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## Two Kinds of Statistics, the Kind You Look Up and the Kind You Make Up: A Critical Analysis of Comparative Provider Statistics and the Doctrine of Informed Consent

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# Two Kinds of Statistics, the Kind You Look Up and the Kind You Make Up: A Critical Analysis of Comparative Provider Statistics and the Doctrine of Informed Consent

## I. INTRODUCTION

Internet technology affords unprecedented accessibility to information previously too difficult or impossible to obtain.<sup>2</sup> This “technological tsunami” has washed over the medical field by allowing both private and public agencies to compile and manage comparative provider statistics.<sup>3</sup> This comment introduces the question of whether the enhancement of technology indeed benefits a patient in providing his/her true informed consent.<sup>4</sup> At least one court has already held that access to these comparative provider statistics can be material in making up a patient’s mind regarding going forward with a particular procedure or using a particular provider.<sup>5</sup> For example, in 1996, the Wisconsin Supreme Court found a doctor liable under the state’s informed consent laws because he failed to inform a patient about a competing physician’s practice nearby.<sup>6</sup> Although there has not as yet been a stampede through the courts, it is just a matter of time before the rest of the country eventually follows suit with Wisconsin and broadens the doctrine of informed consent to include provisions of provider statistics.<sup>7</sup>

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1. Rex Stout, *American Writer* (1886-1975).

2. See generally Jean Hellwege, *Law of Informed Consent Poised for Revolution, Experts Say*, 36 TRIAL 128 (July 2000).

3. *Id.* at 128.

4. *Id.*

5. *Johnson v. Kokemoor*, 545 N.W.2d 495 (Wis. 1996).

6. *Id.* at 510 (discussing when the duty of sharing statistics is material to a patient’s decision, the next step would be for a doctor to refer the patient elsewhere).

7. Hellwege, *supra* note 2, at 129.

Section II of this comment provides a comprehensive historical background on the creation, growth, and purpose of informed consent.<sup>8</sup> Focusing on the principles supporting this doctrine, this section begins looking at the 1957 decision of *Salgo v. Leland Stanford Junior University Board of Trustees*,<sup>9</sup> and quickly moves through the following decades, specifically analyzing the first patient-based standard of informed consent decided in 1972.<sup>10</sup>

Part III undertakes a detailed analysis of the comparative provider statistics that may shape the future of medical practitioners' disclosure requirements under the law of informed consent.<sup>11</sup> These statistics and their assumed value will likely be used to further future legislative acts<sup>12</sup> and judicial decisions.<sup>13</sup> This section explores the multitude of variables that can make these statistics unwieldy and unreliable, as well as to what extent a medical provider would be expected to know, rely on, and inform patients based on these statistics.<sup>14</sup> Finally, this section attempts to determine when statistics become more burdensome than helpful to the patient, despite the goal of obtaining comprehensive and informed decision-making on the part of the patient.<sup>15</sup>

Part IV contemplates the effects of enforcing the use of comparative provider statistics in informed consent cases.<sup>16</sup> There are potentially grave consequences for surrounding legal issues in the medical field.<sup>17</sup> If the ultimate purpose of the doctrine is to give patients accurate information that is useful in aiding informed decision-making about his/her health care, comparative provider statistics must prove to be accurate, comprehensible and trustworthy before mandating their use in informed consent.<sup>18</sup> The analysis suggests that medical statistics will not support the spirit of informed consent.<sup>19</sup>

Finally, Part V sets forth a proposal for obtaining a healthy balance between doctor and patient autonomy, and concludes this comment.<sup>20</sup>

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8. See *infra* notes 21-112 and accompanying text.

9. 317 P.2d 170, 181 (Cal. Dist. Ct. App. 1957).

10. *Canterbury v. Spence*, 464 F.2d 772, 783-84 (D.C. Cir. 1972) (rejecting the "professional" standard and opting for a patient-based standard for measuring the physician's disclosure duty).

11. See *infra* notes 113-144 and accompanying text.

12. Massachusetts has already enacted the Public Access Data statute regulating public access to data regarding physicians. MASS. GEN. LAWS ANN. ch. 111, § 53B; ch. 118G, § 6; ch. 221, § 26 (West 1997) (recognizing the enactment by 1996 legislative session as ch. 307, "Physicians - Public Access to Data Concerning Physicians").

13. See *infra* note 95 and accompanying text.

14. See *infra* notes 113-144 and accompanying text.

15. See *id.*

16. See *infra* notes 145-193 and accompanying text.

17. See *id.*

18. See *id.*

19. See *id.*

20. See *infra* notes 195-99 and accompanying text.

## II. HISTORICAL BACKGROUND OF INFORMED CONSENT

Obtaining a patient's consent before undertaking a medical procedure has been required for more than 200 years.<sup>21</sup> This historical duty of obtaining a patient's consent "bears only a minimal similarity" to present-day "informed consent."<sup>22</sup> Prior to the doctrine of informed consent, physicians avoided actions of battery<sup>23</sup> by proving their patients were advised of the upcoming medical treatment.<sup>24</sup> Until recently, patients were not seen as being able to make autonomous decisions, able to be partners with their physicians in medical decision-making, but were still able to sue doctors if they did not receive disclosures and were treated without having given their permission.<sup>25</sup> Currently, the doctrine of informed consent affords a client two causes of action: one against a care giver for treating without any consent,<sup>26</sup> and a second for failing to disclose enough information to be considered true informed consent.<sup>27</sup> Once a physician is found to have breached his/her duty to disclose, he/she will be liable for any damages which resulted from treatment.<sup>28</sup>

21. See *Slater v. Baker*, 95 Eng. Rep. 860, 862 (K.B. 1767) ("[I]t is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation.").

22. Honorable Armand Arabian, *Informed Consent: From the Ambivalence of Arato to the Thunder of Thor*, 10 ISSUES L. & MED. 261, 262 (1994).

23. If a patient is physically and mentally able to consent to a procedure, in the absence of an emergency, consent is a "prerequisite to a surgical operation by his physician, and an operation without the patient's consent is a technical assault." *Gouse v. Cassel*, 615 A.2d 331, 333-34 (Pa. 1992) (quoting *Moscicki v. Shor*, 163 A. 341, 342 (Pa. Super. Ct. 1932); see also *Ford v. Ford*, 10 N.E. 474, 475 (Mass. 1887) ("[T]he absence of lawful consent is part of the definition of an assault.") (citing *Christopher v. Bare*, 116 Eng. Rep. 554, 556 (Q.B. 1848)).

24. *Id.*

25. Jay Katz, M.D., *Informed Consent - Must it Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 73 (1993). Patients had to wait until the late 1950's before the idea that doctors were the only competent individuals to make medical decisions, and thus were the only ones to have the authority and power over those decisions, was abolished. *Id.*

26. Including an action for battery when a surgeon, other than the one the patient approved, performs a consented-to operation. *Risk Analysis: Informed Consent, Hosp. Risk Control*, ECRI (Plymouth Meeting, Pa.) (Nov. 1993).

27. Robert Gatter, *Informed Consent Law and the Forgotten Duty of Physician Inquiry*, 31 LOY. U. CHI. L. J. 557, 561-62 (2000). The most common cause of action arises out of a physician's failure to disclose. See *id.* In order to plead a claim for failure to disclose, "a patient must allege that: (1) the physician had a duty to disclose the particular information; (2) the physician breached this duty; and (3) the physician's breach caused an injury to the patient." *Id.* at 562.

28. *Gouse v. Cassel*, 615 A.2d 331, 333 (Pa. 1992).

