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THE DOCTRINES OF LACK OF CONSENT AND LACK OF INFORMED CONSENT IN MEDICAL PROCEDURES IN LOUISIANA

Gary L. Boland*

It is generally accepted that the average patient does not know much about medicine. This ignorance is important in a medical malpractice cause of action when the patient asserts that he has not been informed of (or did not understand enough about) the risks, benefits, or costs of the particular procedure or treatment to have given the physician permission to proceed with the procedure or treatment.

This article will examine the elements of the causes of action involving patient consent in the light of three recent Louisiana Supreme Court decisions,¹ Louisiana statutory provisions,² and jurisprudence from other jurisdictions.³ The recent Louisiana Supreme Court decisions addressed many of the problems raised by the causation element in lack of consent or informed consent cases, as well as the question of whether a patient's lack of consent provides a different cause of action from that for medical malpractice. And while some problems are answered in title 40 of the Louisiana Revised Statutes, the answers to some of the remaining questions involving patient consent require an examination of the jurisprudence of other jurisdictions.

The doctrine of informed consent has generated considerable controversy in the courts, among legal scholars and attorneys, and within the health care professions.⁴ It also constitutes one of the primary sources of antagonism between doctors and lawyers, since the issue of informed consent is most often raised⁵ in the context of a lawsuit against the doctor for medical negligence.⁵ A patient who has suffered an undesired result

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1. *Gunter v. Plauche*, 439 So. 2d 437 (La. 1983); *Pizzalotto v. Wilson*, 437 So. 2d 859 (La. 1983); *LaCaze v. Collier*, 434 So. 2d 1039 (La. 1983) (Dennis, J., concurring, 437 So. 2d 869).

2. See *infra* notes 197-200 and accompanying text.

3. See *infra* notes 15-142 and accompanying text.

4. Comment, Patient Consent in Louisiana, 27 *Loy. L. Rev.* 1166 (1981).

5. J. Ludlam, *Informed Consent* 6 (1978).

of treatment and is unable to prove that his doctor was negligent can also seek relief on a different basis of liability—lack of informed consent.⁶ An allegation of a lack of informed consent will not only fortify a weak case of medical negligence, it will also guarantee the plaintiff that his case will reach the jury.⁷ As a result, it is hardly surprising that the percentage of malpractice suits alleging a lack of informed consent is increasing.⁸

It has been suggested that the doctrine of informed consent requiring that a patient must be provided with pertinent information regarding the course of his medical and surgical treatment was born of a change in society's attitude toward the doctor-patient relationship.⁹ The patient is no longer viewed as a passive entity within the paternalistic medical system of "doctor knows best."¹⁰ Today, the patient is viewed as having the right to determine the direction of his medical treatment and to base his decisions on accurate information supplied by his doctor. In response to the patient's need for accurate information so that he may be an informed participant in the medical decision-making process, the legal system has developed the concept of informed consent.¹¹

In 1983 the Louisiana Supreme Court decided three informed consent cases.¹² These were the first patient consent cases decided by the court since 1917.¹³ The Louisiana Supreme Court, in applying Louisiana law in many informed consent cases, has relied on decisions from other jurisdictions and doctrinal literature.¹⁴ A review of the pivotal cases from

6. Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance between Competing Values in Medical Decisionmaking*, 1979 *Wis. L. Rev.* 413.

7. J. Ludlam, *supra* note 5, at 6-7.

8. Karlson & Erwin, *Medical Malpractice: Informed Consent to the Locality Rule*, 12 *Ind. L. Rev.* 653, 653 (1979). ("[T]here is a great probability that malpractice suits will increase as patients become more aware of legal remedies. Two legal doctrines, *res ipsa loquitur* and informed consent, are regarded by the medical profession as the legal foundation for the expansion in malpractice liability.").

9. Maldonado, *Strict Liability and Informed Consent: "Don't Say I Didn't Tell You So!"*, 9 *Akron L. Rev.* 609, 611-13 (1976).

10. *Id.*

11. See W. Prosser, *Handbook of the Law of Torts* § 18 (4th ed. 1971).

12. See cases cited *supra* note 1.

13. *Theodore v. Ellis*, 141 La. 709, 75 So. 655 (1917).

14. See, e.g., *Pizzalotto v. Wilson*, 437 So. 2d at 862 (citing *Schloendorff v. Society of New York Hosps.*, 211 N.Y. 125, 105 N.E. 92, 93 (1914); 1 F. Harper & F. James, *The Law of Torts* §§ 3.1-3.3 (1956)); *LaCaze v. Collier*, 434 So. 2d 1039 (La. 1983) (citing *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064, 93 S.Ct. 560 (1972); *Wall v. Brim*, 138 F.2d 478, 479 n.7 (5th Cir. 1943); *Cobbs v. Grant*, 8 Cal. 3d 229, 239-40, 502 P.2d 1, 7-8, 104 Cal. Rptr. 505, 511-12 (1972); *Salgo v. Stanford Univ.*, 154 Cal. App. 2d 560, 317 P.2d 170 (1957); *Natanson v. Kline*, 186 Kan. 393, 403-404, 350 P.2d 1093, 1101-02 (1960); *Perle v. St. Paul Fire & Marine Ins. Co.*, 349 So. 2d 1289, 1298 (La. App. 1st Cir. 1977) (quoting *Trogun v. Fructman*, 58 Wis. 2d 569, 207 N.W.2d 297 (1973)); *State v. Housekeeper*, 70 Md. 162, 16 A. 382 (1889); *McGuire v. Rix*, 118 Neb. 434, 225 N.W. 120, 123 (1929); *Kennedy v. Parrott*, 243 N.C. 355, 90 S.E.2d 754

other jurisdictions from which the issues involving informed consent cases have evolved is therefore appropriate in order to better understand the principles recently enunciated by the Louisiana Supreme Court.

EVOLUTION AND PRINCIPLES OF THE DOCTRINE OF INFORMED CONSENT

Development of the Lack of Consent or Battery Concept in Medical Malpractice Jurisprudence

One of the earliest reported cases in which a physician was sued by a patient who claimed she had never consented to treatment was based on the tort of battery.¹⁵ Anna Mohr went to Dr. Williams, the defendant, who diagnosed a serious disease in her right ear. He did not suggest that there was anything wrong with her left ear. After Mrs. Mohr was anesthetized, Dr. Williams examined both ears and discovered that the left ear was more seriously diseased than the right. He decided to operate upon the left ear while the patient was asleep rather than wake her up, obtain permission to operate on the left ear, and then anesthetize her again. The operation was a success. Mrs. Mohr, however, felt differently about the matter, and sued Dr. Williams on the theory of battery for an unauthorized touching. In *Mohr*, the defendant, Dr. Williams, contended that assault and battery was not the proper cause of action because of the "entire absence of any evidence tending to show an evil intent."¹⁶ The defendant's position was that, since there was no evidence that he was motivated by wrongful intent or was guilty of negligence, there was no assault and battery. The court disagreed with his theory of medical liability, and held that: "If the operation was performed without plaintiff's consent, and the circumstances were not such as to justify its performance without, it was wrongful; and, if it was wrongful, it was unlawful."¹⁷ The effect of this holding was that, even when the patient was unable to consent, such as while under anesthesia, and the performance of a particular procedure would have been in a patient's best interest, the physician could not proceed without consent.

(1956); *Hunt v. Bradshaw*, 242 N.C. 517, 88 S.E.2d 762 (1955); *Cooper v. Roberts*, 220 Pa. Super. 260, 286 A.2d 647 (1971); *Nolan v. Kechijian*, 75 R.I. 165, 64 A.2d 866 (1949); *Paulsen v. Gunderson*, 218 Wis. 578, 260 N.W. 448 (1935); *Slater v. Baker & Stapleton*, 95 Eng. Rep. 860, 862 (K.B. 1767); A. Rosoff, *Informed Consent* 33-41 (1981); Capron, *Informed Consent*, 123 U. Pa. L. Rev. 340, 404-18 (1974); McCoid, *The Care Required of Medical Practitioners*, 12 Vand. L. Rev. 549, 586-90 (1959); Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 Neb. L. Rev. 51, 74-86 (1977); Victor, *Informed Consent*, 1981 Med. Trial Technique Q. 138, 139-41); *Gunter v. Plauche*, 439 So. 2d at 440 (citing no foreign cases, but citing *LaCaze* with approval).

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

16. *Id.* at 270, 104 N.W. at 16.

17. *Id.* at 271, 104 N.W. at 17.

