ceived that a juror had been contacted on plaintiff's behalf. In an attempt to gain evidence of this, the government employed electronic monitoring and recording devices. This action by the government resulted in the declaration of a mistrial. The plaintiff contended that he could maintain an FTCA action against the United States for its interference with the jury because Arkansas law provides a civil damage remedy for violations of its criminal jury tampering statute. The court construed pertinent Arkansas law contrariwise and affirmed the district court's dismissal of the action.

In *Anderson v. United States*,[37] a Federal Tort Claims Act[38] (FTCA) case from the Northern District of Iowa, the court affirmed the trial court's dismissal of the action. Plaintiff was an accountant. As part of the Tax Preparer's Program, which is designed to locate dishonest or incompetent tax preparers, two Internal Revenue Service agents pretended to be taxpayers and sought plaintiff's services in preparing tax returns. After further investigation, plaintiff was arrested and charged with willfully aiding, assisting, procuring, counseling or advising the preparation of a false or fraudulent tax return.[39] At a preliminary hearing, the charges were dismissed.

Plaintiff then filed suit under the FTCA. The district court found the action was barred by 28 U.S.C. section 2680(a), the discretionary acts exception to the FTCA.[40] Plaintiff attempted to place the IRS agents' actions outside the discretionary acts doctrine on two separate grounds. He first asserted that the Tax Preparer's Program was unauthorized by statute and therefore not within the discretionary acts doctrine. The court rejected this contention on the basis of the Commissioner of Internal Revenue's authority to examine books, papers, records and other data which may be relevant to the determination of any person's tax liability or which may be relevant to the accuracy of any tax return.[41] Also held to be untenable was plaintiff's argument that the negligence complained of took place at the operational stage, rather than at the planning stage, of the Tax Preparer's Program. This theory was rejected because the specific acts alleged were set forth by the plaintiff as the consequences, rather than the direct acts, of negligence in establishing the program's objectives and the plans for its implementation.

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37. 548 F.2d 249 (8th Cir. 1977).
38. *See* note 35 *supra*.
39. 28 U.S.C. § 7206(2) (1970).
40. 28 U.S.C. § 2680(a) (1970) reads:
The provisions of this chapter and section 1346(b) of this title shall not apply to—

> (a) Any claim based upon an act or omission of an employee of the Government, exercising due care, in the execution of a statute or regulation, whether or not such statute or regulation be valid, or based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty on the part of a federal agency or an employee of the Government, whether or not the discretion involved be abused.

41. *See* I.R.C. §§ 7602(1), 6213, 6402.

Note

INFORMED CONSENT LIABILITY

I. INTRODUCTION

Medical malpractice claims traditionally tend to be grounded on allegations of the physician's failure to use reasonable care in the diagnosis or treatment of his patient's ills. Another aspect of a physician's duty to use reasonable care extends to disclosure of information to the patient in order to obtain from the patient what has been designated "informed consent."[1] The physician's liability under the doctrine of informed consent may attach irrespective of whether the physician has exercised the care required of medical practitioners in diagnosis or treatment,[2] and even though the purpose of the particular therapy has been successfully realized.[3]

The principle of this concept has been immortally expressed as: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages."[4] This fundamental concept of American jurisprudence has its roots in a philosophical commitment to the proposition that "over himself, over his own body and mind, the individual is sovereign."[5]

The doctrine of informed consent provides that a physician can be held liable for damages to a patient who assented to a particular medical treatment if the physician failed to render an adequate disclosure concerning the diagnosis, the procedure to be followed, the collateral or inherent risks of the procedure, and, in some jurisdictions, the alternative procedures that could be undertaken in lieu of the proposed procedure.[6] Major questions which pervade informed consent analysis have been answered neither uniformly nor adequately by the courts. This confusion has resulted in disagreement over the proper basis of

1. *See* Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628, 643 [hereinafter cited as Waltz & Scheuneman], wherein it is stated: "Consent . . . connotes the dual elements of awareness and assent."

2. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972); Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960).

3. As the doctrine of informed consent is concerned with nondisclosure of risks inherent in a course of treatment, it is possible that the treatment undergone by the patient is successful in curing the patient's malady, but a different type of injury materializes from the unrevealed risk, which may leave the patient in a more serious physical condition. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

4. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

5. J. MILL, ON LIBERTY 13 (Liberal Arts Press 1956).

6. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

liability that should be applicable to such actions, the precise duty to be imposed on physicians and the methods by which this duty should be established, the extent of disclosure that should be required, the standard to be employed to determine causation and the desirable scope of the defenses which the physician may assert.

As presently structured and interpreted by the courts, the informed consent doctrine fails to protect the right of patients to control decisions concerning their own medical therapy. The courts have shown an unwarranted deference to the medical profession in informed consent litigation,[7] resulting in the imposition of an extremely arduous burden of persuasion on the plaintiff-patient. The standards adopted by the courts have also been phrased in somewhat obscure language, thus creating a dilemma for the physician as to what information must be disclosed.[8] This lack of clarity further adds to the doctrine's ineffectiveness.

This Note will provide a basic overview of informed consent litigation, explore the pervasive issues involved, and offer some suggested recommendations for future application. As the courts have increasingly analyzed informed consent cases in the framework of negligence law, this Note will focus on the issues primarily related to such a structure.

II. The Physician-Patient Relationship

As the mechanism governing the extent of disclosure a physician is required to provide to his patient concerning a course of medical treatment, the doctrine of informed consent represents the only legal control over the communication component of the physician-patient relationship.[9] Technological and economic developments in recent years have transformed the nature of the physician's relationships with his or her patients into a less personalized process.[10] The increasing knowledge of medical science, the trend towards specialization in medical practice and the change in treatment settings have all contributed to a fragmentation of physician-patient relationships and a resulting decline in the number of "family doctors."[11] This fragmentation has spawned a relationship in which the physician, as the dominant figure, assumes extensive control over the decision-making process on a course of medical therapy, without possessing the intimate knowledge that the "family doctor" traditionally had at his disposal.[12] This development often results in the physician exercising "authoritarian" control over a "submissive patient" in the communication process, a de-