### A. *The Case History*

The term “informed consent” was born in 1957 in the California Appellate Court,<sup>29</sup> resulting in today’s comprehensive disclosures of risks, benefits and available treatment,<sup>30</sup> including non-treatment.<sup>31</sup> In *Salgo v. Leland Stanford Jr. University Board of Trustees*, plaintiff sought treatment for pain he experienced in his hips and lower back.<sup>32</sup> After an initial examination, the physician expected that plaintiff might have had an aortal clot that was impairing the blood supply to plaintiff’s legs.<sup>33</sup> The doctor proceeded to advise plaintiff regarding the seriousness of his condition and told him he should proceed immediately to the hospital for evaluation.<sup>34</sup> Plaintiff was told that in order to discover the exact location and size of the blockage, he would be put under local anesthetic and a needle would be used to inject material into the aorta, and then x-rays would be taken.<sup>35</sup> Plaintiff was told that this procedure would help the doctor determine whether an operation would be necessary in order to prolong his life.<sup>36</sup> Upon his doctor’s advisement, plaintiff went to the hospital for the procedure.<sup>37</sup> After the procedure, plaintiff recovered from the anesthesia but awoke the next morning permanently paralyzed from the waist down.<sup>38</sup> In a landmark decision, the doctor was held liable for lack of obtaining informed consent.<sup>39</sup> The court held, “[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.”<sup>40</sup>

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29. *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 181 (Cal. Dist. Ct. App. 1957). While the term “informed consent” was first uttered in 1957, the idea that a patient has a fundamental right to make his or her medical decision was clearly invoked in 1914. *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92 (N.Y. 1914). In an earlier case, the unauthorized act of removing a woman’s ovaries and uterus was recognized as a trespass and a battery, which was the theory relied on prior to the concept of informed consent. *Pratt v. Davis*, 79 N.E. 562 (Ill. 1906).

30. Arabian, *supra* note 22, at 263.

31. *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993). California requires “reasonable disclosure of the available choices with respect to proposed therapy including nontreatment and the dangers inherently and potentially involved in each.” *Id.* at 383. When a patient refuses treatment they must be apprized of the risks of not undergoing treatment. *Truman v. Thomas*, 611 P.2d 902, 906-07 (Cal. 1980).

32. *Salgo*, 317 P.2d at 173.

33. *Id.*

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.* at 174-75.

39. *Id.* at 181.

40. *Id.* The court also made it clear that a physician may not discount or minimize the risks involved in order to obtain informed consent from a patient, and the physician must inform the patient of every risk, no matter how remote. *Id.*

Three years later, Kansas followed California and attempted to add clarifications to the new law.<sup>41</sup> In *Natanson v. Kline*, plaintiff, a breast cancer patient, sought treatment from a radiologist after her mastectomy.<sup>42</sup> After radiation treatment, plaintiff's "entire chest, skin, cartilage and bone were completely destroyed" in the treated areas.<sup>43</sup> Adding to the *Salgo* decision, the court stated that in order to obtain informed consent successfully, a physician is "to disclose and explain to the patient, in language as simple as necessary, the nature of the ailment, the nature of the proposed treatment, the probability of success or of alternatives,<sup>44</sup> and perhaps the risks of unfortunate results and unforeseen conditions within the body."<sup>45</sup>

### B. Changes in Perspective

While one approach to informed consent is to require that a physician be responsible for disclosing information that a reasonable medical provider would disclose,<sup>46</sup> the national trend is to define requirements based on the patient's point of view.<sup>47</sup> Often the doctor and patient disagree, but while the

41. *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960).

42. *Id.* at 1095.

43. *Id.* at 1097.

44. Although it is common for jurisdictions to require a physician to disclose treatment alternatives, some even require disclosure of alternatives that are more hazardous than the treatment he/she is recommending. See e.g., *Logan v. Greenwich Hosp. Ass'n.*, 465 A.2d 294, 301-02 (Conn. 1983). But see *Pratt v. Univ. of Minn. Affiliated Hosps. & Clinics*, 414 N.W.2d 399, 402 (Minn. 1987) (having no duty to disclose risks associated with diagnoses other than the one which the physician is, in fact, making).

45. *Id.* at 1106.

46. Gatter, *supra* note 27, at 566. Although the "Prudent Physician Standard" calls for a physician to disclose information that the average reasonable physician would disclose in the same position, it still accommodates the subjective patient characteristics. *Id.* After speaking to a patient and hearing his/her subjective concerns, the physician must then decide what to disclose based on the information gathered from the patient. *Id.*; see also *infra* notes 44-76 and accompanying text.

47. See *Arato v. Avedon*, 858 P.2d 598 (Cal. 1993). For a national trend of cases interpreting informed consent from the perspective of the reasonable patient, see *Sinclair v. Block*, 633 A.2d 1137, 1140 (Pa. 1993) (noting that the doctrine of informed consent in Pennsylvania requires disclosures of the facts, risks, complications, and alternatives to surgery that a reasonable person in the patient's position would have considered significant); *Ramon v. Farr*, 770 P.2d 131, 136 n.6 (Utah 1989) (stating information a reasonable person in the position of the plaintiff would deem important); *Pedersen v. Vahidy*, 552 A.2d 419, 425 (Conn. 1989) (using a lay standard of disclosure that obligates the physician to provide the patient with that information which a reasonable patient would have found material) (citing *Logan v. Greenwich Hosp. Ass'n.*, 465 A.2d 294 (Conn. 1983)); *Hondroulis v. Schuhmacher*, 553 So. 2d 398, 412 (La. 1989) (acknowledging that a risk is material when a person in what the doctor knows or should know to be the patient's position would be likely to attach significance to the risk); *Pauscher v. Iowa Methodist Med. Ctr.*, 408 N.W.2d 355, 359 (Iowa 1987) (noting that the physician's duty to disclose is measured by the patient's need to receive material information); *Precourt v. Frederick*, 481 N.E.2d 1144, 1148 (Mass. 1985) (recognizing that

doctor may be looking out for his/her patient's best interest, "[a] doctor's altruism notwithstanding, his agenda and value system are not the same as those of the patient."<sup>48</sup> Thus, in many jurisdictions, it is for the patient to decide what is and what is not "material" when making his/her decision.<sup>49</sup>

In 1972, *Canterbury v. Spence* was the first case to adopt an objective standard.<sup>50</sup> *Canterbury* involved a case where a man became paralyzed after a laminectomy.<sup>51</sup> In this landmark decision, the court clearly stated that the information required to be divulged was "all risks potentially affecting the [patient's] decision."<sup>52</sup> The objective standard that was adopted was the "prudent person in the patient's position," effectively denying patients the ability to act on "irrational" preferences.<sup>53</sup> This perspective of what the average patient would want to know is "dictated by the needs and feelings of individual patients."<sup>54</sup>

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material information is that which the physician knows or should know a person in the plaintiff's position would consider important) (citing *Harnish v. Children's Hosp. Med. Ctr.*, 439 N.E.2d 240, 243 (Mass. 1982)); *Wheeldon v. Madison*, 374 N.W.2d 367, 374 (S.D. 1985) (adopting a reasonableness standard based on the patient and rejecting the "professional" theory and noting that an increasing number of courts have rejected the "professional rule"); *Sard v. Hardy*, 379 A.2d 1014, 1021-22 (Md. 1977) (joining an "ever-expanding number of courts" that have rejected the professional standard of care and adopting a standard measuring the physician's duty to disclosure by what is material to the patient); *Small v. Gifford Mem'l Hosp.*, 349 A.2d 703, 707 (Vt. 1975) (describing that physician's duty is to furnish information material to intelligent choice by a reasonable person situated as was the patient). Possibly the first in this line of cases is the influential decision of *Canterbury v. Spence*, 464 F.2d 772, 784, 787 (D.C. Cir. 1972) (rejecting the "professional" standard and opting for a patient-based standard for measuring the physician's disclosure duty). *But see* *Smith v. Weaver*, 407 N.W.2d 174, 179 (Neb. 1987) (noting that Nebraska has been committed by its legislature to the "professional" theory under which disclosure is based on what an ordinary health care provider in the same or similar locality would disclose) (citing NEB. REV. STAT. § 44-2816 (1984); *Fuller v. Starnes*, 597 S.W.2d 88, 90 (Ark. 1980) (rejecting the patient-based view and adopting the "professional" theory).

48. See *Katz*, *supra* note 25, at 75 (quoting a 1993 interview with surgeon Sherwin Nuland).

49. *Harnish v. Children's Hosp. Med. Ctr.*, 439 N.E.2d 240, 243-44 (Mass. 1982). The court defined materiality as "the significance a reasonable person, in what the physician knows or should know is his patient's position, would attach to the disclosed risk or risks in deciding whether to submit or not to submit to surgery or treatment." *Id.* at 243 (quoting *Wilkenson v. Vessey*, 295 A.2d 676, 689 (R.I. 1972)). A few years later, in an attempt to clarify the meaning of materiality, the Massachusetts Supreme Court described materiality as "the product of the risk and its chance of occurring. A severe consequence, ordinarily of interest to the patient, would not require disclosure if the chance of the consequence occurring was so remote as to be negligible." *Precourt v. Frederick*, 481 N.E.2d 1144, 1148-49 (Mass. 1985) (quoting *LaCaze v. Collier*, 434 So.2d 1039, 1046 (La. 1983)).

