice*, AM. MED. NEWS, June 7, 2004, available at <http://www.ama-assn.org/amednews/2004/06/07/gvsc0607.htm> (last visited May 18, 2007) (discussing results of the second trial in *Marsingill* and the effect of extension of the duty to disclose on a physician's call-taking and ER referrals); Telephone Interview with James Jordan, Executive Director, Alaska State Medical Association (May 18, 2007) [hereinafter Jordan Interview]; Telephone Interview with Howard Lazar, Defense Counsel for Dr. O'Malley (May 19, 2007) [hereinafter Lazar Interview].

111. Albert, *supra* note 110; Jordan Interview, *supra* note 110; Lazar Interview, *supra* note 110.

IV. INFORMED CONSENT IN ALASKA POST-MARSINGILL

Only two cases have cited *Marsingill* about informed consent.¹¹² In *Roukounakis v. Messer*,¹¹³ a case addressing whether an informed consent claim properly accompanies a failure to diagnose claim, the Court of Appeals of Massachusetts cites *Marsingill* as the only court, to date, to hold that the duty to disclose a condition may arise prior to a physician's awareness of the diagnosis.¹¹⁴

In the second, *Harrold v. Artwohl*,¹¹⁵ the Alaska Supreme Court reversed a trial court grant of summary judgment for the defendant, Dr. Artwohl, on an informed consent claim because there were issues of material fact not considered by the trial court in granting summary judgment.¹¹⁶ The court merely reiterated the holding of *Korman* that adequacy of disclosure was to be judged under the reasonable patient standard.¹¹⁷

With the support of the Alaska State Medical Association, Dr. O'Malley sought without success in 2004 to change section 09.50.556 of the Alaska Statutes to specifically "clarify the law of informed consent in medical malpractice cases" and "modify" the common law decisions of *Korman* and *Marsingill*.¹¹⁸

112. A third case cited *Marsingill I* for an issue unrelated to informed consent. *Marron v. Stromstad*, 123 P.3d 992, 1012 n.97 (Alaska 2005) (discussing the closing argument of the defense attorney in *Marsingill I* about defendant's ability to pay a judgment if one were rendered in favor of the plaintiff).

113. 826 N.E.2d 777 (Mass. App. Ct. 2005).

114. *Id.* at 781 (citing *Backlund v. Univ. of Wash.*, 975 P.2d 950, 956 n.2 (Wash. 1999) (recognizing that under Washington's informed consent statute, section 7.70.050 of the Revised Code of Washington, a physician should not be additionally liable for a condition "unknown" to him); see also *Bays v. St. Lukes Hospital*, 825 P.2d 319, 322 (Wash Ct. App. 1992) (holding that duty to disclose does not arise until the physician becomes aware of the condition by diagnosing it)).

115. 132 P.3d 276 (Alaska 2006).

116. *Harrold v. Artwohl*, 132 P.3d at 277.

117. *Id.*

118. See H.B. 0472, 23d Leg., 2d Sess. (Alaska 2004), available at http://www.legis.state.ak.us/cgi-bin/folioisa.dll/me23/query=*/doc/%7Bt2069%7D? (last visited May 18, 2007). The primary changes proposed sought to excuse from liability any practitioner who by telephone or other electronic communication gave advice that the patient seek further care at a health care facility and the patient elected not to follow that advice, and to reinstate a professional standard for determining the scope of disclosure. See *id.* In the next session the Alaska State Medical Association sought to concentrate its efforts on achieving other tort reform measures and the changes sought in H.B. 0472 were not reintroduced.

CONCLUSION

Other courts to date have declined to venture where the Alaska Supreme Court chose to go in its extension of the duty to disclose in *Marsingill*. Whether courts in states with similar statutory schemes and common law jurisprudence will identify AMA Section 8.08 as a source of law and the origin of a duty to disclose and see fit to impose the duty to disclose on physicians who have had no opportunity to exercise their professional expertise, remains open to speculation. Absent a legislative solution, physicians have only unsatisfactory choices. Turn off the phone, inconvenience your patients, and contribute to the rising cost of healthcare, or assume the risk and trust in the good sense of juries to understand what judges apparently cannot: that without an evaluation, a physician cannot divine all the material risks that a patient needs to know.