After *Mohr*, several other jurisdictions followed the court's ruling that the nonconsensual treatment of a patient constituted a battery.¹⁸ The landmark case that entrenched the principle in the jurisprudence of a majority of jurisdictions for the next forty-six years was *Schloendorff v. Society of New York Hospitals*,¹⁹ written by Judge Cardozo while he was serving on the Court of Appeals of New York. The principle set forth in *Schloendorff* is generally regarded as the touchstone for the doctrine that it is the patient's right to determine the fate of his body and life. This principle embodies a basic right to physical integrity which many authorities have interpreted as being protected by the United States Constitution. The physician's obligation in treatment is to save lives, but he must have the patient's consent before proceeding unless an emergency exists and the patient can not give consent. The following passage has been quoted in almost every treatise or journal article on informed consent.

In the case at hand, the wrong complained of is not merely negligence. It is trespass. 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. *Pratt v. Davis . . . Mohr v. Williams . . .* This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained. The fact that the wrong complained of here is trespass rather than negligence, distinguishes this case from most of the cases that have preceded it. In such circumstances the hospital's exemption from liability can hardly rest upon implied waiver. Relatively to this transaction, the plaintiff was a stranger. She had never consented to become a patient for any purpose other than an examination under ether. She had never waived the right to recover damages for any wrong resulting from this operation, for she had forbidden the operation.²⁰

The early "battery principle" cases have a common thread which distinguishes them from those cases involving a cause of action for negligence.²¹ In a battery cause of action, the procedure is performed without prior disclosure by the physician to the patient of the nature of

18. See, e.g., *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906) (affirming a judgment for trespass to the person, *i.e.*, battery); *Rolater v. Strain*, 39 Okla. 572, 137 P. 96 (1913) (holding that where plaintiff expressly refused to allow the physician to remove a bone from her foot, his doing so anyway constituted an actionable battery).

19. 211 N.Y. 125, 105 N.E. 92 (1914).

20. *Id.* at 129-30, 105 N.E. at 93.

21. See Plante [sic], *An Analysis of "Informed Consent,"* 36 *Fordham L. Rev.* 639, 650 (1968) [hereinafter cited as *Plant, Analysis*].

“that treatment,” and the patient may actually be unaware that a procedure is going to be performed.²² In a negligence cause of action, the nature of the particular treatment is explained to the patient, but possible complications, risks of treatment, and alternatives are not disclosed.

The battery action, which is still a viable cause of action under certain circumstances,²³ was clarified and distinguished from the negligence action by the California Supreme Court in 1972 in *Cobbs v. Grant*.²⁴ The court indicated the need to distinguish these theories of recovery by discussing whether liability for the failure to disclose “material information” in informed consent cases should be based on a theory of battery or of negligence.

The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient 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.²⁵

When the battery theory of liability is used, the patient must prove that the doctor’s “touching” caused an injury, but the patient does not have to prove a causal link between the doctor’s failure to disclose information and the decision to undergo the procedure in question.

The *Cobbs* decision is still regarded as the most authoritative statement of the crucial elements necessary in the battery theory.

Development of the Concept of the Physician’s Duty to Inform the Patient of the Risks of Treatment.

The physician’s duty to disclose the risks of medical procedures to his patients was not a concern of the early consent cases as the courts continued to develop and apply the battery theory to these situations. In *Salgo v. Stanford University*,²⁶ the California Court of Appeals recognized for the first time that, not only was the patient’s consent required,

22. See *Keen v. Coleman*, 67 Ga. App. 331, 20 S.E.2d 175 (1942).

23. See, e.g., *Pizzalotto v. Wilson*, 437 So. 2d at 862-63 (La. 1983).

24. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

25. *Id.* at 240, 502 P.2d at 8, 104 Cal. Rptr. at 512 (1972).

26. 154 Cal. App. 2d 560, 317 P.2d 170 (1957). See Comment, *New Trends in Informed Consent*, 54 Neb. L. Rev. 66, 68 (1975).

but that this must be an informed consent. Thus, the doctor was under a duty to disclose to his patient all facts necessary to enable the patient to give an intelligent consent.

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. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent²⁷

The *Salgo* court also recognized the need for the physician to balance the duty to disclose the information necessary for the patient to consent intelligently to medical treatment against the duty to withhold other information that might jeopardize the patient's welfare.

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.²⁸

The requirement that the physician's disclosure of the information necessary for the patient to consent intelligently be tempered with his consideration of the patient's physical and mental condition was to become known as the "therapeutic privilege," and is a defense to the lack of informed consent. Later cases have attempted to clarify the circumstances in which the "therapeutic privilege" may be invoked.²⁹ These include situations where disclosure will prevent a rational decision, cause psychological damage to the patient,³⁰ or unduly upset or weaken an unstable patient.³¹

27. 154 Cal. App. 2d at 578, 317 P.2d at 181.

28. *Id.*

29. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Repr. 505 (1972); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972).

30. *Canterbury v. Spence*, 464 F.2d at 789.

31. *Wilkinson v. Vesey*, 110 R.I. at 628, 295 A.2d at 689.

The only definite restriction is that a physician may not remain silent merely because disclosure might induce a patient to refuse therapy which the physician feels is essential to the patient's well-being.³²

Additional exceptions to the disclosure requirement include the absence of any duty to disclose risks involved in a procedure when the risks are in fact known to the patient due to a previous experience with the procedure.³³ Physicians are also not required to inform their patients of dangers of which persons of average sophistication are likely to be aware.³⁴ The *Salgo* court articulated the two competing considerations which are integral parts of the doctrine of lack of informed consent: (1) the "duty" on the part of the physician to disclose enough information to the patient to form the basis of an intelligent consent;³⁵ and (2) the physician's therapeutic privilege to withhold potentially harmful information from the patient.³⁶

Not until *Natanson v. Kline*³⁷ was the issue raised of whether the physician's duty to disclose the risks that might result from a proposed medical treatment should allow the patient to recover under a theory of negligence. Mrs. Natanson, in her lawsuit against Dr. Kline for medical malpractice based on negligence, alleged that Dr. Kline was negligent in the administration of the therapy and in the failure to warn her that the treatment involved great risk of bodily injury or death.³⁸ Citing *Salgo*,³⁹ the court held that the physician was obligated to make a full disclosure of the facts necessary to insure an "informed consent."⁴⁰ The court further noted that the physician's duty of disclosure is limited to those disclosures that a reasonable medical practitioner would make under the same or similar circumstances.

How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment. So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses

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

33. *Id.* at 788; *Butler v. Berkeley*, 25 N.C. App. 325, 329, 213 S.E.2d 571, 580 (1975) (quoting *Canterbury*, 464 F.2d at 788); *Wilkinson v. Vesey*, 110 R.I. at 627-28, 295 A.2d at 689.

34. *Canterbury*, 464 F.2d at 778; *Butler*, 25 N.C. App. at 342, 213 S.E.2d at 582; *Wilkinson*, 110 R.I. at 627, 295 A.2d at 689.

35. *Salgo v. Stanford Univ.*, 154 Cal. App. 2d at 578, 317 P.2d at 181.

36. *Id.*

37. 186 Kan. 393, 350 P.2d 1093, reh'g denied, 187 Kan. 186, 354 P.2d 670 (1960) (cobalt radiation treatment for breast cancer resulting in severe injury to the skin, cartilage, and bone of the plaintiff's chest wall).

38. 186 Kan. at 400, 350 P.2d at 1099.

39. See *supra* notes 26-28 and accompanying text.

40. 186 Kan. at 410, 350 P.2d at 1106.

should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.⁴¹

In its opinion denying a rehearing, the court adopted what might be termed the "locality rule" of disclosure; it requires the plaintiff to produce expert testimony bearing on whether the disclosure was in accordance with "that of a reasonable medical practitioner under the same or similar circumstances."⁴² The court also stated that a physician has a legal duty to make a reasonable disclosure to his patient "as a matter of law."⁴³

Two days after the issuance of the first *Natanson* opinion, the Supreme Court of Missouri dealt with the same informed consent issue in *Mitchell v. Robinson*.⁴⁴ In *Mitchell*, the court recognized a duty on the part of a physician to advise the patient of the collateral hazards (side effects) of a proposed medical treatment. Since the plaintiff claimed that the physician had not informed him of the risks inherent in the treatment, the court held that the question of whether the hazards of the therapy had been explained was a question of fact for the jury. The court cited *Mohr*⁴⁵ and an article in the *Minnesota Law Review*⁴⁶ as authority for the existence of a "duty" of a physician to make a reasonable disclosure of the hazards of a particular procedure.⁴⁷ The court also determined that, since this case involved a fact issue to be presented to a jury, no expert medical testimony was needed.⁴⁸

[C]onsidering the nature of Mitchell's illness and this rather new and radical procedure with its rather high incidence of serious and permanent injuries not connected with the illness, the doctors owed their patient in possession of his faculties the duty to inform him generally of the possible serious collateral hazards; and in the detailed circumstances there was a submissible fact issue of whether the doctors were negligent in failing to inform him of the dangers of shock therapy.⁴⁹

Professor Plant in an article written in 1968⁵⁰ characterized *Natanson*

41. *Id.*

42. 187 Kan. at 187, 354 P.2d at 671.