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7. *See* Riskin, *Informed Consent: Looking for the Action*, 1975 U. Ill. L.F. 580 [hereinafter cited as Riskin]; Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 Yale L.J. 1533 (1970) [hereinafter cited as Yale Note]; Comment, *Informed Consent in Medical Malpractice*, 55 Cal. L. Rev. 1396 (1967).
8. Riskin, *supra* note 7, at 582.
9. *Id.*
10. E. Jaco, Patients, Physicians and Illness 3-5 (1958) [hereinafter cited as Jaco].
11. *Id.* at 4.
12. *Id.*

velopment which is hardly consistent with the patient's legal right to be the ultimate decision-maker about his own medical therapy.[13]

An emerging approach which differs from the more prevalent authoritarian framework is that of a system wherein the patient exercises a greater degree of participation in the decision-making process.[14] The justification for this shared decision-making relationship can be advanced at two levels. First, a patient's interest in his own dignity and worth is reinforced through greater participation and involvement. It has been recognized that:

> To fail to acquaint a subject of observation or experiment with what is happening as fully as possible within the limits of the communication system is to that extent to degenerate him as a full human being and reduce him to the category of a dependency in which he is not permitted to judge for himself.[15]

The second level of justification for a greater assumption of responsibility by the patient in the decision-making process is that of the practical benefits which would accrue to the relationship and the treatment decision. These practical results have been held to include increasing rational decision-making,[16] diminishing the potential for fraud and duress,[17] encouraging the self-scrutiny of medical professionals,[18] reducing the level of the patient's anticipatory fear[19] and generally increasing the potential for a positive response on the part of the patient to the therapy provided.[20]

The mechanism of informed consent provides a unique instrument to enforce the patient's right to greater participation and involvement in the decision-making process. As the future of medical knowledge and technology promises to provide ever increasing forms of therapy, it seems reasonable to conclude that this expansion has the potential for an even greater fragmentation of the traditional communication framework between physicians and their patients.[21] It seems crucial to the right of the individual to exercise the ultimate judgment on a course of medical treatment and to maximize his potential for a positive response to his treatment and physician, that there exists an effective means to encourage greater disclosure on the part of physicians to patients.

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13. For an excellent discussion of the physician-patient relationship models, *see* Riskin, *supra* note 7; YALE Note, *supra* note 7.

14. *See* J. KATZ & A. CAPRON, CATASTROPHIC DISEASES: WHO DECIDES WHAT? 79-116 (1975) [hereinafter cited as KATZ & CAPRON].

15. Mead, *Research with Human Beings: A Model Derived from Anthropological Field Practice*, 98 DAEDALUS 361, 375 (1969).

16. KATZ & CAPRON, *supra* note 14, at 88-90.

17. *Id.* at 85-87.

18. *Id.* at 87-88.

19. I. JANIS, PSYCHOLOGICAL STRESS 352-53 (1958).

20. KATZ & CAPRON, *supra* note 14, at 89-90, wherein the authors conclude: "A well-informed patient, after all, is more alert to facts about his own condition that may be of great significance to the investigator, and he also feels freer about reporting what he experiences to his physician, without fear of upsetting him or losing his support. Similarly, a 'patient-partner' is better able to endure the often arduous period of recuperation."

21. *See generally* KATZ & CAPRON, *supra* note 14, at 79-116.

III. Basis of Liability:

The Battery-Negligence Distinction

The element of consent is the legal mechanism by which the physician becomes empowered to treat a patient. Without legally adequate consent, a physician who treats a patient may be held liable in tort for damages.[22] Consent may be ineffective because the physician has misrepresented the purported treatment,[23] has exceeded the limits of the consent obtained[24] or has failed to provide the patient with sufficient information concerning the risks of or the potential alternatives to the proposed therapy.[25] The courts have generally utilized battery theory in the first two situations, while adopting negligence theory for application in the latter situation.[26]

This distinction can best be explained by the reasoning that the physician's representations in the first two situations are directed to the nature and character of the proposed treatment, with the result that the patient fails to understand the true nature or character of the treatment actually given.[27] Thus, the patient's consent is vitiated. On the other hand, where a patient assents to the course of treatment actually performed by the physician, the physician's failure to disclose the risks or alternatives to the treatment does not consist of misrepresentations as to the nature and character of the treatment.[28] Thus, while the patient under these circumstances understands the nature and character of the treatment to be performed, he is unaware of the possibility of avoiding the collateral or increased injury which may result from the treatment. A failure to disclose the risks inherent in the procedure to be adopted, and, in some jurisdictions, the alternatives to the proposed treatment, has also been treated as rendering ineffective the patient's consent. In this situation, courts have increasingly recognized a duty to disclose this pertinent information as an extension of the physician's duty to use the care required of reasonable medical practitioners.[29] Thus, liability is based on negligence principles.

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22. This liability may arise under either assault and battery theory or negligence theory.

23. Funke v. Fieldman, 212 Kan. 524, 512 P.2d 539 (1973) (anesthesiologist's disclosure to the plaintiff that headaches were the only risk involved in the administration of spinal anesthesia constituted a misleading statement since the anesthesiologist knew of the risk of paralysis); Bang v. Charles T. Miller Hosp., 251 Minn. 427, 88 N.W.2d 186 (1958) (plaintiff assented to a prostate operation without disclosure from his physician that the operation necessitated the severance of his spermatic chords).

24. Gray v. Grunnagle, 423 Pa. 144, 223 A.2d 663 (1966) (defendant-surgeons attempted a corrective procedure during an "exploratory operation" without the patient's assent).

25. Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960) (physician's failure to inform the plaintiff of any of the risks involved in cobalt irradiation therapy was a breach of his duty of disclosure as a matter of law).

26. *See* Plante, *An Analysis of "Informed Consent"*, 36 Fordham L. Rev. 639, 648-50 (1968) [hereinafter cited as Plante].

27. *Id.*

28. *Id.*

29. Prosser, Law of Torts 165 (4th ed. 1971) [hereinafter cited as Prosser].

In *Cobbs v. Grant*,[30] the plaintiff alleged that his physician failed to disclose the risks of stomach and spleen injury inherent in a particular ulcer operation. In discussing the proper basis for liability for failure to disclose the perils inherent or collateral to a proposed course of treatment, the California Supreme Court stated:

> We agree with the majority trend. The battery theory should be reserved for those circumstances when a doctor performs an operation to which the plaintiff has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. However, when the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears: rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation the action should be pleaded in negligence.[31]

A battery consists of an unpermitted touching of one person by another person.[32] Where the physician performs a different course of treatment than the one assented to, or exceeds the limits of the consent given, a cause of action for battery arises. The factual issues to be determined in such a case are whether the physician informed the patient of the treatment he intended to perform and whether the patient had an adequate understanding of what the physician intended to do.[33] Since the legal wrong in a battery action is the touching itself, causation is presumed once the touching without permission is established.[34] However, in those jurisdictions utilizing the battery theory as a basis of liability for failure to disclose information regarding risks or alternatives,[35] some of the courts have muddled the battery theory of causation by incorporating a type of "but for" test from negligence law.[36] This addition has resulted in somewhat of a hybrid cause of action in those jurisdictions utilizing battery theory as a basis of liability in the situation where the risks and alternatives have not been adequately disclosed.