50. 464 F.2d 772 (D.C. Cir. 1972). The court rejected the physician-based standard because it is "at odds with the patient's prerogative to decide on projected therapy." *Id.* at 786.

51. *Id.* at 777. A laminectomy is a surgical procedure that reduces the pressure and irritation on the nerve roots in the lower back which are caused by the degeneration of ligaments. Cleveland Clinic Foundation Anesthesiology Education Center, available at <http://www.anes.ccf.org:8080/pilot/ortho/lumbarla.htm>.

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

53. *Id.* at 791. To determine what a reasonable person in the patient's shoes would want to know, the court looks to a jury. *Id.* at 788.

54. Richard A. Heinemann, Note, *Pushing the Limits of Informed Consent: Johnson v. Kokemoor and Physician-Specific Disclosure*, 1997 Wis. L. REV. 1079, 1085 (1997).

### 1. How Well a Doctor Must Know His/Her Patient

In the many jurisdictions that approach true informed consent from the perspective of the patient, the burden of determining the position of the patient is placed on the shoulders of the physician.<sup>55</sup> There is a presupposition that in order to determine the point of view of his/her patient, a physician would conduct an adequate inquiry with each patient.<sup>56</sup> Included in this presupposition is a belief that in order to competently and properly obtain the views of the patient, the physician must take into consideration subjective points of view which would include medical as well as non-medical characteristics.<sup>57</sup> After talking to the patient and determining what the treatment options are, it would be the provider's responsibility to transfer the subjective information onto a faceless objective reasonable patient.<sup>58</sup>

Despite the fact that both the reasonable patient and reasonable physician standards require doctors to take into consideration the subjective characteristics of their patients, there still is no exact definition of the physician's duty.<sup>59</sup> Interpretation of the extent to which a physician must know his or her patient before he or she can disclose treatment advice varies from jurisdiction to jurisdiction.<sup>60</sup> In some jurisdictions, despite how easy it would be for a physician to spend minimal time interviewing their patient to avoid a false diagnosis, it is simply not required for informed consent.<sup>61</sup> For instance, in *Bush v. Stack*,<sup>62</sup> a patient sought treatment from his physician regarding the pain his wife was having during sexual intercourse.<sup>63</sup> After talking with his patient, the physician determined that the patient's spouse was experiencing discomfort due to the curvature of the patient's penis and

55. See Gatter, *supra* note 27, at 564.

56. *Id.* There is a presupposition that the reasonable standard demands that the doctor first assess a patient's circumstances before recommending a course of treatment. *Id.* Not until the doctor assesses the patient's position can he/she determine what course of treatment would be applicable to a reasonable patient in this patient's position. *Id.*

57. *Id.* Subjective characteristics that belong to a patient, and should be taken into consideration, include religious beliefs, background, idiosyncrasies, as well as circumstances surrounding the medical reasons that the patient seeks treatment. *Id.*

58. *Id.* This average reasonable patient approach suggests that the standard is neither subjective, nor objective, but a combination of the two. *Id.* Both the reasonable patient and the reasonable physician standard take on this hybrid approach to what should be disclosed. *Id.* at 566; see also *supra* notes 21-54 and accompanying text.

59. Gatter, *supra* note 27, at 567.

60. See *infra* notes 59-64 and accompanying text.

61. *Bush v. Stack*, 95 Wash. App. 1073 (Wash. Ct. App. 1999), *petition for review denied*, 139 Wash. 2d 1019 (2000).

62. *Id.*

63. *Id.* at 1084.



accordingly recommended a surgical procedure to reduce the curvature.<sup>64</sup> The source of pain, however, was the wife's episiotomy scar.<sup>65</sup> The court held that unless the patient told the physician that his wife's scar was the source of the pain, the physician did not have a duty to disclose to the patient that the recommended procedure was unlikely to cure or reduce the pain caused by the scar.<sup>66</sup> While the cause of the wife's pain could have easily been determined through a series of simple follow-up questions, the court held that a patient has a responsibility to communicate certain pertinent facts to his/her doctor.<sup>67</sup>

## 2. How Well a Patient Can Know His/Her Physician

Most courts have refused to include a doctor's experience as a material fact that needs to be disclosed to a patient in medical decision-making.<sup>68</sup> However, when patients specifically seek information from their physician regarding their educational background and experience, the doctor has a duty to answer questions truthfully and recognize that this particular patient deems the information material in making his/her decision.<sup>69</sup>

## 3. Only Disclosure of Medical Circumstances Necessary

Courts generally require "physicians to discover and account for only patient's medical circumstances as physicians determine what treatment information to disclose to patients."<sup>70</sup> What should be disclosed to the patient from the patient's position, that is what the patient would find

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64. *Id.*

65. *Id.* at 1085.

66. *Id.* at 1091. Once the physician identifies the medical condition, it is not necessary for him/her to attempt to discover any additional information from the patient. *Id.*

67. *Id.*

68. See e.g., *Whiteside v. Lukson*, 947 P.2d 1263 (Wash. Ct. App. 1997) (rejecting "expansive approach" to informed-consent law and holding that the surgeon's lack of experience in performing surgical procedure is not a "material fact" triggering disclosure requirement); *Ditto v. McCurdy*, 947 P.2d 952 (Haw. 1997) (holding no duty to disclose physician's lack of experience or incompetence); *Foard v. Jarman*, 387 S.E.2d 162 (N.C. 1990) (holding no duty to disclose physicians lack of experience); *Abram v. Children's Hosp. of Buffalo*, 151 A.D.2d 972 (N.Y. App. Div. 1989) (holding no duty to disclose medical personnel's qualifications or lack thereof); *Wachter v. United States*, 689 F. Supp. 1420 (D. Md. 1988) (holding no duty to disclose experience of physician under federal or state law). See also *Helmbrecht v. Dental Implant Ctr. of Orange County*, unpublished (Cal. Ct. App. 1999) (holding that an assisting doctor, specialist or consultant has no duty to "inform a patient as to the graduation date, number of years of practice, or experience level of her treating physician").

69. Tracy Blitz Newman, *If Patient Asks, Doctor's Experience Becomes Relevant to Informed Consent*, THE LEGAL INTELLIGENCER, October, 1999. "A surgeon who, when answering a patient's inquiries, misinforms the patient about this information and misleads the patient into believing that the hands of an experienced surgeon will be performing the operation, does not have the true consent of that patient." *Duttry v. Patterson*, 741 A.2d 199, 201 (Pa. Super. Ct. 1999), *rev'd*, 771 A.2d 1255.

70. *Gatter*, *supra* note 27, at 570. Most courts only require a physician to inquire into the patient's medical condition and proposed treatment and not to inquire about the patient's non-medical characteristics, no matter how relevant or helpful. See *id.* at 568.

material or relevant in his/her circumstance, is often determined solely by the medical condition or treatment options, rather than non-medical characteristics that can influence a patient's decision.<sup>71</sup> This trend toward judicial restraint can be seen clearly in the California Supreme Court decision of *Arato v. Avedon*.<sup>72</sup> In *Arato*, a decedent's family sued on a