43. *Id.* at 189, 354 P.2d at 673.

44. 334 S.W.2d 11 (Mo. 1960) (Patient under insulin shock treatment fractured vertebrae in convulsive reaction, a risk undisclosed by the physician.).

45. 95 Minn. 261, 104 N.W. 12 (1905).

46. McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment, 41 Minn. L. Rev. 381 (1957).

47. 334 S.W.2d at 15. See *supra* text accompanying notes 15-17.

48. *Id.* at 16.

49. *Id.* at 19.

50. Plant, *Analysis*, *supra* note 21, at 648. Professor Plant attributes the erroneous impression that a new cause of action was created to several writers' misinterpretations of

and *Mitchell* as being interpreted by lawyers as a new cause of action. Other writers have traced the beginning of "informed consent" claims to the combined legal effect of the *Mitchell* and *Natanson* decisions because after those decisions were published the frequency with which "informed consent issues" have been litigated has increased both in number and in relation to nearly every other issue litigated in malpractice actions.⁵¹

The Quality or Standards of the Disclosure

Once the courts recognized the existence of the physician's duty to inform the patient of the risks of the medical procedure, the difficult problem of how much information to disclose to the patient remained. At first the courts followed *Salgo* and required full disclosure,⁵² but objections were soon made that full disclosure of all risks was too burdensome for physicians and too anxiety-producing for patients.⁵³ The courts developed three standards of disclosure: (1) the professional standard; (2) the materiality or objective standard (also known as the reasonable man view); and (3) the subjective standard.

The Professional Standard

The professional standard of due care is based on the custom of a profession.⁵⁴ This standard has been expressed in many different ways,⁵⁵ but it commonly requires first, that compliance with custom be sufficient to avoid liability⁵⁶ and second, that the plaintiff establish his case through expert testimony.⁵⁷ Although custom is usually not a defense in a negligence action,⁵⁸ the medical profession enjoys the privilege of adopting its own custom as a standard of due care.⁵⁹ This privilege is justified as supplying

both *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960), and *McCoid*, supra note 46, as well as to a misleading American Law Report annotation, Annot., 79 A.L.R. 2d 1028 (1961).

51. *Plant, Analysis*, supra note 21, at 647-48.

52. *Salgo v. Stanford Univ.*, 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

53. See, e.g., *Woods v. Brunlop*, 71 N.M. 221, 228, 377 P.2d 520, 525 (1962), overruled, *Gerety v. Demers*, 92 N.M. 396, 411, 589 P.2d 180, 195 (1978) (replacing the "full disclosure" standard with a "subjective standard"); cf. *Watson v. Clutts*, 262 N.C. 153, 159, 136 S.E.2d 617, 621 (1964) (refusing to adopt the "extreme" disclosure standard of *Salgo*), modified on other grounds, *McPherson v. Ellis*, 305 N.C. 266, 273, 287 S.E.2d 892, 897 (1982) (holding that plaintiff may testify that he would have refused treatment if informed).

54. W. Prosser, *Handbook of the Law of Torts* § 32 (3d ed. 1964); *McCoid*, supra note 14, at 606.

55. *McCoid*, supra note 14, at 558-59.

56. Lambert, *Malpractice Liability Concepts Affecting All Professions*, in *Medical Malpractice—the ATL Seminar 7* (L. Harolds & M. Block eds. 1966).

57. *McCoid*, supra note 14, at 606.

58. Lambert, supra note 56, at 7.

59. *Id.* at 9.

the only workable test⁶⁰ to apply to medical care cases since, in this area, the lay person is considered incapable of evaluating a doctor's conduct and because the courts want to allow doctors a great deal of discretion.⁶¹ Expert testimony is required because lay people presumably are not familiar with medical custom.⁶²

The majority of jurisdictions have adopted the position exemplified by the 1974 holding of the United States Fifth Circuit Court of Appeals in *Karp v. Colley*.⁶³ The *Karp* rule "compels a physician to disclose facts which a reasonable medical practitioner in a similar community and of the same school of medical thought would have disclosed regarding proposed treatment."⁶⁴ *Karp* makes clear that "only doctors are competent to testify about medical customs,"⁶⁵ and therefore requires the plaintiff in an informed consent medical malpractice case to introduce expert testimony to show that the physician had a duty to disclose. Therefore, in the states which adhere to the *Karp* test, a plaintiff must show, not only that the physician defendant failed to inform him of the nature or hazards of the procedure,⁶⁶ but also that the physician deviated from the disclosure practices of other physicians in the same or similar locality.⁶⁷

The Objective or Reasonable Man View

A minority of jurisdictions has adopted the objective or reasonable man view that a physician's duty to disclose is measured by the average or reasonable patient's need for information relevant to his decision of whether to accept the proposed treatment.⁶⁸ This approach places emphasis upon the perceptions of patients rather than upon those of the medical community. The first court to adopt this reasoning was the Circuit Court of Appeals for the District of Columbia in *Canterbury v. Spence*.⁶⁹ The majority in *Canterbury* held that the law, not medical custom, must define the standard of disclosure and that the standard should be based on what the patient needs to know in order to make an informed decision.⁷⁰ Respect for the patient's right of self-determination demands an external standard

60. McCoid, *supra* note 14, at 607-08.

61. *Id.*

62. E.g., *Decho v. Shutkin*, 144 Conn. 102, 106, 127 A.2d 618, 620 (1956).

63. 493 F.2d 408 (5th Cir. 1974).

64. *Id.* at 419.

65. *Id.*

66. *Gravis v. Physicians and Surgeons Hosp.*, 415 S.W.2d 674, 679 (Tex. Civ. App. 1967), *rev'd on other grounds*, 427 S.W.2d 210 (Tex. 1968).

67. D. Warren, *Problems in Hospital Law* 126 (3d ed. 1978). See also *Anderson v. Hooker*, 420 S.W.2d 235, 238-39 (Tex. Civ. App. 1967).

68. *Canterbury v. Spence*, 464 F.2d at 783-85.

69. *Id.* at 776.

70. *Id.* at 786-87.

set by law for physicians rather than a standard over which physicians have complete control.⁷¹ The court, however, rejected a subjective standard requiring disclosure of those risks which the particular patient would have deemed significant.⁷² Instead, the court adopted an objective standard requiring disclosure whenever "a reasonable person in the patient's position" would have attached significance to the risk in deciding whether to consent to the proposed procedure.⁷³ Under the objective standard, expert witnesses are unnecessary to show the materiality of risks to a patient's decision.⁷⁴ The elimination of the need for expert testimony to establish whether a risk should have been disclosed makes the materiality standard a much more favorable one for plaintiffs than is the professional standard.⁷⁵ Furthermore, the plaintiff is relieved of the burden of supplying expert testimony,⁷⁶ and the jury decides whether the physician's disclosure was adequate for a reasonable person's informed consent.⁷⁷

The Subjective Standard

Another minority view is the subjective standard, illustrated by *Scott v. Bradford*,⁷⁸ a 1979 Oklahoma Supreme Court decision. Rejecting the medical paternalism of *Karp* jurisdictions and refusing to apply the reasonable man view of the *Canterbury* jurisdictions, the *Scott* court adopted a full disclosure standard.⁷⁹ Hence, under *Scott* the finder of fact determines what risks were material to the particular patient's treatment decision.⁸⁰ The question to be answered by the jury is whether this patient wanted to undergo this operation and, if he had known of the risk of the procedure, whether he would have consented to it. Therefore, the focus of the subjective standard is the testimony of the patient as to whether he would have undergone the procedure. The need for expert medical testimony is eliminated.

An expansion of patients' rights beyond those inherent in the doctrine of informed consent was articulated by the California Supreme Court

71. *Id.* at 784.

72. *Id.* at 787.

73. *Id.*

74. See *Wilkinson v. Vesey*, 110 R.I. at 625-26, 295 A.2d at 688 (stating that either side may still introduce expert testimony to explain difficult concepts).

75. See Bucklin, *Informed Consent: Past, Present, and Future*, in *Legal Medicine Annual* 1975, at 203, at 213 (C. Wecht ed. 1976).

76. The plaintiff often encounters significant problems in obtaining expert testimony due to the "conspiracy of silence" among physicians. See *infra* text accompanying notes 97-109.