The differences between negligence and battery as a basis of liability for nondisclosure of pertinent information are not merely theoretical. An action under negligence theory imposes a more stringent measure of damages, the plaintiff being limited to recovery for injuries attributable to the undisclosed risk

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30. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).
31. Cobbs v. Grant, 8 Cal. 3d 229, 240-41, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972). *See also* Perin v. Hayne, 210 N.W.2d 609, 618 (Iowa 1973).
32. Plante, *supra* note 26, at 648.
33. *Id.* at 657-58.
34. *Id.* at 666.
35. Fogal v. Genesee Hosp., 41 App. Div. 2d 468, 344 N.Y.S.2d 552 (1973); Cooper v. Roberts, 220 Pa. Super. 260, 286 A.2d 647 (1971).
36. *See, e.g.*, Zeleznik v. Jewish Chronic Disease Hosp., 47 App. Div. 2d 199, 366 N.Y.S.2d 163 (1975); Fogal v. Genesee Hosp., 41 App. Div. 2d 468, 344 N.Y.S.2d 552 (1973).

that actually caused the injury sustained by the plaintiff.[37] On the other hand, damages under battery theory extend to all injuries flowing from the unconsented touching, and in some cases, punitive damages.[38] Another significant distinction is that under battery theory, a plaintiff need not establish the physician's duty of disclosure by expert medical testimony as is required in the majority of those jurisdictions applying the negligence framework.[39] Additionally, in a number of jurisdictions, the statute of limitations governing battery is shorter than the limitations period for negligence.[40] Perhaps the most significant variance between the two theories concerns the burden of proof imposed upon the plaintiff. Due to the elimination of the necessity for proof on the duty of disclosure and the lessened risk of nonpersuasion on the question of causation, a plaintiff bringing an action based on battery faces a far less demanding burden of proof than the burden under negligence theory, which one jurist has characterized as "almost . . . insurmountable."[41]

A number of reasons have been offered by the courts to justify the adoption of the negligence framework in recoveries for nondisclosure of risks or alternatives. First, the courts appear hesitant to label informed consent liability as battery because of the criminal origin of battery and the resulting social stigma that would fall upon physicians held liable under this label.[42] Second, the courts have exhibited some concern about whether malpractice liability insurance coverage includes liability for assault and battery.[43] Third, the courts have shown a reluctance to allow physicians to be held liable for the punitive damages traditionally allowed under a battery theory.[44] Fourth, and perhaps the most perplexing reason offered by the courts to distinguish informed consent claims from usual battery actions is that, in informed consent situations, the physician is invariably acting in "good faith" with an absence of "hostile intent."[45]

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37. *See* Riskin, *supra* note 7, at 585. The courts have not focused much attention on damages standards. The general standard has been properly criticized by commentators as "unduly harsh." *See* Waltz & Scheuneman, *supra* note 1, at 648-49. *See also* Note, *Informed Consent—A Proposed Standard for Medical Disclosure*, 48 N.Y.U.L. REV. 548, 550 (1973) [hereinafter cited as N.Y.U. Note], wherein the authors conclude that where a nondisclosed risk is involved, the plaintiff's damages should be measured by the difference between his probable condition if he had remained untreated and his condition after treatment, and where a nondisclosed alternative is involved, by the difference between the patient's actual condition and his probable condition if he had undergone treatment after being informed of all pertinent alternatives.

38. *See* Riskin, *supra* note 7, at 585.

39. *Id.* at 584.

40. Plante, *supra* note 26, at 669.

41. Nishi v. Hartwell, 52 Haw. 188, —, 473 P.2d 116, 127 (1970) (Abe, J., dissenting).

42. *See* Trogun v. Fruchtman, 58 Wis. 2d 596, 207 N.W.2d 297 (1973).

43. *Id.*

44. *Id.*

45. *See* Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Trogun v. Fruchtman, 58 Wis. 2d 596, 207 N.W.2d 297 (1973). This distinction is perplexing for the reason that normally all that is required is "the intent to bring about such a contact." PROSSER, *supra* note 29, at 37. *See also* F. HARPER & F. JAMES, THE LAW OF TORTS 216 (1956) [hereinafter cited as HARPER & JAMES], wherein it is stated that the requisite element of intent for battery "need not be malicious, nor need it be an intention to inflict actual damage. It is sufficient if the actor intends to inflict either a harmful or offensive contact without the other's consent."

On a theoretical plane, the trend in characterizing informed consent actions as negligence deprives the plaintiff of the protection of his interest in dignity. Battery theory protects an individual from interference with his bodily integrity in a physical sense and from interference with his interest in dignity by the guarantee of freedom from offensive contact. The rejection of battery as a basis of liability and the resulting adoption of negligence would seem to preclude recovery solely for an infringement of an individual's interest in dignity since under a negligence theory recovery is precluded unless actual physical harm has resulted by virtue of the nondisclosure.[46]

IV. Negligence as a Framework for Informed Consent

A. *What Constitutes the Duty of Disclosure?*

As the courts began to interpret the failure of a physician to disclose the risks in a proposed course of treatment as an aspect of the physician's duty to use reasonable care, it was only natural that the standards adopted to govern informed consent would be analogous to those standards governing medical malpractice in general.[47] The initial efforts at analyzing informed consent as a theory of negligence liability adopted the principle from malpractice law that the duty of the physician is dependent upon the standard of care exercised by similar practitioners in like circumstances.[48] A corollary requirement of this principle is that the standard of care exercised by medical practitioners in like circumstances be proven by expert medical testimony.[49] Due to these traditional tort principles, the rule has evolved that, at the risk of nonpersuasion, the plaintiff must prove through expert medical testimony that the failure of the physician to disclose a certain risk or alternative was not in accord with professional custom and therefore the nondisclosing physician failed to exercise the duty required of him.[50] Failure to meet this burden mandates a finding that the physician was under no duty of disclosure, and therefore cannot be held liable for negligence. In many cases, where the plaintiff was unable for whatever reason to introduce expert testimony on the question of the duty to disclose, a

46. *See* Riskin, *supra* note 7, at 603-04.