71. For cases determining the patient's point of view based on his/her medical condition, see *Heazeau v. Pendleton Methodist Mem'l Hosp.*, 715 So. 2d 756, 762 (La. Ct. App. 1998) (upholding a lower court finding that the risk of infection during knee surgery is a risk about which a reasonable person in the patient's position would want to know, where the only facts presented about the plaintiff concerned his medical history and condition); *Caputa v. Anitles*, 686 A.2d 356, 362 (N.J. Super. Ct. App. Div. 1996) (holding that "[a] patient with no fever, only partial obstruction of one kidney, intermittent pain, and who vomited only once without question would desire to be informed not only of the option of surgery, but also of the much less intrusive alternative . . ."); *Metzler v. Dichraff*, 570 N.W.2d 63 (Wis. Ct. App. 1997) (unpublished opinion), available at 1997 WL 370036 July 8, 1997) (concluding that an issue of fact exists about whether a reasonable person in the plaintiff's position would have considered material information about the availability of specialists to perform a third molar extraction, when the only factual information reported about the plaintiff was that she had an impacted third molar). For cases determining the patient's point of view based on his/her treatment options, see *Kain v. United States*, No. Civ. A. 93-2466, 1994 WL 71261, at 2-3 (E.D. Pa. March 9, 1994) (finding that the risk of a hernia associated with the surgical removal of the gallbladder is not material based only upon the evidence concerning the likelihood and seriousness of the risk for patients undergoing the same surgery); *Finnegan v. Yamour*, No. 715, 1990 WL 119244, at 7 (Ohio Ct. App. Aug. 8, 1990) (noting that testimony that a patient undergoing the kind of surgery performed on the plaintiff should be informed of the risks of hemorrhage, infection, and difficulty in healing was sufficient to support a jury finding that the plaintiff had been informed of all material risks). For cases that determine the patient's point of view based on someone suffering from the same medical condition, considering the same courses of treatment, see *Wachter v. United States*, 877 F.2d 257, 258-61 (4th Cir. 1989) (stating that the patient's position included having a clogged coronary artery despite prior bypass surgery and considering whether to undergo a second bypass procedure); *Ellis v. Smith*, 528 N.E.2d 826, 828 (Ind. Ct. App. 1988) (describing the key issues as "the reasonable disclosure and informed consent necessary for elective foot surgery on a muscular dystrophy patient . . ."); *Rowinsky v. Sperling*, 681 A.2d 785, 789-90 (Pa. Super. Ct. 1996) (noting that evidence on the record that plaintiff suffered from grand mal seizures originating in the left temporal lobe of his brain and that brain surgery to remove the damaged section of the brain had been recommended was sufficient to support the jury's finding that a reasonable person in the patients position would have wanted to know the risk that memory or speech abilities could be lost). For cases that determine the reasonable physician's point of view based on patient's with the same medical circumstances and treatment alternatives, see *Shepard v. United States*, No. CV-S-87-726-PMP (RJJ), 1989 WL 248215, at 3 (D. Nev. Sept. 19, 1989) (implying that a prudent physician in the same or similar circumstances is the one advising a patient about the bone graft surgery performed on the patient); *Bloskas v. Murray*, 646 P.2d 907, 913 (Colo. 1982) (defining a prudent physician rule to require disclosure of risks that are "medically significant to the patient's surgical decision . . ."); *Shabinaw v. Brown*, 963 P.2d 1184, 1189-1192 (Idaho 1998) (in overturning trial court's grant of a judgment notwithstanding the verdict against a physician, the state supreme court reviewed the expert testimony concerning standards for disclosure, including testimony describing the relevant circumstances as treating a patient in whom the physician "suspected a total bowel obstruction," and decided that there was ample evidence to support the jury's verdict); *Wecker v. Amend*, 918 P.2d 658, 660, 662 (Kan. Ct. App. 1996) (determining that the trial court erred when it failed to instruct the jury that the duty of disclosure includes disclosing the treatment alternatives for patients with potentially cancerous cervical warts).

72. 858 P.2d 598 (Cal. 1993).

theory of informed consent because a doctor did not inform the patient of the mortality rate for his disease on grounds that if the patient had known, he would have taken care of his financial affairs before he died.<sup>73</sup> The court held that a physician need not “disclose every contingency that might affect the patient’s nonmedical rights and interests.”<sup>74</sup> However, when a physician knows about a patient’s medical past and specific fears regarding medical outcomes, court’s have held physicians liable for failure to disclose potential outcomes, however remote.<sup>75</sup> For example, after consulting with her doctor, a female patient decided to proceed with an operation designed to leave her sterile.<sup>76</sup> After becoming pregnant, she sued the physician for failing to inform her that there was a 0.1 to 0.3 percent chance of still getting pregnant despite the surgery.<sup>77</sup> Notwithstanding the small risk of getting pregnant after the procedure, the court held in favor of the plaintiff, reasoning that the plaintiff’s medical background as well as her fears of the procedure supported a cause of action against the physician for violating his duty to disclose.<sup>78</sup> This case is a perfect example of why the logical starting place for treating a patient is to explore the “patient’s subjective characteristics and circumstances” when determining what information needs to be disclosed.<sup>79</sup>

Another obstacle a physician faces when obtaining informed consent is when a patient refuses treatment.<sup>80</sup> Although as a general proposition, a doctor has no duty to treat an individual after that individual refuses the care, the physician does have a duty to provide the patient with “reasonable disclosure of the available [alternate] choices . . . [for] therapy . . . and of the dangers . . . potentially involved in each.”<sup>81</sup> In *Thor v. Superior Court*, a particular case of medical care referral, the California Supreme Court balanced the integrity of an individual with a state’s interest in the well-being of an individual, ultimately siding with the patient.<sup>82</sup> In *Thor*, a patient had become a quadriplegic after a fall and subsequently refused to eat or receive medical treatment.<sup>83</sup> The court held “that a physician has no duty to

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73. See *id.* at 608.

74. *Ibid.* at 609.

75. Hartke v. McKelway, 707 F. 2d 1544 (D.C. Cir.1983).

76. See *id.* at 1547.

77. Gatter, *supra* note 27, at 575 n.109. In fact, the doctor informed the patient that the procedure was one hundred percent effective. *Id.* The patient further testified, that had she known the procedure for having herself sterilized was less than one hundred percent effective, her boyfriend would have proceeded with a vasectomy in order to avoid future pregnancies. *Id.*

78. *Id.* at 576. The plaintiff had previously informed her doctor about her “history of gynecological problems, including an ectopic pregnancy, and . . . she had been told by another physician that she would not survive additional pregnancies.” *Id.*

79. *Id.*

80. *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993).

81. *Id.* at 383 (quoting *Cobbs v. Grant*, 502 P.2d 1 (1972)).

82. *Id.* at 375.

83. *Id.* at 379. The right to refuse medical treatment is derived from the right to privacy implied

treat" a patient who refuses health care after making a "reasonable disclosure of the available choices with respect to proposed therapy [including nontreatment] and of the dangers inherently and potentially involved in each."<sup>84</sup>

#### 4. Comparing Doctors: a New Disclosure Requirement?

In 1996, a Wisconsin Supreme Court held that a reasonable patient, before consenting to a surgical procedure, would want to know how his/her physician ranked compared to other physicians.<sup>85</sup> This is the first case in the country to suggest that a doctor may have an obligation to disclose his own level of experience regarding a particular procedure, before obtaining "true" informed consent.<sup>86</sup> Although the doctor in *Johnson v. Kokemoor* provided his patient with misleading information,<sup>87</sup> the court did not confine its opinion to the narrow reading regarding misinformation, but instead observed that a reasonable patient, in certain undefined circumstances, would want to know, and should thus be informed, how his/her physician ranks with other physicians.<sup>88</sup> The court stated that "[w]hen different physicians have substantially different success rates, whether surgery is performed by one rather than another represents a choice between "alternate, viable medical modes of treatment," and requires disclosure under

in the penumbra of the United States Constitution. *Cruzan v. Director. Mo. Dep't of Health*, 497 U.S. 261, 292 (1990). Since the landmark decision in *Cruzan*, many states have followed its lead based on common law and the constitutional right to privacy. See e.g., *Thor v. Superior Court*, 855 P.2d 375, 387 (Cal. 1993) (common law); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978) (constitutional right to privacy); *In re Spring*, 405 N.E.2d 115, 119 (Mass. 1980) (constitutional right to privacy); *In re Farrell*, 529 A.2d 404, 410 (N.J. 1987) (grounded in common law and protected by federal and state constitutional rights of privacy); *In re Beth Israel Med. Ctr.*, 519 N.Y.S.2d 511, 513-14 (N.Y. Sup. Ct. 1987) (constitutional right to privacy); *Leach v. Akron Gen. Med. Ctr.*, 426 N.E.2d 809, 814 (Ohio C.P. 1980) (constitutional right to privacy); *In re Grant*, 747 P.2d 445, 449 (Wash. 1987) (en banc) (constitutional right to privacy and a common-law right).

84. *Thor*, 855 P.2d at 383 (quoting *Cobbs v. Grant*, 502 P.2d 1, 10 (1972)). Accordingly, a patient has the right to refuse medical treatment regardless of age or health; the right is static. See *In re Conroy*, 486 A.2d 1209, 1226 (N.J. 1985).