77. *Miller v. Kennedy*, 11 Wash. App. 272, 288, 522 P.2d 852, 864 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975).

78. 606 P.2d 554 (Okla. 1979).

79. *Id.* at 558-59.

80. *Id.* at 558.

in *Truman v. Thomas* and is known as "informed refusal or dissent."⁸¹ While the Court ostensibly used the objective disclosure standard, it actually applied the subjective standard. In *Truman* the court determined that a physician must supply a patient with all material information concerning a proposed test before the patient can make a properly informed decision of whether to submit to the proposed procedure.⁸² The court defined material information as that information which is not commonly known and which would be "regarded as significant by a reasonable person in that patient's position."⁸³ Moreover, the duty to inform requires the physician to determine and satisfy each patient's special needs for information.⁸⁴

These guidelines apply equally to treatment and to diagnostic procedures,⁸⁵ regardless of whether the patient accepts the suggested procedure.⁸⁶ Even if the test or the treatment itself is without risk, the court imposed an obligation on the physician to describe "all material risks" which a patient might assume in refusing to submit to a procedure.⁸⁷

The *Truman* court quoted four basic assumptions upon which the *Cobbs* court had based the physician's duty to disclose information.

81. *Truman v. Thomas*, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980). Mrs. Truman visited Dr. Thomas repeatedly from 1964 to 1969. Dr. Thomas frequently advised her to have a Pap smear test which she refused. In 1969, another doctor discovered that she had a large cancerous tumor on her cervix. Mrs. Truman died of cervical cancer in 1970 at the age of 30. Her two minor children brought an action for the wrongful death of their mother in which they contended that Dr. Thomas had breached a duty of care to the decedent in failing to inform her of the risks of not consenting to a Pap smear. The expert medical testimony established that if a Pap smear had been performed between 1964 and 1969, the cervical cancer would have been discovered. The trial court refused to instruct the jury as follows:

[I]t "is the duty of a physician to disclose to his patient all relevant information to enable the patient to make an informed decision regarding the submission or refusal to take a diagnostic test. [¶] Failure of the physician to disclose to his patient all relevant information including the risks to the patient if the test is refused renders the physician liable for any injury legally resulting from the patient's refusal to take the test if a reasonably prudent person in the patient's position would not have refused the test if she had been adequately informed of all of the significant perils."

Id. at 289-90, 611 P.2d at 904-05, 165 Cal. Rptr. at 310.

82. *Id.* The appellate court affirmed the trial court's decision in not requiring this instruction, but the California Supreme Court reversed and decided that Dr. Thomas's failure to inform Mrs. Truman of the possible consequences of her refusal to submit to a diagnostic test was a breach of his duty under the doctrine of informed consent.

83. *Id.* at 291, 611 P.2d at 905, 165 Cal. Rptr. at 311.

84. *Id.* at 291, 611 P.2d at 906, 165 Cal. Rptr. at 312 ("If the physician knows or should know of a patient's unique concerns or lack of familiarity with medical procedures, this may expand the scope of required disclosure.").

85. *Id.* at 291, 611 P.2d at 906, 165 Cal. Rptr. at 312.

86. *Id.* at 292, 611 P.2d at 906, 165 Cal. Rptr. at 312.

87. *Id.*

The first is that patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity. The second is that a person of adult years and in sound mind has the right, in the exercise of control of his own body, to determine whether or not to submit to lawful medical treatment. The third is that the patient's consent to treatment, to be effective, must be an informed consent. And the fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arms-length transactions.⁸⁸

The court then applied these four basic assumptions to create a rule defining the physician's duty to disclose.⁸⁹ Although *Cobbs v. Grant* involved consent to treatment,⁹⁰ the majority rejected Dr. Thomas's contention that, since Mrs. Truman rejected the recommended treatment, he was exempt from the *Cobbs* duty.⁹¹ The majority appeared to base its rejection on the patient's right to exercise control over his body and to decide whether or not to submit to lawful medical treatment.⁹² Dr. Thomas further contended that he had no duty to disclose the risks of failing to undergo the procedure (in this case a Pap smear) because the danger of cancer was remote and commonly understood. But the majority also rejected this argument,⁹³ stating that the circumstances of a particular case may require disclosure even if there is no general duty to disclose.⁹⁴ The Court reasoned that the "patient standard" for the physician's disclosure created in *Cobbs* was sufficiently broad to include the facts of *Truman*.⁹⁵ This use of the subjective test imposes a new duty on the physician to

88. *Id.* at 291, 611 P.2d at 905, 165 Cal. Rptr. at 311 (quoting *Cobbs v. Grant*, 8 Cal. 3d at 242, 502 P.2d at 9, 104 Cal. Rptr. at 513).

89. 27 Cal. 3d at 292, 611 P.2d at 906, 165 Cal. Rptr. at 312. The careful physician should inform the patient, not only of the risks inherent in the procedure, treatment, or diagnostic test, but also of the risks of a decision not to undergo the procedure and if the recommended procedure is risk free, of the probability of a successful outcome of the treatment. On the other hand, if the recommended test or treatment presents any risk, then the physician should always explain the potential consequences of declining to follow the recommended course of action.

90. 8 Cal. 3d at 234-35, 502 P.2d at 4, 104 Cal. Rptr. at 508.

91. 27 Cal. 3d at 292-93, 611 P.2d at 906, 165 Cal. Rptr. at 312.

92. "To now hold that patients who reject their physicians' advice have the burden of inquiring as to the potential consequences of their decisions would be to contradict *Cobbs*." *Id.*

93. 27 Cal. 3d at 293-94, 611 P.2d at 906-07, 165 Cal. Rptr. at 312-13.

94. *Id.* at 294, 611 P.2d at 907, 165 Cal. Rptr. at 313.

95. See *supra* notes 81-94 and accompanying text.

disclose to the patient the risks of refusing to submit to a simple diagnostic test.⁹⁶ In previous case law, a physician only had the duty to warn the patient of the risks involved in undergoing treatment or surgical procedure. Under *Truman*, it is no longer necessary for the physician to actually administer treatment to the patient to be held liable for failing to give a full disclosure. The physician, as a fiduciary, has the obligation to provide to the patient all information material to that patient's decision to accept or reject treatment. *Truman*, therefore, strengthens the patient's right to decide for himself what will be done to his body, and imposes a responsibility on the physician to communicate the material medical risks to the patient in such a way that the patient is made to understand the consequences of his acceptance or rejection of medical treatment. This requirement should cause the physician to take more time with each patient. He will have to explain the procedure, and ask questions of the patient, as well as answer the patient's questions, before he can be sure that the patient understands his explanation and can give a valid informed consent.

Comparison of the Professional, Objective, and Subjective Standards; Proof of Causation

Under *Karp*, *Canterbury*, and *Scott* the doctor's duty to disclose is not contingent on the patient's request for information.⁹⁷ All of these cases hold that a physician, absent a privilege to withhold information, has an affirmative duty to disclose. There also seems to be a consensus that the physician need not advise a patient of dangers of which he is already aware, or of which the physician is unaware.⁹⁸ Additionally, the doctor need not give the patient a mini-medical course, but only a reasonable explanation "in nontechnical terms as to what is at stake: the therapy alternatives open to him, the goals expectedly to be achieved, and the risks that may ensue from particular treatment and no treatment."⁹⁹

96. The majority opinion refers to this as an "additional duty" while the dissent calls it a "new duty." 27 Cal. 3d at 292, 298, 611 P.2d at 906, 910, 165 Cal. Rptr. at 312, 316. The court's suggestion that a physician may have a duty to disclose the consequences of refusing a diagnostic test would seem to allow the physician to claim the therapeutic privilege as a defense to a failure to disclose. But the therapeutic privilege is, by its nature, inappropriate in the context of informed refusal. Where the patient has initially refused a test, perhaps from ignorance of the possible consequences of refusal, the physician's disclosure of these risks can only serve to increase the likelihood that the patient will eventually consent to the test. On the other hand, if the patient is unaware of an undiagnosed illness and had already refused the diagnostic test, it is not likely that information relating to the consequences of refusal would distress the patient.

97. But cf. Note, *Malpractice: Toward a Viable Disclosure Standard for Informed Consent*, 32 Okla. L. Rev. 868, 888 (1979).

98. There might, however, be a cause of action for failure to inform the patient of what the physician should have known. *Canterbury v. Spence*, 464 F.2d at 788.

99. *Id.* at 782 n.27.

It should be recalled that under *Truman*, a physician has the duty to advise patients of all "material risks" that might develop if a common diagnostic medical procedure is declined. The chief flaw of the *Truman* decision is that it failed to establish disclosure guidelines applicable to other common diagnostic procedures. As a result of this omission, courts in future cases will have to apply the standard on a case-by-case basis. Since the term "material risks" does not define precisely what information must be provided, prudent physicians will probably need to engage in lectures explaining each test and establish a dialogue with each patient, since the physicians' explanations may be evaluated in court. The dialogue should be reduced to writing and made a part of the doctor's medical records.