47. The initial case adopting negligence as a standard appears to have been Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960), which involved the failure of the physician to disclose the risks inherent in cobalt irradiation therapy.

48. *See, e.g.*, DiFilippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961); Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966); Roberts v. Young, 369 Mich. 133, 119 N.W.2d 627 (1963); Govin v. Hunter, 374 P.2d 421 (Wyo. 1962).

49. *See* Aiken v. Clary, 396 S.W.2d 668, 675 (Mo. 1965), where the court stated: "we hold that plaintiff, in order to sustain his burden of proof, is required to offer expert testimony to show what disclosures a reasonable medical practitioner, under the same or similar circumstances, would have made." *See also* Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966).

50. DiFilippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961); Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966); Collins v. Meeker, 198 Kan. 390, 424 P.2d 488 (1967); Haggerty v. McCarthy, 344 Mass. 136, 181 N.E.2d 562 (1962); Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965); Roberts v. Young, 369 Mich. 133, 119 N.W.2d 627 (1963); Zebarth v. Swedish Hosp. Medical Center, 81 Wash. 2d 12, 499 P.2d 1 (1972); Govin v. Hunter, 374 P.2d 421 (Wyo. 1962).

dismissal or a directed verdict for the physician was the ultimate disposition.[51] The fundamental premise of the rule requiring the plaintiff to show the custom of the relevant medical community by expert testimony in order to establish the very existence of a tort duty[52] is that the physician's decision regarding disclosure is peculiarly a medical judgment which is incomprehensible to the jury or court without the assistance of the physician's fellow practitioners' testimony.[53]

However, some courts have begun to move away from the requirement of expert testimony to establish the duty of disclosure. In the seminal case of *Canterbury v. Spence*,[54] the plaintiff alleged that the defendant-physician failed to inform him of the risk of paralysis inherent in a laminectomy procedure. The District of Columbia Court of Appeals reversed the lower court decision which had granted a directed verdict for the defendant, and in so doing, initiated a new chapter in the evolution of informed consent law. The *Canterbury* court rejected the proposition that the existence of a duty to disclose should be dependent on "professional tradition," grounding this rejection on the premise that the decision to disclose is not a peculiarly medical determination. The court stated that:

> The decision to unveil the patient's condition and the chances as to remediation, as we shall see, is ofttimes a *non-medical* judgment and, if so, is a decision outside the ambit of the special standard. Where that is the situation, professional custom hardly furnishes the legal criterion for measuring the physician's responsibility to reasonably inform his patient of the options and the hazards as to his treatment.
>
> The majority rule, moreover, is at war with our prior holdings that a showing of medical practice, however probative, does not fix the standard governing recovery for medical malpractice. Prevailing medical practice, we have maintained, has evidentiary value in determinations as to what the specific criteria measuring challenged professional conduct are and whether they have been met, but does not itself define the standard.[55]

The ultimate result of the *Canterbury* decision and its progeny is that it is not incumbent upon the plaintiff to prove by a preponderance of the *expert medical testimony* that the "reasonable medical practitioner" would have made disclosure under the circumstances. Although such testimony has evidentiary value, it is not essential in order to establish the existence of a tort duty upon the physician. Thus, the plaintiff's prospects of avoiding a dismissal or directed verdict for lack of evidence on the issue of duty are improved.

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51. *See, e.g.*, Karp v. Cooley, 493 F.2d 408 (5th Cir. 1974); Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970); Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966); Roberts v. Young, 369 Mich. 133, 119 N.W.2d 627 (1963); Govin v. Hunter, 374 P.2d 421 (Wyo. 1962).

52. The concept of a duty in tort has been said to embrace the question of "whether, upon the facts in evidence, such a relation exists between the parties that the community will impose a legal obligation upon one for the benefit of the other—or, more simply, whether the interest of the plaintiff which has suffered invasion was entitled to legal protection . . . ." PROSSER, *supra* note 29, at 206.

53. *See* Grosjean v. Spencer, 258 Iowa 685, 692, 140 N.W.2d 139, 143-44 (1966).

54. 464 F.2d 772 (D.C. Cir. 1972).

55. Canterbury v. Spence, 464 F.2d 772, 785 (D.C. Cir. 1972) (emphasis added).

Canterbury v. Spence[56] and its progeny[57] advanced ample justification for the rejection of the foundations of the majority rule requiring expert medical testimony. These decisions essentially characterized the majority rule as "needlessly overbroad"[58] and generally adopted the rule that a physician's duty to disclose is defined by what information is material to the patient's decision with "modifications only to the extent that medical judgment enters the picture."[59] The courts base their rejection of the majority rule on a number of considerations. The major thrust of their concern is the "virtual absolute discretion"[60] afforded the medical profession where the "professional custom" rule is operative. The assertion is also made that medical custom in disclosure cases is more difficult to establish concretely than in the traditional malpractice areas of treatment or diagnosis due to the unique circumstances present in each physician-patient relationship.[61] Furthermore, the courts are concerned about the so-called "conspiracy of silence"[62] and its impact on the plaintiff's ability to meet his burden of proof.[63] These courts also embrace the concept that the standards to be applied in informed consent actions should focus on what is of importance to the patient, and the emphasis of the majority rule on general medical practice relegates the patient's needs and rights to secondary importance.[64]

B. *What is the Scope of the Disclosure Duty?*

Those jurisdictions which follow the traditional rule of requiring expert testimony to establish a duty to disclose require that the scope or extent of the

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56. 464 F.2d 772 (D.C. Cir. 1972).