85. See *Johnson v. Kokemoor*, 545 N.W.2d 495, 507 (Wis. 1996).

86. Eau Claire, *Medical Case a National First*, *BELOIT DAILY NEWS*, Dec. 16, 1996. One other court has required disclosure of medical experience in the past, but only in certain circumstances. *Hales v. Pittman*, 576 P.2d 493, 500 (Ariz. 1978) (holding where patient's seeks elective surgery, they are "entitled to information concerning the treating physician's experience with the particular procedure.").

87. See *Johnson*, 545 N.W. 2d at 506. Plaintiff was scheduled to undergo surgery for a brain aneurysm. Before doing so, she inquired as to the doctor's experience with her particular surgery, and his response was that he had done them "dozens" of times, when this was, in fact, not true. See *id.* at 505.

88. *Id.*

Wisconsin law.<sup>89</sup> In addition to providing the patient with comparative provider statistics, the court further commented that the physician may also be required to advise the patient that better treatment is available elsewhere and that the next logical step would be to provide a referral.<sup>90</sup> Of course the court in *Johnson v. Kokemoor* did not address how such statistics are to be gathered or offer guidance in how they should be used, just that in certain undefined circumstances, a patient would find them material in his/her medical decision-making.<sup>91</sup> Countless questions have been left in the wake of *Johnson v. Kokemoor*.

Should the physician provide statistics concerning all similar surgeries he or she has performed, or should the physician restrict the analysis to his or her experience with patients of similar age, health or attendant medical complications? Is the physician required to obtain a comparable breakdown of data from other physicians? Should he or she include local physicians, or should the data include all physicians in the state? In the nation? Further difficulties are easy to imagine.<sup>92</sup>

Many see this decision as the “poster child for requiring physicians to provide comparative statistics.”<sup>93</sup> While most courts that have entertained the issue of physician experience have declined to require such disclosure,<sup>94</sup> the *Kokemoor* decision will likely have great effect and often be cited for the “sweeping statements to the effect that ‘[t]he duty to provide information may require . . . [p]hysicians . . . to identify and correlate risk factors and to communicate the results to patients.’”<sup>95</sup>

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89. *Id.* at 507 (quoting WIS. STAT. §448.30).

For example, while there may be a general risk of ten percent that a particular surgical procedure will result in paralysis or death that risk may climb to forty percent when the particular procedure is performed by a relatively inexperienced surgeon. It defies logic to interpret this statute as requiring that the first, almost meaningless statistic be divulged to a patient while the second, far more relevant statistic should not be.

*Id.*

90. *Id.* at 510.

91. *Id.*

92. L. Rachel Lerman Helyar & Judith E. Gordon, *Informed Consent; Courts Divided Over Physicians' Duty to Disclose Their "Track Records" to Patients*, 17 MEDICAL MALPRACTICE LAW & STRATEGY 3, 2 (Jan. 2000).

93. Email from Daniel L. Icenogle, M.D., J.D. to Jennifer Wolfberg (2000) (on file with the author); “Other courts don’t seem to be jumping on the bandwagon, but Miami lawyer and former ATLA president Larry Stewart said it is just a matter of time.” Hellwege, *supra* note 2, at 129.

94. *See supra* note 68 and accompanying text.

95. Helyar & Gordon, *supra* note 92 (citing *Johnson v. Kokemoor*, 545 N.W.2d 507 (1996)). An interesting side note in the *Kokemoor* case was that the court did not suggest the physician should have been required to inquire into any non-medical characteristics of the patient. *Johnson v. Kokemoor*, 545 N.W.2d 495 (Wis. 1996). Incidentally, a Pennsylvania court has recently cited *Johnson v. Kokemoor*, positing that the disclosure of comparative provider statistics is material to a patient’s decision-making. *Duttry v. Patterson*, 741 A.2d 199, 201 (Pa. Super. Ct. 1999).

Notwithstanding a physician's truthful response regarding his/her own experience and expertise, it is the comparative provider statistics that may cause significant problems despite honest dissemination of the same. It is this misrepresentation of the statistics that can be both harmful to, or unjustly enrich the physician, and cause consumers to misuse the data to their detriment.<sup>96</sup>

### C. *The Purpose of the Doctrine*

The purpose of the doctrine of informed consent is to protect the patient.<sup>97</sup> The doctrine of informed consent is a basic social policy that "gives patients a voice in medical decision making," after hearing risks, benefits and recommendations from their doctors.<sup>98</sup> "[T]echnological advances in the diagnosis and treatment of disease, spawned by medical science, provide[] patients and doctors with ever-increasing therapeutic options, each having its own particular benefits and risks."<sup>99</sup> Through the evolution of informed consent, one principle has remained constant: a patient's personal autonomy of decision-making.<sup>100</sup>

Almost thirty years ago, a court vocalized its appreciation of the sanctity of the patient-doctor relationship by stating, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body,"<sup>101</sup> and defined meaningful informed consent as the patient's "opportunity to evaluate knowledgeably the options available and the risks attendant upon each."<sup>102</sup> However, in cases like *Arato*,<sup>103</sup> with patient

96. Douglas Sharrott, Note, *Provider-Specific Quality-of-Care Data: A Proposal for Limited Mandatory Disclosure*, 58 BROOK. L. REV. 85, 104 (1992).

97. See Gatter, *supra* note 27, at 561. The doctrine of informed consent "is founded upon a policy of promoting bodily integrity and self-determination among patients." *Id.*

98. Katz, *supra* note 25, at 76. Informed consent requires both the patient and the doctor to make joint decisions and have open lines of communication where their thoughts and ideas can both be treated with respect. See *id.*

99. *Id.* at 76.

100. *Id.* at 83. "Respect for individuals as autonomous agents entitles them to such autonomous determinations without limitation on their liberty being imposed by others." *Id.* (citations omitted). See also Arabian, *supra* note 22, at 68.

101. *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) (quoting *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)). The facts of *Canterbury* make it ironically ill-suited to be a landmark informed consent case as Mr. Canterbury's injuries were more likely caused when he fell out of bed after the surgery. See JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 48, 72 (1984).

102. *Canterbury*, 464 F.2d at 780. In order to grant the consent any legal or moral significance, it must be knowledgeable in some meaningful sense. Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 900 (1994).

103. *Arato v. Avedon*, 858 P.2d 598 (Cal. 1993).

autonomy in mind, doctors need to wait for a patient's instruction before disclosing medical information that a patient might otherwise find useful or material to their decision-making process.<sup>104</sup> This stance taken by California, a state that generally is extremely influential in the area of informed consent, is directly contrary to former concentrations of patient autonomy.<sup>105</sup>

As essential as the trust component of the doctor-patient relationship is, "informed consent was not designed to serve as a medical blueprint for interactions between physicians and patients."<sup>106</sup> Another potential concern in preserving the trust and good will between the doctor and patient is the right to privacy.<sup>107</sup> A patient may become offended by discussing matters of life and death with his/her physician, which may cause a physician to curtail future discussions.<sup>108</sup> As uncomfortable as a patient may get, it is imperative the information be conveyed.<sup>109</sup> In reference to this concern, Justice Stevens has wisely quipped, "[i]t is far better to permit some individuals to make incorrect decisions than to deny all individuals the right to make decisions that have a profound effect upon their destiny."<sup>110</sup>

It is well-settled law that the presumption that individuals are competent and capable of managing their private affairs is correct,<sup>111</sup> and thus the ultimate purpose of informed consent is that information "be disclosed to the patient who will interpret it and apply it, seeking the advice of others only if so inclined."<sup>112</sup>

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104. Heinemann, *supra* note 54 at 1088.

105. Truman v. Thomas, 611 P.2d 902, 906 (Cal. 1980) (extending the duty to disclose material information in situations where a patient rejects medical treatment).

106. Katz, *supra* note 25, at 79; *see also supra* notes 59-67 and accompanying text.

107. *Id.* at 85. The idea of having in-depth discussions with a patient to obtain their consent may offend the patient's right to privacy. *Id.*

108. *Id.* at 85-86.

109. *Id.*

110. *Id.* at 86 (quoting Thornburgh v. Am. College of Obstetricians & Gynecologists, 476 U.S. 747, 781 (1986) (Stevens, J., concurring)).