Although the cases agree that the burden of proving the physician's breach of duty must be borne by the plaintiff, disagreement continues over how the existence of that duty is to be proven in the courtroom. In those jurisdictions following *Karp*, the physician's duty is proven by the introduction of expert testimony¹⁰⁰ as to what a reasonable medical doctor in a similar community and the same school of thought would have disclosed.¹⁰¹ However, most jurisdictions following *Canterbury*, having dispensed with the need for expert medical testimony, measure the duty by determining what the average reasonable patient would have deemed material to his treatment decision. *Scott* goes one step further than *Canterbury*'s "reasonable patient" standard by measuring the physician's duty of disclosure by the subjective understanding of the individual patient. The physician must make full disclosure of all of the material risks incident to treatment. *Truman* goes one step further than *Scott* and requires that the patient be told of the risks of refusing treatment. These cases articulate no purely legal standard of materiality, leaving materiality as a question of fact for the jury. Under this standard, when the materiality of a particular risk is open to debate, the issue is for the finder of fact.¹⁰² Hence, the majority (*i.e.*, professional) standard position is one that favors the paternalistic beliefs that the doctor knows best and that good medicine must, therefore, be good law. Accordingly, the standard of disclosure is one set by the physicians themselves. On the other hand, the objective and subjective minority positions are that respect for a patient's right of self-determination demands a standard set by law. The objective minority view favors the patient by letting the fact finder establish the standard of duty by measuring the doctor's disclosure against what a reasonable

100. Comment, Standard of Care for Medical Practitioners: Abandonment of the Locality Rule, 60 Ky. L.J. 209, 210 (1971). The disadvantages of this view to the plaintiff are exacerbated by the "conspiracy of silence" in which doctors are reluctant to testify against one another.

101. See generally Note, *supra* note 97.

102. *Canterbury v. Spence*, 464 F.2d at 787.

patient would have deemed material. The subjective position measures the doctor's duty to disclose by what the individual patient would have deemed material to his giving of consent. Briefly speaking, the three standards can be characterized as being based on the perceptions of the physician in a similar community of the same school of thought, or on the average reasonable patient's material needs, or on the individual patient's needs.

Sometimes, a particular disclosure would be sufficient under any of the three positions. A comparison of the respective standards indicates that those jurisdictions that have adopted the *Canterbury* approach offer the patient a greater opportunity to protect his right to self-determination than do those which adhere to the majority approach. In short, the duty to disclose can be sometimes higher under the rule of *Canterbury* than under that of *Karp*. It should be noted that neither the *Karp* nor the *Canterbury* test operates subjectively from the perspective of either the physician or the patient, but *objectively* from the perspective of the physician in a similar community in the same school of thought or from the perspective of the average reasonable patient and what information he would deem to be material.¹⁰³ Thus, even under the *Canterbury* rule, if the plaintiff patient would not have undergone the therapy, would have undergone alternative therapy, or would not have undergone therapy at all, he could not prevail if the jury finds that an average reasonable patient would have decided otherwise.¹⁰⁴ Therefore, under the rule of *Canterbury*, an individual patient's right of self-determination is no greater than that of the average patient. As a result, under both the *Karp* and *Canterbury* positions, there is no individual choice. This shortcoming is directly addressed in the *Scott* and *Truman* approaches which specifically protect and preserve the individual patient's freedom of choice.

Under all three standards (the professional, the objective or reasonable man view, and the subjective), a plaintiff bringing an informed consent negligence action must prove a causal connection between the physician's

103. The *Canterbury* rationale for not using the subjective standard is that Such a requirement, however, would summon the physician to second-guess the patient, whose ideas on materiality could hardly be known to the physician. That would make an undue demand upon medical practitioners, whose conduct, like that of others, is to be measured in terms of reasonableness. Consonantly with orthodox negligence doctrine, the physician's liability for nondisclosure is to be determined on the basis of foresight, not hindsight; no less than any other aspect of negligence, the issue on nondisclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's informational needs. If, but only if, the fact finder can say that the physician's communication was unreasonably inadequate is an imposition of liability legally or morally justified.

Id.

104. Cf. *Haven v. Randolph*, 342 F. Supp. 538 (D.D.C. 1972), *aff'd*, 494 F.2d 1069 (D.C. Cir. 1974).

failure to inform and the subsequent injury.¹⁰⁵ His proof of causation must include two elements: demonstration that his injury resulted from an unrevealed risk that should have been disclosed to him,¹⁰⁶ and that he would not have consented to the operation or treatment if he had known of the risks.¹⁰⁷

Customarily, courts have applied a subjective test in determining whether a particular patient would have consented to the treatment had he been adequately informed of the risk and alternatives. The more recent trend, however, is to use an objective approach¹⁰⁸ and to consider what a reasonably prudent person in the patient's position would have decided had adequate disclosure been made.¹⁰⁹ The medical profession prefers the objective standard because it does not depend on the plaintiff's self-serving testimony as to what he would have decided if all of the material risks had been disclosed, and because objective standard testimony is easier for the defendant's expert medical witnesses to rebut than is plaintiff's testimony under the subjective standard. On the other hand, the subjective standard enables the jury to consider the patient's individual circumstances, (his personal beliefs, his experiences, religion, etc.) in deciding whether he would have made the same decision had the physician adequately informed him of the risks of the procedure or treatment.

Exceptions and Defenses to the Doctrine of Informed Consent and the Patient's Right to Refuse Treatment

Notwithstanding the doctrine of informed consent, situations occur in which a physician will not be liable for administering treatment without a patient's informed consent.¹¹⁰ The first exception arises when an emergency situation renders disclosure impractical.¹¹¹ This exception is invoked

105. *Downer v. Veilleux*, 322 A.2d 82, 92 (Me. 1974).

106. *Shetter v. Rochelle*, 2 Ariz. App. 358, 367, 409 P.2d 74, 83 (1965), modified, 2 Ariz. App. 607, 411 P.2d 45 (1966) (This causal requirement is an application of the "but for" rule "which comes as close to being of the essence of the proximate cause doctrine as any concept.").

107. See, e.g., *Poulin v. Zartman*, 542 P.2d 251, 275 (Alaska 1975); *Wilkinson v. Vesey*, 110 R.I. at 628-29, 295 A.2d at 690 (1972).

108. See, e.g., *Reidinger v. Colburn*, 361 F. Supp. 1073, 1078 (D. Idaho 1973); *Sard v. Hardy*, 281 Md. 432, 450, 379 A.2d 1014, 1024-25 (1977); *Fogal v. Genesse Hosp.*, 41 A.D.2d 468, 474, 344 N.Y.S.2d 552, 560 (1973); *Small v. Gifford Mem. Hosp.*, 133 Vt. 552, 558, 349 A.2d 703, 707 (1975); *Funke v. Fieldman*, 212 Kan. 524, 537, 512 P.2d 539, 550 (1973).

109. For a proposed standard of the scope of the physician's duty to inform the patient of risks, see Note, *Informed Consent—A Proposed Standard for Medical Disclosure*, 48 N.Y.U. L. Rev. 548, 554-63 (1973).

110. See J. Ludlam, *supra* note 5, at 36. For an in-depth discussion of exceptions to the duty to disclose, see Meisel, *supra* note 6.

111. See *Canterbury v. Spence*, 464 F.2d at 788; *Pratt v. Davis*, 224 Ill. 300, 309-10,

ed when "the patient is unconscious or otherwise incapable of consenting and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment."¹¹² In this circumstance, the courts will imply the patient's consent because they assume that a reasonable person in the patient's position would have consented to treatment.¹¹³

A second exception is made for the physician's "therapeutic privilege."¹¹⁴ If the physician determines that full or even partial disclosure is not in the patient's best interest, a well recognized privilege to withhold the information arises.¹¹⁵ In *Watson v. Clutts*, the North Carolina Supreme Court held that a physician has two duties: to do what is best for his patient and to make adequate disclosure.¹¹⁶ The court held that in situations where these two duties conflict, the primary duty of doing what is best for the patient must prevail.¹¹⁷ The impact of this rule is that the therapeutic privilege can be quite broad and that, unless carefully limited, it has the potential to swallow up the duty to disclose.¹¹⁸ Nevertheless, in situations where either the emergency or the therapeutic privilege is invoked, the physician should attempt to make disclosures to the relatives of the patient.