57. Riedinger v. Colburn, 361 F. Supp. 1073 (D. Idaho 1973); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); Hamilton v. Hardy, 549 P.2d 1099 (Colo. Ct. App. 1976); Zeleznick v. Jewish Chronic Disease Hosp., 47 App. Div. 2d 199, 366 N.Y.S.2d 163 (1975); Fogal v. Genesee Hosp., 41 App. Div. 2d 468, 344 N.Y.S.2d 552 (1973); Congrove v. Holmes, 37 Ohio Misc. 95, 308 N.E.2d 765 (Ct. Common Pleas 1973); Getchell v. Mansfield, 260 Ore. 174, 489 P.2d 953 (1971); Cooper v. Roberts, 220 Pa. Super. 260, 286 A.2d 647 (1971); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972); Longmire v. Hoey, 512 S.W.2d 307 (Tenn. Ct. App. 1974); Small v. Gifford Memorial Hosp., 349 A.2d 703 (Vt. 1975); Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd per curiam*, 85 Wash. 2d 151, 530 P.2d 334 (1975); Trogun v. Fruchtman, 58 Wis. 2d 569, 207 N.W.2d 297 (1973).

The "trend" towards the *Canterbury* decision, however, is by no means universal. A number of recent decisions have opted for the "majority" rule. *See* Pegram v. Sisco, 406 F. Supp. 776 (W.D. Ark. 1976); Walker v. North Dakota Eye Clinic, Ltd., 415 F. Supp. 891 (D.N.D. 1976); Karp v. Cooley, 493 F.2d 408 (5th Cir. 1974); Riedesser v. Nelson, 111 Ariz. 542, 534 P.2d 1052 (1975); Miceikis v. Field, 37 Ill. App. 3d 763, 347 N.E.2d 320 (1976); Ficklin v. Macfarlane, 550 P.2d 1295 (Utah 1976); Bly v. Rhoads, 222 S.E.2d 783 (Va. 1976).

58. Cobbs v. Grant, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

59. Canterbury v. Spence, 464 F.2d 772, 785 (D.C. Cir. 1972).

60. Cobbs v. Grant, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

61. *See, e.g.*, Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676, 687 (1972).

62. *See* Huffman v. Lindquist, 37 Cal. 2d 465, 234 P.2d 34, 46 (1951) (Carter, J., dissenting), for a discussion of the "conspiracy of silence." The subject is also discussed in Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment*, 1 VILL. L. REV. 250 (1956).

63. Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676, 687 (1972).

64. *Id.*

disclosure be in accord with reasonable medical custom.[65] This standard is subject to a number of qualifications. First of all, the scope of the physician's duty does not demand "full" disclosure. In *Williams v. Menehan*,[66] the Kansas Supreme Court stated:

> it is the duty of a doctor to make a reasonable disclosure to his patient of the nature and probable consequences of the suggested or recommended treatment, and to make a reasonable disclosure of the dangers within his knowledge which are incident or possible in the treatment he proposes to administer. But this does not mean that a doctor is under an obligation to describe in detail all of the possible consequences of treatment. To make a complete disclosure of all facts, diagnoses and alternatives or possibilities which might occur to the doctor could so alarm the patient that it would, in fact, constitute bad medical practice.[67]

A second qualification is that a physician is under a duty to disclose only pertinent risks or alternatives of which he has actual knowledge or reason to know. If the evidence presented justifies a finding that the physician had no actual knowledge of the nondisclosed risk or alternative and that the nondisclosed risk or alternative was not generally known within the relevant medical community, the plaintiff is not entitled to recover.[68] Another limitation on the prevailing standard is that the physician need not disclose relatively minor risks inherent in common procedures where it is common knowledge that such risks are incidental to the treatment[69] or where the patient has actual knowledge of the risk that later materializes.[70] A physician also need not disclose information concerning the course of therapy proposed if the patient requests that he not be so informed.[71]

Those jurisdictions rejecting the majority rule, while retaining the usual limitations on the scope of disclosure enumerated above, follow a different approach on the general standard governing the extent or scope of the disclosure required of physicians. Rather than focusing on prevalent medical custom, the test generally adopted is one of "materiality to the patient's decision."[72] However, the jurisdictions are apparently not in agreement on how to determine materiality. In *Wilkinson v. Vesey*,[73] the Supreme Court of Rhode Island adopted an "objective" test in measuring what is material to the patient's decision by focusing on the physician's view of the patient's position:

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65. *See, e.g.*, Aiken v. Clary, 396 S.W.2d 668, 675 (Mo. 1965).
66. 191 Kan. 6, 379 P.2d 292 (1963).
67. Williams v. Menehan, 191 Kan. 6, 8, 379 P.2d 292, 294 (1963). *See also* Grosjean v. Spencer, 258 Iowa 685, 693-94, 140 N.W.2d 139, 144 (1966).
68. *See* Trogun v. Fruchtman, 58 Wis. 2d 569, 207 N.W.2d 297 (1973) (physicians in the Milwaukee area had insufficient knowledge of the side effects of the drug administered to the plaintiff).
69. *See* Roberts v. Young, 369 Mich. 133, 119 N.W.2d 627 (1963) (physician need not disclose the risk of an infection developing subsequent to a hysterectomy).
70. Canterbury v. Spence, 464 F.2d 772, 788 (D.C. Cir. 1972).
71. Cobbs v. Grant, 8 Cal. 3d 229, 245, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972).
72. *Id.* at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.
73. 110 R.I. 606, 295 A.2d 676 (1972).

> [A] physician is bound to disclose all the known material risks to the proposed procedure. Materiality may be said to be 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.[74]

The opposing approach in determining whether an undisclosed risk or alternative is material is that taken in *Cobbs v. Grant*.[75] The California court appears to have implicitly adopted a "subjective" test which focuses on whether the particular patient would have considered the nondisclosed information sufficiently significant so as to affect his decision.

C. *Proximate Cause: The Plaintiff's Burden*

The decisions on informed consent, in applying traditional negligence principles, have required the plaintiff to establish a causal connection between the nondisclosure of the legally required information and the injury and damages sustained by the plaintiff. A component of this burden imposed upon the plaintiff is that the unrevealed risk that should have been disclosed later materializes and causes the physical injury upon which the claim for damages is grounded.[76] The burden which the plaintiff assumes as to this element of his cause of action is basically a form of the traditional "but for" test. In order to prevail on the causation issue, the plaintiff must establish that the undisclosed risk later materialized to cause his harm and that if the required disclosure of the risk or alternatives had been made prior to his agreement to the treatment adopted, the plaintiff would not have given his consent to the particular treatment undergone.