111. *See e.g.*, In re MacCrellish's Estate, 141 P. 257, 259 (Cal. 1914); Walton v. Malcolm, 106 N.E. 211, 214 (Ill. 1914); Rose v. Rose, 182 S.W.2d 977, 978 (Ky. 1944); White v. White, 196 S.W. 508, 515 (Tex. 1917); *see generally* 61 AM. JUR. 2D *Physicians, Surgeons and Other Healers* § 176 (1981).

112. Arabian, *supra* note 22, at 269.

III. THERE ARE THREE KINDS OF LIES: LIES, DAMNED  
LIES, AND STATISTICS<sup>113</sup>

“Statisticians study the mathematical relationships among variables.”<sup>114</sup> However, a causal relationship is not inherent when an association between variables is found.<sup>115</sup> And while we shouldn’t “ignore all statistics, or . . . assume that every number is false,”<sup>116</sup> comparative provider statistics “are not now, nor will they ever be, perfect.”<sup>117</sup> On their face, statistics should be approached with a critical eye, evaluating the numbers and distinguishing between good statistics and bad statistics.<sup>118</sup>

A. *Accurate Statistical Data: The Randomized Clinical Trials v. The Observational Database*

The decision a patient reaches regarding a course of treatment after a discussion of relevant provider statistics is seriously jeopardized when the manner in which the data is obtained is not optimal.<sup>119</sup> The ideal manner of comparing alternative therapies is the randomized clinical trial.<sup>120</sup> Patients are divided into two groups, using a blinded random assignment of treatment, without any considerations of age or other coexisting factors.<sup>121</sup> The groups are then given two forms of therapy, or one type of treatment and one placebo.<sup>122</sup> It then follows that differences in outcome should be directly attributable to the therapy itself or other confounds such as sampling variability or patient-noncompliance.<sup>123</sup>

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113. While Mark Twain’s autobiography gives credit to Disraeli, current quotation books suggest that author is unidentified, or alternatively, additional credit should extend to Henry Labouchère, Abram S. Hewitt, and Holloway H. Frost. RESPECTFULLY QUOTED: A DICTIONARY OF QUOTATIONS REQUESTED FROM THE CONGRESSIONAL RESEARCH SERVICE (Suzy Platt ed., 1989).

114. David W. Barnes, *Too Many Probabilities: Statistical Evidence of Tort Causation*, 64 LAW & CONTEMP. PROBS. 191, 197 (2001).

115. *Id.*

116. Joel Best, *Telling the Truth About Damned Lies and Statistics*, THE CHRONICLE OF HIGHER EDUCATION, May 4, 2001, § 2, at B8 (recognizing that statistics in general have a bad reputation by citing phrases like “[y]ou can prove anything with statistics” and even a book, more than 40 years old entitled, *How to Lie With Statistics*).

117. Sharrott, *supra* note 96, at 120.

118. *Id.*

119. Jesse Green, *Problems in the Use of Outcome Statistics to Compare Health Care Providers*, 58 BROOK. L. REV. 55, 56 (1992).

120. *Id.* at 57.

121. *Id.*

122. *Id.*

123. *Id.*



In non-randomized trials, patients are assigned to groups and therapies based solely on conditions necessitating each form of treatment.<sup>124</sup> This method weakens the inferences regarding the direct relationship and statistical outcome of a trial because elements such as duration and severity of illness are introduced, which skews the results and creates tremendous bias.<sup>125</sup> In practicality, only non-randomized studies are undertaken because eliminating a patient's right to choose a physician or treatment would be counter-productive to the ultimate goal of benefitting the patient.<sup>126</sup>

Most or all of the statistics provided to patients are based on "observational databases" used in an abstract format to compile comparisons.<sup>127</sup> As such, "[b]iases in published mortality statistics are not surprising given the inherent limitations of observational databases."<sup>128</sup> This flawed data is presented to the patient as the basis of a well-informed decision, even when "[s]ome of the health care databases . . . contain many inaccuracies."<sup>129</sup> This is critical during litigation when it becomes "important that courts be fully aware of the limitations of these data."<sup>130</sup> As evidenced by *Arato v. Avedon*, at least one court has already focused its decision on the questionable nature of these being statistics applicable in individual cases.<sup>131</sup>

#### *B. Accurate Statistical Data: Accounting for Patient's Emotions and Physician's Ulterior Motives*

Statistical information can sometimes be helpful to a patient in making a decision when the numerical risk is low but the consequences are so great that it would be imperative for a patient to be informed.<sup>132</sup> Accordingly, courts often believe that reasonable patients would like these statistics made available to them.<sup>133</sup> However, even if the release of comparative provider statistics to patients can be purportedly useful, the important issue is whether they should be believed.<sup>134</sup> For example, comparative provider statistics may be used when comparing the effectiveness of care available from each of the

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124. *Id.*

125. *Id.* at 58.

126. *Id.*

127. *Id.* at 58-59.

128. *Id.* at 62.

129. *Id.* at 65-66. Even before statistical data regarding treatment can be determined, all data concerning the physician must be accounted for and controlled. See Heinemann, *supra* note 54, at 1107. Concerns regarding the physician compound the problems that arise when trying to come up with accurate and reliable statistical data. *Id.*

130. Green, *supra* note 119, at 71.

131. 858 P.2d 598 (Cal. 1993).

132. See *Martin v. Richards*, 192 Wis. 2d 156, 174 (1995).

133. See *id.*

134. See Green, *supra* note 119. Even statistical morbidity rates have been treated as inherently unreliable, offering little assurance to individual patients. See *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972).

providers.<sup>135</sup> However, reliability in determining what therapy yields better results—that is whether drugs are favored over an invasive procedure—is difficult to ascertain when one is using an uncontrolled, non-parallel comparison as available in an observational database.<sup>136</sup> By the same token, these comparisons can be even more problematic when trying to determine whether or not certain outcomes are due to a physician's quality of care rather than other factors.<sup>137</sup> Patients with the same diagnosis, for instance, could have different prognoses.<sup>138</sup> Medical advice given to a patient regarding their future course of treatment does not consist solely of comparative patient data.<sup>139</sup> “[The] non-quantifiable ‘human elements’ will always be part of the mix.”<sup>140</sup> Ergo, the reasonable patient can be expected to make a decision based upon the combination of hard data, and a physician's subjective input, as well as his or her own emotions and state of mind.<sup>141</sup> Accordingly, a physician's own biases may surface regardless of his/her intent.<sup>142</sup>

Despite the fact that some statisticians make adjustments accounting for the severity of the patient's illness, these adjustments alone do not remedy the fact that providers who treat severely-ill patients still tend to have greater mortality figures in statistical mortality reports.<sup>143</sup> In an effort to avoid a poor evaluation, doctors and hospitals may be inclined to report patients more severely ill before treatment or more well after treatment or even refuse care to a patient who may negatively affect their numbers.<sup>144</sup>

135. See Green, *supra* note 119, at 58.

136. *Id.*

137. *Id.* at 62. “For example, David P. Byar analyzed thyroid tumor registry data and found that prognostic factors, such as age, sex, histology of tumor, size and location of tumor and extent of metastasis, were associated with enormous variation in patients' survival duration.” *Id.*

138. *Id.* at 63.

139. Aaron D. Twerski & Neil B. Cohen, *Comparing Medical Providers: A First Look at the New Era of Medical Statistics*, 58 BROOK. L. REV. 5, 8 (1992).

140. *Id.* at 9.

141. *Id.* at 8-9. However, it should be noted this is a reasonable patient standard and boilerplate informed consent forms or discussions are ill-suited for the more sophisticated patient who requires additional information in order for the physician to obtain “true” informed consent. *Scaria v. St. Paul Fire & Marine Ins. Co.* 227 N.W.2d 647, 653-54 (Wis. 1975).

142. See Katz, *supra* note 25, at 88. Sometimes a doctor, without being aware of his/her own biases may end up dispensing only the information they see fit in order to influence a patient's decision making, not because of self-serving reasons, but alternatively, because the doctor sees himself/herself in control and more knowledgeable regarding the best interests of the patient. *Id.* See also Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990) (upholding a decision that a physician's judgment can be clouded by economic interests).