Another exception has been developed for incompetent and minor patients whereby the patient's parent or legal guardian is given the authority to consent for the patient¹¹⁹ because a patient should not be deprived of medical care due to his inability to make medical decisions.¹²⁰ There

79 N.E. 562, 565 (1906); *Crouch v. Most*, 78 N.M. 406, 410, 432 P.2d 250, 254 (1967).

112. *Canterbury*, 464 F.2d at 788. For a discussion of the emergency exception in Louisiana, see *infra* notes 143-53 and accompanying text.

113. *Cobbs v. Grant*, 8 Cal. 3d at 243-44, 502 P.2d at 10, 104 Cal. Rptr. at 514; *Gravis v. Physicians and Surgeons Hosp.*, 415 S.W.2d at 677-78.

114. The courts commonly consider four factors in their determination of whether a doctor breached his duty to disclose: (1) the likelihood and gravity of adverse results; (2) the frequency or percentage of cases in which such risk, harm or adverse result is seen; (3) the probable effect of the procedure or treatment on the patient's health or well-being; and (4) the probable effect of disclosure on the patient's mental health or well-being. See generally *Perdue*, *The Law of Texas Medical Malpractice*, 11 Hous. L. Rev. 1075 (1974); and *Waltz & Scheuneman*, *Informed Consent to Therapy*, 64 Nw. U.L. Rev. 628 (1970).

115. See *Salgo v. Stanford Univ.*, 154 Cal. App. 2d at 578, 317 P.2d at 181.

116. 262 N.C. 153, 159, 136 S.E.2d 617, 621 (1964), overruled, *McPherson v. Ellis*, 287 S.E.2d 892 (N.C. 1982) (adopting subjective standard of determining consent).

117. *Id.*

118. See, e.g., *Canterbury*, 464 F.2d at 789; Note, *supra* note 109, at 558; *Kessenick & Mankin*, *Medical Practice: The Right to be Informed*, 8 U.S.F.L. Rev. 261, 276-77 (1976).

119. See, e.g., *Cobbs v. Grant*, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514. For a discussion of the Louisiana law regarding the consent of minors, incompetents, and other persons who lack legal capacity to consent, see *infra* notes 198-201 and accompanying text.

120. See *In re Long Island Jewish-Hillside Medical Center*, 73 Misc. 2d 395, 398-99, 342 N.Y.S.2d 356, 360-61 (Sup. Ct. 1973); *Collins v. Davis*, 44 Misc. 2d 622, 623, 254

are other exceptions to the disclosure requirement. For example, the courts recognize a privilege of non-disclosure when an average patient would have been aware of the risks,¹²¹ when the physician was unaware of the risks at the time disclosure was made,¹²² or when the patient has been made aware of the possibility of harm, but has chosen to forego or waive the disclosure of risks.¹²³ Exceptions to the disclosure requirements are affirmative defenses which the defendant may utilize when he is being sued under a theory of lack of informed consent.¹²⁴

One of the problems which physicians face in light of the *Truman* requirements of informed consent and informed refusal to treatment is what to do with the patient who wants to die.¹²⁵ It should be recalled that, under *Truman*, the physician has a duty to inform the patient of the risks which may occur if the patient refuses treatment. If the patient still refuses treatment, it might be argued that the physician should wait until an emergency exists and the patient is unconscious and then render treatment to save life and limb under the emergency exception. In so doing, the physician may be overlooking the patient's constitutional right to privacy¹²⁶ and the patient's right to make an informed choice of whether to submit to medical treatment.¹²⁷ However, in *Roe v. Wade*, the United States Supreme Court noted that "it is not clear to us that the . . . unlimited right to do with one's body as one pleases [is included within] the right to privacy."¹²⁸ Although the Court noted that it had refused to recognize this kind of unlimited right in the past, it did recognize a qualified right to make a private and personal abortion decision.¹²⁹ Although the United State Supreme Court has not yet established the limits

N.Y.S.2d 666, 667 (Sup. Ct. 1964); Meisel, *supra* note 6, at 439.

121. See Bucklin, *supra* note 75, at 212.

122. See *Small v. Gifford Mem. Hosp.*, 133 Vt. at 557, 349 A.2d at 706; *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 13, 227 N.W.2d 647, 653 (1975).

123. See *Cobbs v. Grant*, 8 Cal. 3d at 245, 502 P.2d at 12, 104 Cal. Rptr. at 516.

124. *Id.*

125. The right is also known as the "right to die" or the right to "death with dignity." See Comment, North Carolina's Natural Death Act: Confronting Death with Dignity, 14 Wake Forest L. Rev. 771 (1978); Death with Dignity: An Inquiry into Related Public Issues: Hearings Before the Special Senate Comm. on Aging, 92d Cong., 2d Sess. 70 (1972) (statement of Warren T. Reich, Senior Resident Scholar at the Kennedy Center for Bioethics, Georgetown University, Washington, D.C.).

126. In *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973), the Supreme Court stated that although the Constitution does not explicitly mention any right of privacy, "In a line of decisions the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution." *Id.* at 152, 93 S. Ct. at 726.

127. *Truman v. Thomas*, 27 Cal. 3d at 291, 611 P.2d at 905, 165 Cal. Rptr. at 311.

128. *Roe v. Wade*, 410 U.S. at 154, 93 S. Ct. at 727.

129. *Id.* Subsequent cases do not make it clear whether the right involved is truly the right to decide or merely the right to have an abortion. *Harris v. McRae*, 448 U.S. 297, 100 S. Ct. 2671 (1980); *Maher v. Roe*, 432 U.S. 464, 97 S. Ct. 2376 (1977).

of this right to privacy,¹³⁰ the New Jersey Supreme Court has stated that the right to decline medical treatment is included within this right.¹³¹ The constitutional status of the patient's right to determine whether to submit to medical treatment is further supported by the patient's constitutional right to exercise freedom of religion.¹³²

If the patient's right to decide is fundamental and if the disclosure is insufficient to provide the patient with adequate information to exercise effectively his right to decide, then an inadequate standard for disclosure may unconstitutionally infringe the exercise of that right.¹³³ Furthermore, the right to information may be included in the right to privacy.¹³⁴ Finally, a state's interest in withholding material information with which a patient could make an intelligent and informed decision is minimal.¹³⁵ Thus, the patient should be entitled as a matter of federal constitutional law to sufficient material information to allow an intelligent decision concerning his life and death. However, strict constitutional analysis requires that there be some kind of state action before the protections of the United States Constitution be invoked.

THE LOUISIANA DOCTRINES OF LACK OF CONSENT AND LACK OF INFORMED CONSENT IN MEDICAL PROCEDURES: JURISPRUDENCE AND LEGISLATION

In *LaCaze v. Collier*,¹³⁶ *Pizzalotto v. Wilson*,¹³⁷ and *Gunter v. Plauche*,¹³⁸ the Louisiana Supreme Court thoroughly reviewed the historical development of the doctrines of lack of consent and lack of informed consent. (Recall that the lack of consent constitutes a battery and that lack of informed consent is generally recognized as medical negligence.¹³⁹)

130. See generally Epstein, Substantive Due Process by Any Other Name: The Abortion Cases, 1973 Sup. Ct. Rev. 159; Note, *H.L. v. Matheson*, 50 U. Cin. L. Rev. 867, 869 (1981).

131. In re *Quinlan*, 70 N.J. 10, 40-42, 355 A.2d 647, 663-64 (1976), cert. denied, 429 U.S. 922 (1976) (stating that the constitutional right of privacy is presumably "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions"). Id. at 40, 335 A.2d at 663.

132. See Note, The Legal Aspects of the Right to Die: Before and After the *Quinlan* Decision, 65 Ky. L.J. 823 (1977).

133. But cf. Meisel, supra note 6, at 446-47.

134. Cf. Dixon, The "New" Substantive Due Process and the Democratic Ethic: A Prolegomenon, 1976 B.Y.U. L. Rev. 43, 84. See also *Planned Parenthood v. Danforth*, 428 U.S. 52, 67, 96 S. Ct. 2831, 2840 (1976) (noting that "the decision to abort is an important and often stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences").

135. See Annot., 93 A.L.R. 3d 67, 74-77 (1979).

136. *LaCaze v. Collier*, 434 So. 2d 1039 (La. 1983) (Dennis, J., concurring, 437 So. 2d 869).

137. *Pizzalotto v. Wilson*, 437 So. 2d 859 (La. 1983).

138. *Gunter v. Plauche*, 439 So. 2d 437 (La. 1983).

139. Plant, Analysis, supra note 21, at 649-52; Note, Informed Consent in Medical Malpractice, 55 Calif. L. Rev. 1396, 1399-1401 (1967).