There is some disagreement among the jurisdictions as to the proper standard to apply concerning the causation test. The vast majority of courts prefer what has been termed the "objective" test, which has been expressed as:

> what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance. If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not.[77]

The alternative to the objective test for causation is the "subjective" test, with the essential inquiry being whether the particular plaintiff would have consented to the therapy adopted if he had been apprised of the undisclosed risk or alternatives.[78]

The dominant objection advanced by those courts rejecting the subjective test is that the determination of causation under this test turns solely on the

74. Wilkinson v. Vesey, 110 R.I. 606, —, 295 A.2d 676, 689 (1972). *See also* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972), which adopted a similar approach.
75. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).
76. Canterbury v. Spence, 464 F.2d 772, 790 (D.C. Cir. 1972).
77. *Id.* at 791.
78. Wilkinson v. Vesey, 110 R.I. 606, —, 295 A.2d 676, 690 (1972).

patient's credibility.[79] This objection is based on the court's apprehension over the possibility that the hindsight of the plaintiff will subject the physician to the bitterness and disillusionment of the injured patient.[80] Another problem inherent in the use of the subjective test is that since the standard is so dependent upon the testimony of the patient-plaintiff, if that testimony is unavailable due to the plaintiff's death, the plaintiff's representative will be held to an even more arduous burden of proof.[81]

D. *The Physician's Defenses*

1. *Absence of a Duty*

The majority of decisions on informed consent have focused primarily on the question of whether a duty of disclosure existed under the circumstances.[82] In those jurisdictions utilizing the traditional rules, the physician's first defense may be that the custom or practice of the relevant medical community does not demand disclosure under the circumstances, and therefore no tort duty of disclosure should be imposed. Physicians have had a great deal of success utilizing this argument, since the plaintiff often fails to produce the necessary expert medical testimony, while the physician does not normally have this difficulty.[83]

In those jurisdictions governed by the materiality standard, the physician's usual contention may very well be that the lack of disclosure was immaterial. This contention could embrace a variety of considerations: that the likelihood that the peril would materialize was minimal;[84] that the severity of the peril was minimal;[85] that the physician had no knowledge at the time when disclosure should have been made of the existence of the alternative or of the likelihood that the particular risk would materialize;[86] or, that the danger which materialized was actually known by the patient or was of such common knowledge that the court should impute knowledge to the plaintiff-patient.[87]

2. *Existence of an Emergency*

Another defense available to avoid liability under the informed consent doctrine is the presence of an emergency which requires immediate treatment. Where such an emergency is present, the physician's duty to disclose is inoperative, as the law implies that consent is present due to the impracticability of

79. Cobbs v. Grant, 8 Cal. 3d 229, 245, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972).
80. *Id.*
81. *See, e.g.*, Karp v. Cooley, 493 F.2d 408 (5th Cir. 1974).
82. *See* text accompanying notes 47-75 *supra.*
83. *See* Agnew v. Parks, 172 Cal. App. 2d 756, 343 P.2d 118 (1970), wherein a patient sued a group of doctors for their refusal to testify.
84. Canterbury v. Spence, 464 F.2d 772, 788 (D.C. Cir. 1972).
85. *Id.*
86. *See* Trogun v. Fruchtman, 58 Wis. 2d 569, 207 N.W.2d 297 (1973).
87. *See* Roberts v. Young, 369 Mich. 13, 119 N.W.2d 627 (1963).

securing the patient's consent.[88] In emergency situations, or where the patient is incapable of providing his consent, it has been suggested that the physician should attempt to obtain the consent for the treatment from a relative of the patient,[89] but it appears doubtful that the recipient of the disclosure can make a valid refusal to the treatment unless a special relationship is present, such as parenthood or guardianship.[90] The question of what constitutes an emergency should be determined by whether the harm from a failure to treat the patient is imminent and whether such harm outweighs any harm threatened by the proposed treatment.[91]

3. *Therapeutic Privilege*

The physician's major option in his arsenal of defenses is what the courts have denominated the physician's "therapeutic privilege." This privilege justifies the failure of a physician to disclose risks inherent or collateral to the therapy adopted on the basis that, under the particular circumstances, medical reasons dictate that no disclosure should be made due to the precarious state of the patient's physical or emotional condition. The foundation of this principle was first clarified in *Salgo v. Leland Stanford Jr. University Board of Trustees*,[92] wherein the court stated:

> At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.[93]

The therapeutic privilege concept appears to have been universally adopted by those courts considering the action of informed consent. The decisions are somewhat unclear as to whether the privilege operates as a component of the plaintiff's burden to show the existence of a duty to disclose under the circumstances,[94] or whether the assertion of the privilege operates as an affirmative

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88. Plante, *supra* note 26, at 654.
89. Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir. 1972).
90. *See* Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970).
91. Canterbury v. Spence, 464 F.2d 772, 788 (D.C. Cir. 1972).
92. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).
93. Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).
94. *See* Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970).

defense with the risk of nonpersuasion on the physician.[95] There is also some degree of confusion over the methods to be utilized and the quantum of proof necessary to render the privilege operative.[96]

Deference to the discretion of the medical profession in the determination of whether the patient's therapeutic interests would benefit from disclosure is certainly warranted. However, some courts have viewed the scope of the discretion afforded to physicians with some concern. In *Canterbury v. Spence*,[97] the court expressed such concern when it stated:

> The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well being.
>
> The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs.[98]

Thus, it would appear that standards relating to the quantum of proof necessary for the application of the privilege need to be fashioned by the courts in future litigation.

V. The Argument For Reform

A. *The Duty to Disclose: Potential Directions*

The resolution of the issue of whether the existence of a duty to disclose information concerning risks or alternatives should be determined by medical custom as established by expert witnesses is dependent upon whether disclosure is essentially a medical judgment and whether policy considerations justify the imposition of such an onerous burden of proof upon the plaintiff-patient. The physician's decision about whether to disclose pertinent information certainly embraces medical factors. However, the ultimate judgment to be rendered is essentially an interpretation of the patient's subjective concerns.[99] The underlying rationale of the expert testimony rule used by a majority of jurisdictions is that the nature of the subject matter is incomprehensible to laymen without the aid of experts.[100] Requiring the plaintiff to establish by expert medical

95. Cobbs v. Grant, 8 Cal. 3d 229, 246, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972).

96. *See* Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970) (Abe, J., dissenting); Yale Note, *supra* note 7, at 1564-69.

97. 464 F.2d 772 (D.C. Cir. 1972).

98. Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir. 1972).

99. *See* Cobbs v. Grant, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972), wherein the court concludes: "The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone."