143. See Green, *supra* note 119, at 72.

144. Lynn M. LoPucki, *Twerski and Cohen's Second Revolution: A Systems/Strategic Perspective*, 94 NW. U. L. REV. 55, 63 (1999). “Risk adjustment is not perfect, and as a result, hospitals and doctors do not always receive the ratings they should.” *Id.*

#### IV. IMPACT

Medical statistical data in general may be used for a variety of reasons, including studies for employee review, rate setting by insurance companies, and in malpractice litigation, including negligence and informed consent.<sup>145</sup> For example, Blue Cross and Blue Shield currently adjust hospital reimbursement rates, and use the rates allotted as punishment or reward for the failures and successes of the medical care provided.<sup>146</sup> Notwithstanding any proffered benefit medical statistics could yield in informed consent, "the data are not now, nor will they ever be, perfect."<sup>147</sup> However, the use of comparative provider statistics, even if proven accurate, will not necessarily assist a plaintiff in making an informed decision.<sup>148</sup> Barraging a patient with additional information may confuse them, which not only steers away from the spirit of the doctrine of informed consent, but could damage an already tenuous relationship between the patient and physician.<sup>149</sup>

##### A. *Maintaining Patient Autonomy With Statistics*

"[C]onsent must be informed or knowledgeable in some meaningful sense if we are to accord it legal or moral significance."<sup>150</sup> Even if a physician has in their control accurate comparative provider statistics, having a physician translate the statistics adds chance to misleading or confusing their patients.<sup>151</sup> Allowing the patient to interpret the statistics offers no solution.<sup>152</sup> A patient who is inundated with statistical data, valid or not, is not generally equipped with the expertise to determine which statistics are relevant in making his/her decision, or how to interpret the statistics once they have decided what is relevant.<sup>153</sup> As a result, a patient

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145. See Twerski & Cohen, *supra* note 139, at 7-8.

146. See Green, *supra* note 119, at 56.

147. Douglas Sharrott, Note, *Provider-Specific Quality-of-Care Data: A Proposal for Limited Mandatory Disclosure*, 58 BROOK. L. REV. 85, 120 (1992).

148. See generally Green, *supra* note 119.

149. See *id.* at 70. Physicians who are against the dissemination of comparative provider statistics maintain that statistical information may be too complex for the patients to understand and may "ignore the data or draw erroneous and detrimental conclusions from the data." Sharrott, *supra* at note 147, at 93.

150. Schuck, *supra* note 102, at 900. See also *e.g.*, *Choctaw, Okla. & Gulf Ry. v. Jones*, 92 S.W. 244, 248 (Ark. 1906); *Baer v. Baird Mach. Co.*, 79 A. 673, 675 (Conn. 1911); *Fitzgerald v. Conn. River Paper Co.*, 29 N.E. 464, 465 (Mass. 1891); *Zurich Gen. Accident & Liab. Ins. Co. v. Childs Co.*, 171 N.E. 391, 392 (N.Y. 1930).

151. Schuck, *supra* note 102, at 900.

152. See generally Green, *supra* note 119. Including comparative provider statistics into the physician-patient discussions of the patient's options may enrich the informed consent process if the patient had some context in which to evaluate the new information, which in most cases, will not be likely. See Schuck, *supra* note 102, at 951.

153. Schuck, *supra* note 102, at 951. For example, in order to interpret and use to her benefit, the plaintiff in *Kokemoor* would have had to understand she needed the statistics on large posterior circulation aneurysm surgery rather than the statistics on aneurysm surgery generally that she was

can find they are suffering from “information overload, stress, and illness” which potentially vitiates any consent received from their treating physician.<sup>154</sup> Not being equipped to process the material provided prevents the patient from granting their informed consent, as confusion from the deluge of information contradicts the very purpose of the doctrine itself.<sup>155</sup> Some propose it is utility that is the most important element to evaluating informed consent.<sup>156</sup> That is, if the information provided by the physician does not affect, much less improve, the patient’s ability to make an informed decision, it is difficult to justify the requirement of disclosure in the first place, and such disclosure is useless.<sup>157</sup> Presumably, the decision in *Natanson v. Kline*,<sup>158</sup> which obliged physicians to use “language as simple as necessary,” comes from the belief that it is important for the patient to understand information disclosed by the physician.<sup>159</sup> It is in the delicate balance between too much difficult-to-understand information and not enough digestible information that the patient will be protected.<sup>160</sup> With the current informed consent laws, physicians are permitted to ignore all non-medical characteristics of patients.<sup>161</sup> Not listening to a patient’s needs and avoiding the more personal interaction, the doctor risks violating the autonomous purpose of the doctrine.<sup>162</sup> Accordingly, continuing the policy of not requiring a doctor to probe a patient for their needs that are driven by non-medical reasons, and instead requiring the physician to communicate characteristics of the physician to the patient, further jeopardizes the integrity of the doctrine.<sup>163</sup>

Furthermore, providing a patient with comparative provider statistics will not necessarily assist a plaintiff in proving a case against a physician.<sup>164</sup> Even the most sophisticated of patients will have a difficult time deciphering

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provided. See *Johnson v. Kokemoor*, 545 N.W.2d 495, 505 (Wis. 1996). Patients on the whole are not as medically sophisticated as the physicians from whom they seek treatment, and, as a result, rather than obtaining consent from the patient, physicians refer to the requirement as “consenting the patient.” Schuck, *supra* note 102, at 951.

154. Sheldon F. Kurtz, *The Law of Informed Consent: From “Doctor is Right” to “Patient Has Rights,”* 50 SYRACUSE L. REV. 1243, 1253 (2000) (citing CHARLES W. LIDZ ET AL., *INFORMED CONSENT: A STUDY OF DECISION MAKING IN PSYCHIATRY* 323 (Guilford Press 1984)).

155. See *supra* notes 77-90 and accompanying text.

156. See generally Schuck, *supra* note 102.

157. *Id.*

158. 350 P.2d 1093, 1106-07 (Kan. 1960).

159. Kurtz, *supra* note 153, at 1248.

160. See generally Gatter, *supra* note 27.

161. See *supra* notes 93-126 and accompanying text.

162. *Id.*

163. *Id.*

164. See Twerski & Cohen, *supra* note 139, at 32.

the figures presented to them. A patient who doesn't know the source of the statistics or the definitions of terms (such as "success rate") will be ill-provided with the tools to manage the information.

Is the definition so broad that it encompasses too many false positives (or so narrow that it excludes too many false negatives)? How would changing the definition alter the statistic? Similarly, how do the choices of measurements and samples affect the statistic? What would happen if different measures or samples were chosen? And how is the statistic used? Is it being interpreted appropriately, or has its meaning been mangled to create a mutant statistic? Are the comparisons that are being made appropriate, or are apples being confused with oranges? How do different choices produce the conflicting numbers found in stat wars?<sup>165</sup>

Moreover, from a legal standpoint, plaintiffs will still have the burden of proving that the harm would not have occurred if an alternative provider had performed the procedure.<sup>166</sup> Instead, patients may have a more difficult time securing treatment from the physicians they want treatment from, and physicians may be distracted from their patients and focused instead on their "batting averages."<sup>167</sup> In fact, the top ranked hospital in 1990 was ranked 24 of 30 just a year earlier.<sup>168</sup> One explanation for this hospital's quick rise to the top was the decision "not to do as many tougher cases."<sup>169</sup> This is only one example of how a patient could be harmed by relying on a particular provider being superior, when it is inaccurately reported statistics that make a poor provider look good.<sup>170</sup>

### *B. Doctor -Patient Relationship: Bedside Manner and Referrals*

Before taking into account the possibility of disclosing comparative provider statistics, it is important to acknowledge that the doctrine of informed consent requires only that the physician consider a patient's condition when talking about treatment options, and not personal or emotional concerns.<sup>171</sup> The motivation to obtain proper informed consent

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165. See Best, *supra* note 116.