Before these three cases were decided, the Louisiana Courts of Appeal inconsistently applied the theories of recovery in both types of informed consent cases.¹⁴⁰ Furthermore, the circuits were divided on the issue of whether to use the objective or the subjective standard of causation.¹⁴¹ Additionally, the courts of appeal had not determined whether the provisions of the Louisiana Uniform Consent Law¹⁴² constituted a binding legislative determination of the physician's duty of disclosure.

Lack of Consent or Battery in Medical Malpractice

In *Pizzalotto v. Wilson*, the Louisiana Supreme Court distinguished lack of informed consent from lack of consent and held that the lack of consent on the part of a patient to a physician for a medical procedure is a battery. Dietrich Wilson, a twenty-seven-year-old single woman went to Dr. Pizzalotto in September, 1978. Dr. Pizzalotto diagnosed her

140. See Comment, Patient Consent in Louisiana, 27 Loy. L. Rev. 1166 (1981).

141. *Zachary v. St. Paul Fire & Marine Ins. Co.*, 249 So. 2d 273 (La. App. 1st Cir. 1971) (lack of informed consent); *Carroll v. Chapman*, 139 So. 2d 61 (La. App. 2d Cir. 1962) (examples of lack of consent, battery); *Rogers v. Lumbermens Mut. Cas. Co.*, 119 So. 2d 649 (La. App. 2d Cir. 1960). The "subjective standard" of causation was utilized in *Bush v. St. Paul Fire & Marine Insurance Co.*, 264 So. 2d 717 (La. App. 1st Cir.), cert. denied, 266 So. 2d 452 (La. 1972), and the "objective standard" of causation was formulated in *Goodwin v. Aetna Casualty & Surety Co.*, 294 So. 2d 618 (La. App. 4th Cir.), cert. denied, 299 So. 2d 788 (La. 1974).

142. La. R.S. 40:1299.40 (1977) provides:

A. Notwithstanding any other law to the contrary, written consent to medical treatment means a consent in writing to any medical or surgical procedure or course of procedures which (a) sets forth in general terms the nature and purpose of the procedure or procedures, together with the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures, (b) acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner, and (c) 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 by a person who has legal authority to consent on behalf of such patient in such circumstances. Such consent shall be presumed to be valid and effective, in the absence of proof that execution of the consent was induced by misrepresentation of material facts.

B. Except as provided in Subsection A of this Section, no evidence shall be admissible to modify or limit the authorization for performance of the procedure or procedures set forth in such written consent.

C. Where consent to medical treatment from a patient, or from a person authorized by law to consent to medical treatment for such patient, is secured other than in accordance with Subsection A above, the explanation to the patient or to the person consenting for such patient shall include the matters set forth in Paragraph (a) of Subsection A above, and an opportunity shall be afforded for asking questions concerning the procedures to be performed which shall be answered in a satisfactory manner. Such consent shall be valid and effective and is subject to proof according to the rules of evidence in ordinary cases.

condition as pelvic inflammatory disease (P.I.D.) and a potential adnexal cyst or an endometrioma. Ms. Wilson read extensively about her condition to understand the nature of the tests and treatment prescribed. In November she signed a consent to operate form which stated that sterility might result from the operation. The procedure to which she consented was a laparoscopy which Ms. Wilson knew did not cause sterility, so she struck out and initialed the sterility warning. The procedure confirmed the presence of P.I.D. and endometriosis.

Dr. Pizzalotto then recommended a laparotomy, an exploratory abdominal operation, but he did not discuss with Ms. Wilson the risk of sterility from this operation or an alternative method of treatment. Also, Dr. Pizzalotto did ask Ms. Wilson if she had any questions. Ms. Wilson testified that since she understood the possible consequences of endometriosis, she did not ask any questions. The printed consent form provided that the doctor or his associate could do anything they considered necessary, and indicated that sterility was a risk of this operation. Although the consent form listed the procedure as "Dx (1) Pelvic inflammatory disease, marked (2) endometrosis Rec (1) Laparotomy—Lysis of adhesions, Fulguration of endometrioma,"¹⁴³ on the hospital chart Dr. Pizzalotto wrote that a "probable salpingo-oophorectomy" (surgical removal of the uterine tube and an ovary) would be performed.¹⁴⁴ Ms. Wilson, however, was not informed of this notation; nor did she cross out the sterility provision as she had done previously.

Dr. Pizzalotto commenced the procedure but during the course of the operation found Ms. Wilson's condition to be worse than he had anticipated. Dr. Pizzalotto's assistant agreed with his findings, so without attempting to obtain an informed consent from her or another qualified person,¹⁴⁵ Dr. Pizzalotto removed all of Ms. Wilson's reproductive organs (a total hysterectomy and bilateral salpingo-oophorectomy). When Ms. Wilson learned what had happened in surgery, she refused to pay Dr. Pizzalotto's bill. This refusal precipitated the litigation.

Ms. Wilson argued that she had not given her consent to the operation which was performed, and that the consent form which she had signed was invalid because Louisiana Revised Statutes 40:1299.40 requires that the procedure to be performed be named and that the attendant risks of the named procedure be discussed with the patient. In response, Dr. Pizzalotto contended that the "blanket consent form" signed by Ms. Wilson gave him the option of exercising his judgment in doing whatever was necessary or advisable in the course of the operation and that it was an implied consent to the procedure actually performed. He also argued

143. 437 So. 2d at 862.

144. *Id.*

145. *Id.* at 866 (Marcus, J., dissenting).

that according to Louisiana Revised Statutes 40:1299.54, whenever an emergency exists in which the life or health of the person may be affected, a consent to surgery will be implied.¹⁴⁶

Justice Dennis, writing for the majority, found that the evidence adduced at trial indicated that a medical emergency as defined by Louisiana Revised Statutes 40:1299.54 did not exist.¹⁴⁷ Turning to the consent form, the court determined that the evidence did not support the contention that the blanket consent language gave the physician either express or implied permission to remove the patient's reproductive organs, particularly since the physician was aware of the patient's intent to have children in the future. The operation was thus unauthorized, and therefore, a battery.

A surgeon commits a battery on his patient when he undertakes a particular surgical procedure without the consent of the patient or an authorized person, except when an emergency requires immediate surgery for the preservation of life or health under circumstances when such consent cannot be practicably obtained. . . . Though a battery is generally manifested as an act of hostility, the basis of this battery is not the hostile intent of the physician, but rather the absence of consent on the part of the patient to a treatment that may in fact be beneficial.¹⁴⁸

The majority concluded that although Ms. Wilson was not entitled to recover damages for negligence or malpractice, an unauthorized operation that was skillfully performed nevertheless constituted a battery for which she was entitled to recover damages.¹⁴⁹ Justice Lemmon concurred with reasons questioning the use of the term battery and the determination of the damages, but agreeing with the result.¹⁵⁰

Justice Marcus, in his dissent, concluded that a medical emergency existed, and therefore, according to Louisiana Revised Statutes 40:1299.54, a consent to surgery should have been implied. He also stated that the language in the consent form allowing the surgeon to do whatever in his opinion was necessary gave him the discretion to remove the diseased

146. *Id.* at 867 (Marcus, J., dissenting); see also La. R.S. 40:1299.54 (Supp. 1984) (stating that consent shall be implied where an emergency exists).

147.

[A]n emergency is defined as a situation wherein: (1) in competent medical judgment, the proposed surgical or medical treatment or procedures are reasonably necessary; and (2) a person authorized to consent under Section 1299.53 is not readily available, and any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected, or could reasonably result in disfigurement or impair faculties.

La. R.S. 40:1299.54(A) (Supp. 1984).

148. 437 So. 2d at 862.

149. *Id.* at 865.

150. Telephone interview with Justice Lemmon (Oct. 14, 1983) (copy of Justice Lemmon's concurring opinion filed with *Louisiana Law Review*).

organs. Because the decision to remove the diseased organs was concurred in by the assistant surgeon and the pathologist who examined the organs after the surgery had been performed, Justice Marcus found that the language in the consent form allowing the surgeon to exercise his medical judgment permitted the removal of the organs.¹⁵¹

Justice Blanche, in his dissent, also found that the removal of the organs was properly within the medical judgment of the physician and in the best interest of the patient since both of her ovaries were destroyed by disease and her fallopian tubes were completely blocked by adhesions. He concluded that "[f]ailure to remove them would have been a 'marked breach of competence' "¹⁵² and observed that "[a]lthough not relevant to the case before us, this writer wonders which way the sword would have swung had the doctor subjected plaintiff to another operation which may either have caused her serious pain and suffering or possibly loss of life."¹⁵³

Lack of Informed Consent

Pizzalotto was decided by the Court on September 2, 1983. *Lacaze v. Collier* was decided June 17, 1983 with concurring opinions published July 8, 1983 and September 26, 1983 by Justices Blanche and Dennis respectively. Although the facts of the two cases are quite similar, it should be noted that the court distinguished them, deciding them on two entirely different theories of recovery. The patient in *Pizzalotto* recovered under the "lack of consent-battery theory" as first set out in *Mohr*.¹⁵⁴ The court in *LaCaze*, applying the objective or reasonable man causation standard of *Canterbury*,¹⁵⁵ denied the plaintiff's claim which was grounded in the theory of lack of informed consent.