100. *See, e.g.*, Grosjean v. Spencer, 258 Iowa 685, 692, 140 N.W.2d 139, 143-44 (1966).

Although the materiality standard may not offer physicians concrete guidance as to their responsibilities regarding information disclosure, the standard is preferable when weighed against the infirmities and vagueness inherent in the medical custom approach to the existence of a duty to disclose. As informed consent theory guarantees a patient the right to base his decision on sufficient information, the materiality standard has the advantage of focusing on the patient's needs. The standard is also superior to the extent that it eliminates an unwarranted obstacle from the plaintiff's burden of proof. Finally, the materiality standard tends to encourage greater patient involvement in the decision-making process,[112] which may in turn create medical and social benefits.[113]

B. *The Causation Issue: Resolving the Inconsistencies*

The issue of informed consent causation, as currently interpreted by the courts, is fraught with difficulty. The reliance on traditional negligence concepts here is but another example of the unrealistic structural obstacles imposed on the plaintiff-patient. The structure of the causation requirement as a type of "but for" test imposes an onerous burden of proof on the plaintiff.[114] A number of recent decisions have focused on this issue, often resulting in a denial of relief to the plaintiff-patient.[115]

The principle underlying the informed consent doctrine has been expressed as follows: "The keystone of this doctrine is every competent adult's right to forego treatment, or even cure, if it entails what for him are intolerable consequenses or risks however unwise his sense of values may be in the eyes of the medical profession or even the community."[116] This principle reflects the law's commitment to the individual's right to make whatever decision he deems appropriate regardless of how unreasonable it may be. However, the causation

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plegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures, with the probability of each such risk if reasonably determinable.

2. Acknowledges that the disclosure of that information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

3. Is signed by the patient for whom the procedure is to be performed, or if the patient for any reason lacks legal capacity to consent, is signed by a person who has legal authority to consent on behalf of that patient in those circumstances.

IOWA CODE § 147.137 (1977).

112. *See* Riskin, *supra* note 7, at 589.

113. *See generally* KATZ & CAPRON, *supra* note 14, at 79-116. These authors conclude that the practical benefits which would result from greater patient participation include: an increase in rational decision making; diminution of the potential for fraud and duress; encouragement of the development of self-scrutiny on the part of medical professionals; and an increase in the potential for a positive response on the part of the patient to the therapy. *Id. See also* text accompanying notes 9-21 *supra*.

114. *See* Riskin, *supra* note 7, at 589.

115. Poulin v. Zartman, 542 P.2d 251 (Alas. 1975) (no evidence presented to establish causation); Riedisser v. Nelson, 111 Ariz. 542, 534 P.2d 1052 (1975) (insufficient evidence to establish causation); Morgenroth v. Pacific Medical Center, Inc., 54 Cal. App. 3d 521, 126 Cal. Rptr. 681 (1976) (insufficient evidence to establish causation).

116. Wilkinson v. Vesey, 110 R.I. 606, —, 295 A.2d 676, 687 (1972). *See also* HARPER & JAMES, *supra* note 45, at 61 (Supp. 1968).

test utilized by the vast majority of jurisdictions is in many respects theoretically and practically inconsistent with this underlying premise. As the objective causation test[117] is measured in terms of what a "reasonable" or "prudent" patient would decide concerning the treatment if he had known of the nondisclosed information prior to giving his assent, the test is essentially inconsistent with the doctrine's theoretical foundation in that the mythical "reasonable" or "prudent" man would presumably not make unreasonable decisions. Due to this contradiction, the objective test offers no protection to the patient who exercises his theoretical right to make an unreasonable decision.

Although the so-called subjective test[118] is more consistent with informed consent theory, the courts have with near unanimity rejected its adoption out of concern for reducing the issue of causation to a credibility contest and subjecting the physician to the disillusioned hindsight of the plaintiff.[119] A factor in this criticism is the valid proposition that the plaintiff, at the time of trial, is in reality in no position to determine what course of action he would have pursued prior to treatment if he had known of the nondisclosed information.

If negligence is retained as the proper analytic structure for an informed consent action, and if the doctrine is to be effective in protecting the rights of patients, modification of the causation standards now applicable is desirable. However, while at least one jurist[120] and one commentator[121] have advocated the discontinuance of the "but for" standard, it seems unlikely that the courts would follow such an approach. A potential modification of the causation test might be as follows: whether the failure of the physician to disclose the material information to the plaintiff-patient was a substantial factor in the plaintiff's decision to undergo the particular treatment adopted.[122] This standard results in a lesser burden of proof for the plaintiff and includes a subjective element. At least in theory, this test protects the right of the patient to exercise an unreasonable decision on a course of therapy. Although the burden of proving causation remains with the plaintiff, the risk of persuasion would be reduced from the present onerous burden.[123]

The "substantial factor" standard has been successfully applied by the courts in situations involving the potential of concurrent negligence.[124] The ef-

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117. *See* text accompanying notes 76-77 *supra.*
118. *See* text accompanying notes 78-81 *supra.*
119. Cobbs v. Grant, 8 Cal. 3d 229, 245, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972); Zebarth v. Swedish Hosp. Medical Center, 81 Wash. 2d 12, —, 499 P.2d 1, 12-13 (1972).
120. Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970) (Abe, J., dissenting).
121. *See* Riskin, *supra* note 7, at 600-04.
122. *See, e.g.*, Speed v. State, 240 N.W.2d 901, 905 (Iowa 1976), wherein the court, in discussing proximate cause, stated: "Plaintiff must show that Dr. Paul's negligence was a substantial factor in bringing about the blindness; otherwise the negligence would not create liability."
123. *See* Riskin, *supra* note 7, at 600-06. Riskin advocates a similar approach, but would shift the burden of proof on the issue to the defendant-physician to disprove that the nondisclosure influenced the patient's decision.
124. *See* PROSSER, *supra* note 29, at 238-41.

fect of this test is that the courts are permitting the plaintiff to meet his burden of proof on the causation issue by showing that a defendant's conduct was a probable factor in causing the injury sustained by the plaintiff.[125] Its applicability in informed consent situations would require the patient to show that it was more likely than not that the physician's failure to disclose material information was a substantial factor in his decision to undergo the treatment. The physician, on the other hand, could counter with evidence that the nondisclosure was not a substantial cause under the circumstances, due to the necessity of that particular treatment and the probability therefore that the treatment would have been assented to even had full disclosure been made.