166. *Id.*

167. Green, *supra* note 119, at 72. See also David Zinman, *Hearts in Need MDs: Coronary Specialists Avoiding High Risk Operations*, NEWSDAY, May 11, 1992, available at 1992 WL 7532569. "Severely ill heart patients are finding it increasingly difficult to get surgery, many doctors say, because some surgeons and hospitals are refusing to take patients they fear will lower their standing in state mortality statistics." *Id.*

168. Green, *supra* note 119, at 73.

169. Lawrence K. Altman, *Heart-Surgery Death Rates Decline in New York*, N.Y. TIMES, Dec. 5, 1990, at B10.

170. See Sharrott, *supra* note 96, at 120.

171. See Gatter, *supra* note 27, at 558. This is the case despite one of the main purposes of

can deter a physician from getting to know their patients, taking the time to ask the questions, and finding out what the specific treatment goal is for each patient.<sup>172</sup>

Even if the idealized vision of physician-patient interactions continues to be that of a longstanding relationship based on personal intimacy and earned trust, it seems safe to predict that most health care in the future will be delivered in a highly bureaucratic-technocratic context that discourages such relationships. In this context, informed consent cannot credibly function as the dialogic expression of a relationship that no longer exists. Instead, health care interactions will come to resemble the commercial sales and other episodic transactions to which less demanding informed consent requirements apply in other areas of tort law.<sup>173</sup>

### 1. Conflicts of Interest

Imposing a duty on physicians to disclose their success rates to their patients can further compound the flaws that already exist in the doctrine of informed consent.<sup>174</sup> Patients' emotional input in their decision making play an influential role in the accuracy of provider statistics, affecting any duty a physician may have to disclose them.<sup>175</sup> Doctors can strategically influence a patient's decision by selectively presenting data, and anticipating his/her response.<sup>176</sup> The ramifications of high mortality rates, statistically sound or not, are that a physician must improve or cease practicing.<sup>177</sup>

informed consent being the autonomy in patient decision-making. *Id.*; see also *supra* notes 77-90 and accompanying text. Because of the minimal requirements imposed on the physician, it is rare that a patient will ask follow-up questions. See Schuck, *supra* note 102, at 933.

172. See Gatter, *supra* note 27, at 558.

173. Schuck, *supra* note 102, at 926.

174. See *id.* The idea of creating more of a burden on a physician, that the physician need worry more about potential liability than assisting their patient, may create a divided loyalty. See *id.* Success rates have become more important than ever and the focus on these numbers deters the physician from becoming familiar with the patient and focusing more on insurance coverage in a managed health care system. See *id.*

175. See *supra* notes 92-124 and accompanying text; see also LoPucki, *supra* note 144, at 56.

176. See LoPucki, *supra* note 144. Despite a physicians' attempt to manipulate the outcome of a patient's decision, it is difficult to determine how the human element of that patient would come into play. See Twerski & Cohen, *supra* note 139, at 10. See also notes 109-112 and accompanying text. However, commentators continue to speculate that providers will combat adverse rankings by "cooking the statistics." *Id.*

177. See LoPucki, *supra* note 144, at 63.

Physicians already carry a burden of information disclosure in the states that use the reasonable patient standard.<sup>178</sup> “[T]he failure of providers to develop and communicate relevant statistical information to patients may take on greater significance” adding to this burden.<sup>179</sup> Placing the onus of determining relevant statistical information, as well as its compilation and communication, on the shoulders of the physician furthers the burden on the physician and limits the regulatory power of any outside source to contribute to the accuracy of the data and statistical analysis.<sup>180</sup> Doctors may find themselves likely to treat their patients’ feelings and specific medical needs as secondary to the dissemination of statistical information.<sup>181</sup> The very prospect undermines the purpose of informed consent,<sup>182</sup> which is not only to empower the patient with knowledge, but to give the physician the responsibility of putting his/her interests below the best interest of his/her patient.<sup>183</sup> While those who support this additional duty placed on health-care providers admit that there is no bright-line test regarding what statistical data should be delivered to the patient, they do not offer any guidelines or assistance to physicians in choosing what data to communicate.<sup>184</sup>

Furthermore, flawed statistics present the potential for a physician to falsely slander a “truly good provider’s reputation by incorrectly associating his or her identity with information indicative of bad care.”<sup>185</sup>

## 2. Referring Away the Treatable Patient

A duty to refer to other doctors because they may be better is absurd - the common law has long recognized a duty to refer patients to specialists, but this is typically limited to general practitioners.<sup>186</sup> If a duty to refer patients to the optimal provider is imposed on a doctor, the likelihood is that the doctor will consistently refer the same type of patients to the same doctor, and at some point the doctor who has received the referrals may have

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178. See *supra* note 46.

179. Twerski & Cohen, *supra* note 139, at 9.

180. See generally *id.*

181. See *id.* This is problematic, in light of courts’ determination that a “patient’s need determines the scope of the . . . communications.” Heinemann, *supra* note 54, at 1084.

182. The principal goals of informed consent, promoting and protecting patient autonomy, cannot be achieved without dissemination of reliable information which is communicated in an intelligible and meaningful way. See Schuck, *supra* note 102, at 948.

183. *Id.* at 921.

184. See LoPucki, *supra* note 144, at 65. The additional burden placed on physicians is yet to be clearly defined: “Providers would have to decide what information provides a reasonable basis for decisionmaking, disclose it to their patients, and then, if necessary, defend their choices of information in actions brought by their patients. Providers would not, however, be required to make disclosures that their patients did not want.” *Id.*

185. Sharrott, *supra* note 146 at 120.

186. *Martin v. Richards*, 192 Wis. 2d 156, 167 (1995). This reasoning has been in other jurisdictions as well. See *e.g.*, *Nisenholtz v. Mount Sinai Hosp.*, 483 N.Y.S.2d 568, 571 (N.Y. Sup. Ct. 1984).

to defer patients because of his/her schedule.<sup>187</sup> The patient having this knowledge can strain the relationship between the doctor and patient.<sup>188</sup> For instance, the patient who is referred to another practitioner and then referred again because of scheduling conflicts now is aware that he/she is not receiving the “best” care. Despite the fact that this physician might have been chosen initially, without the benefit of comparative provider statistics, the patient may not be happy with his/her treatment, and therefore subject to unnecessary stress and concern, for no other reason than having acquired knowledge.<sup>189</sup> If the patient has the ability to seek treatment from the physician to whom he/she was referred, the physician doing the referring may be left with little or no business.<sup>190</sup> Newly starting-out physicians may be severely hampered in gaining experience and those with physician records that appear blemished, may be destroyed.<sup>191</sup>

An improvement in the relationship between the doctor and patient is what will lead to improved health and an increase in patient satisfaction and loyalty.<sup>192</sup> In order to obtain more of a symbiotic relationship, doctors should be required to pay closer attention to the treatment goals of their patients,<sup>193</sup> rather than disseminate confusing, and inaccurate statistical data.<sup>194</sup>

#### V. CONCLUSION

While the availability of medical information continues to flourish, the imposition on a physician to disclose comparative-provider statistics to their patients will likely have a negative effect on the doctrine of informed consent.<sup>195</sup> This comment urges those eager to revolutionize informed consent to revisit the purpose of the doctrine itself.<sup>196</sup> Requiring doctors to disclose comparative statistical information can only result in strategically doctored statistics, confusion on the part of patients interpreting data, and a general decay in the doctor-patient relationship.<sup>197</sup> “If patients are

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187. See generally LoPucki, *supra* note 144.

188. *Id.*

189. *Id.* at 71.

190. *Id.* at 56.

191. See generally *id.*

192. *Id.*

193. See *id.* In addition to diagnosing a patient, taking the time to get to know the patient’s goals will also contribute to that patient truly making an autonomous decision. See *id.* An improved communication will assist the patient in their decision-making. *Id.*

194. See *id.*

195. See discussion *supra* Part IV.

196. See discussion *supra* Part II.B.3.

197. See discussion *supra* Part IV.B.



autonomous and capable of making decisions concerning their health care, and if that right is important to us as individuals and as a society, we must act in a way that encourages and enables patients to exercise that responsibility.”<sup>198</sup> And, if patient autonomy is truly the purpose and goal of informed consent, rather than to inundate a patient with potentially confusing and inaccurate information, a doctor should concentrate on listening to the wants and needs of his/her patient, those both medically and non-medically related.<sup>199</sup>

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198. Kurtz, *supra* note 154, at 1254.

199. See discussion *supra* Parts II.B.3., IV.

200. J.D. Candidate, Pepperdine University School of Law 2002. I would like to thank my friends and family and an extra special thank you to my husband Michael for making me a better person. Without their unwavering support and understanding I would never accomplish my goals.