C. *The Therapeutic Privilege*

The therapeutic privilege of physicians concerning information disclosure has generally not been defined with sufficient structural specificity.[126] The degree of discretion afforded physicians in many jurisdictions should be definitively limited or such discretion will have the potential of substantially negating disclosure requirements.[127]

In *Cobbs v. Grant*,[128] the California Supreme Court stated:

> A disclosure need not be made beyond that required within the medical community when a doctor can prove by a preponderance of the evidence he relied upon facts which would demonstrate to a reasonable man the disclosure would have so upset the patient that the patient would not have been able to dispassionately weigh the risks of refusing to undergo the recommended treatment. * * * Any defense, of course, must be consistent with what has been termed the "fiducial qualities" of the physician-patient relationship.[129]

The standard adopted in *Cobbs* properly places the burden of proof on the physician to show that the failure to disclose the required information was medically appropriate.[130] Some jurisdictions appear to require the plaintiff to show that the prevailing circumstances did not warrant the application of the therapeutic privilege, thus interpreting the lack of privilege as a component of the duty requirement.[131] The burden of proof should rest with the defendant in these situations, as the defendant is in a more advantageous position to assert facts necessary to show that the application of the privilege was warranted. Furthermore, treating the application of the privilege as an affirmative defense is consistent with fiduciary principles regarding the shifting of the burden of

125. *See* Riskin, *supra* note 7, at 605.
126. *See* YALE Note, *supra* note 7, at 1564-69.
127. Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir. 1972).
128. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).
129. Cobbs v. Grant, 8 Cal. 3d 229, 246, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972).
130. *See also* Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir. 1972).
131. *See* Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970); Getchell v. Mansfield, 260 Ore. 174, 489 P.2d 953 (1971); Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd per curiam*, 85 Wash. 2d 151, 530 P.2d 334 (1975).

proof.[132] Utilization of the therapeutic privilege as an affirmative defense to informed consent liability diminishes the potential for arbitrary application of the privilege. As a result, a greater degree of shared decision-making in the physician-patient relationship is encouraged and the patient's right to receive sufficient information regarding the proposed course of therapy is better protected.

In any event, the application of the therapeutic privilege should not be dependent upon the subjective interpretation of the physician claiming its exercise. To justify nondisclosure based on the subjective beliefs of a particular physician is to give that physician an unwarranted degree of discretion before liability will attach.[133] The test should be one of reasonableness, and testimony of other disinterested physicians should be required to establish that the circumstances prevailing at the time justified nondisclosure for established medical reasons.[134]

VI. Conclusion

The suggestions offered in this Note would tend to create a more viable legal device to protect a patient's right to act upon sufficient information when deciding on a course of medical therapy. A criticism of these suggestions might be that as a result of their operation informed consent actions would proliferate and impose undue liability on physicians. Yet there is substantial evidence that a major cause of the increase in malpractice claims in recent years is the poor communication between physicians and their patients.[135] More complete information disclosure may very well have a tendency to reduce such claims in the final analysis.[136]

Perhaps the deference afforded the medical profession through the current structure of informed consent law is desirable, but it is not without its costs. If policy considerations dictate that a greater degree of shared decision-making between physicians and patients would be socially beneficial, then the present structure must be modified to make the doctrine of informed consent an effective instrument to achieve this goal.

Bruce C. Recher

132. *See* Pepper v. Litton, 308 U.S. 295, 306 (1939).
133. Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116 (1970) (Abe, J., dissenting).
134. *Id.*
135. *See* Riskin, *supra* note 7, at 609.
136. *Id.*

Case Notes

CONSTITUTIONAL LAW—A STATE MAY CONSTITUTIONALLY REGULATE THE ABORTION DECISION DURING THE FIRST TRIMESTER OF PREGNANCY IF IT CAN SHOW THAT THE REGULATION IS NECESSARY TO PROTECT A COMPELLING STATE INTEREST AND THE REGULATION, AS APPLIED, DOES NOT UNNECESSARILY BURDEN THE WOMAN'S RIGHT TO PRIVACY.—*Planned Parenthood v. Danforth* (U.S. Sup. Ct. 1976).

The state of Missouri enacted a law in 1974 regulating certain abortion decisions.[1] Planned Parenthood of Central Missouri and two physicians challenged the constitutionality of the statute, claiming it violated the limitations on permissible state regulation set forth in *Roe v. Wade*.[2] Plaintiffs sought declaratory and injunctive relief.

Plaintiff physicians were granted standing[3] to challenge the sections of the statute defining viability, proscribing a specified abortion technique, and prescribing the standard of care due aborted fetuses.[4] All of these sections were alleged to unconstitutionally interfere with the physicians' right to practice medicine. The physicians also were granted standing to challenge sections of the statute requiring consent—not only by the woman, but also by a parent if she

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1. The full text of the Missouri statute is reported in Planned Parenthood v. Danforth, 428 U.S. 52, 84-89 (1976).

2. 410 U.S. 113 (1973). Plaintiffs herein claimed that certain provisions in the statute

> deprived them and their patients of various constitutional rights: 'the right to privacy in the physician-patient relationship'; the physician's 'right to practice medicine according to the highest standards of medical practice'; the female patients' right to determine whether to bear children; the patients' 'right to life due to the inherent risk involved in childbirth' or in medical procedures alternative to abortion; the physicians' 'right to give and plaintiffs' patients' right to receive safe and adequate medical advice and treatment, pertaining to the decision of whether to carry a given pregnancy to term and method of termination'; the patients' right under the Eighth Amendment to be free from cruel and unusual punishment 'by forcing and coercing them to bear each pregnancy they conceived; and, by being placed 'in the position of decision making beset with . . . inherent possibilities of bias and conflict of interest,' and the physician's right to due process of law guaranteed by the Fourteenth Amendment.

Planned Parenthood v. Danforth, 428 U.S. 52, 57-58 (1976).

3. The Court reaffirmed its position in Doe v. Bolton, 410 U.S. 179, 188 (1973), that

> '[t]he physician is the one against whom [the Missouri Act] directly operate[s] in the event he procures an abortion that does not meet the statutory exceptions and conditions. The physician-appellants, therefore, assert a sufficiently direct threat of personal detriment. They should not be required to await and undergo a criminal prosecution as the sole means of seeking relief.'

Planned Parenthood v. Danforth, 428 U.S. 52, 62 (1976).

4. *Id.*