In *LaCaze* the female patient visited Dr. Collier on a regular basis from 1972 to 1977. On each visit Dr. Collier diagnosed pelvic inflammatory disease (P.I.D.), a general inflammation of the tissues and organs of the pelvic area due to infection. On the first visit Dr. Collier recommended a hysterectomy and continued to so recommend on each subsequent visit although he did unsuccessfully treat Mrs. LaCaze with antibiotics.

On June 11, 1977, Mrs. LaCaze called Dr. Collier and agreed to have the recommended surgery. Upon admission to the hospital, she signed two separate consent forms, neither of which gave any details of the surgery or related risks. The first form contained the names of the doctor and patient, the date and time, the witness' signature and a statement

151. 437 So. 2d at 866-67.

152. *Id.* at 868.

153. *Id.*

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

155. 474 F.2d at 784-87.

that the possible complications of the "above-named treatment" had been explained by Dr. Collier. The "above-named treatment" was never listed.¹⁵⁶ The first form was signed by Mrs. LaCaze at 2:50 P.M. on June 13, 1977. At 5:00 P.M. that same day Mrs. LaCaze signed the second form which was a consent for a total abdominal hysterectomy. The form did not list any risks of the procedure nor did it acknowledge that the physician had disclosed any of the risks to the patient.

On June 14, the surgery was performed without incident, although complications soon arose which kept Mrs. LaCaze in the hospital for more than a month after the surgery. She saw Dr. Collier for a urinary problem two times after she left the hospital. On her own initiative, the patient consulted a urologist who diagnosed her condition as a vesico-vaginal fistula.¹⁵⁷ On August 23, 1977, the urologist performed surgery on Mrs. LaCaze which corrected her urinary problem.

Mrs. LaCaze filed suit against Dr. Collier alleging lack of informed consent and surgical negligence in causing the vesico-vaginal fistula. The trial judge dismissed Mrs. LaCaze's cause of action for damages and the court of appeal affirmed that decision.¹⁵⁸ The Louisiana Supreme Court granted writs to determine whether Dr. Collier had secured a valid informed consent to the operation from Mrs. LaCaze.

Mrs. LaCaze argued that Louisiana Revised Statutes 40:1299.40, the Uniform Consent Law, created a duty on the part of the doctor to inform the patient of the known risks of the procedure. She further averred that a failure to meet this duty supported an action in negligence. Mrs. LaCaze also contended that Dr. Collier's failure to meet with her for a preoperative conference to answer questions concerning the procedure gave her an action in strict liability. The latter argument was presumably based on the belief that the Uniform Consent Law is a statutory standard for the form and substance of a valid informed consent, and that, if the requirements of the statute are not met, a breach of duty on the part of the physician should be implied. The court did not address this problem.

156. 434 So. 2d at 1047.

157.

A fistula is an abnormal opening between two organs of the body, in this case between the bladder and vagina. Medical evidence presented indicated that the usual cause of a vesico-vaginal fistula forming is a stitch that may be advertently taken into the bladder during the closing of the vaginal cuff. In time, the stitch would pull through the bladder wall. Other possible causes are nicking the bladder with the knife or damaging the blood supply to a portion of the bladder wall with a blunt instrument or clamp. Vesico-vaginal fistulae typically measure only a few millimeters in size, and, once formed, retain their initial size until corrected.

Id. at 1041 n.2.

158. *Lacaze v. Collier*, 416 So. 2d 619 (La. App. 2d Cir. 1982).

Dr. Collier, the defendant, argued that the Uniform Consent Law is an evidentiary rule and does not change the substantive law.¹⁵⁹ He contended that adherence to the provisions of the statute merely creates a presumption of a valid informed consent, but that the statute does not create a duty on the part of the physician to follow those provisions. Thus, he claimed the statute provides protection for the physician, but does not provide any rights to the patient. If the doctor chooses not to make use of the statute, then the question of whether the patient has consented to the procedures performed is to be answered by the courts in light of the jurisprudence.

The majority opinion reviewed the evolution of the doctrine of informed consent as it has been applied in other states and then determined that the informed consent form in this case did not meet the requirements of the Uniform Consent Law and was therefore invalid.¹⁶⁰ But the court then declared that, "the physician ought not be cast in damages in a case in which it would have been unreasonable to withhold an informed consent for treatment."¹⁶¹ The court concluded that, since the plaintiff failed to meet the burden of proof of causation (*i.e.*, since the damages from the vesico-vaginal fistula were not caused by the failure to obtain an informed consent), she could not recover damages.¹⁶² The court, in determining the questions of damages and causation, cited the *Canterbury*¹⁶³ and *Zeno*¹⁶⁴ decisions and declared:

Lack of valid consent gives rise to an action for damages. In

159. 434 So. 2d at 1042. The idea that the Uniform Consent Law is a mere evidentiary rule and not substantive law is not new. When the statute was passed during the medical malpractice "crisis" in the mid-1970's physicians were looking for a consent formula to follow so that they would not be sued. But the theory behind consent is (1) that the patient has the right of control over his own body and, therefore, over medical treatment and (2) that he must understand the nature of the treatment before he can consent and assume the risk of the treatment. Therefore, the information required by the consent statute should be more than a chart or formula given by the physician for his own protection. Instead, the required information should be conveyed to the patient so that he fully understands the information given to him. The "acknowledgment" and "answering the questions of the patient" requirements in the statute are consistent with this interpretation. See also Ohio Rev. Code Ann. § 2317.54 (Anderson 1915); cf. Idaho Code § 39.4304 (1976); Iowa Code Ann. § 147.137 (West 1977); Nev. Rev. Stat. § 41A100 (1975). All are virtually identical to the Louisiana Uniform Consent Law. Ohio additionally requires that the consent be comprehended by the patient in English or whatever language in which the consent is written.

160. *Id.* at 1048.

161. *Id.* at 1049.

162. *Id.*

163. *Canterbury*, 464 F.2d at 790.

164. *Zeno v. Lincoln General Hosp.*, 404 So. 2d 1337, 1343 (La. App. 2d Cir. 1981) (not treating the duty issue, but deciding that if a prudent person would have consented to surgery rather than getting cancer or septicemia, the lack of informed consent is not actionable).

Louisiana, however, only compensatory damages can be recovered. The defendant can only be cast for those damages caused by the breach of duty. This element, in the jurisprudence, has been referred to as the "causation" element. Not only must the plaintiff show that the undisclosed risk actually occurred, but the plaintiff must also prove that if the risk had been disclosed, the treatment and the unwanted consequences would have been avoided. The plaintiff must prove that the failure to inform caused the damaging consequences. If the plaintiff would have undertaken the treatment in any event, in spite of the deficient "informed consent," there could be no recovery.¹⁶⁵

The court stated that the theory of informed consent in Louisiana is founded on the basic premise that the patient, not the physician, should determine what is to be done to his body.¹⁶⁶ Although the patient has an undisputed right to receive information that will enable him to make a treatment choice, the decision as to what information is material¹⁶⁷ is an objective judgment which should be made by the jury based upon "what a reasonable patient would do under these circumstances" rather than a subjective standard¹⁶⁸ which would take into consideration the individual's needs and would require the jury to determine what this person wanted.¹⁶⁹ The patient's burden of proof under *LaCaze* is that he must establish that he was not informed of the material risks, and that a reasonable person would not have consented to the operation if he would have known of those risks. Under this standard, the patient is relieved of the burden of producing medical testimony to determine what a reasonable prudent physician would have done (*i.e.*, the professional standard of causation)¹⁷⁰ because the jury can decide the issue from lay testimony to determine "what a reasonable patient would have done under the circumstances." This is the objective or reasonable man test for causation set forth in *Canterbury* and now adopted by the *LaCaze* court.¹⁷¹

The *Lacaze* court recognized that an allegation of informed consent has traditionally sounded in negligence and required the plaintiff to prove duty, breach of duty, causation, and damages.¹⁷² The *Lacaze* court rejected, however, the professional standard of care formulated in *Karp*

165. *LaCaze*, 434 So. 2d at 1048.

166. *LaCaze*, 434 So. 2d at 1043 (quoting *Schloendorff v. Society of New York Hosps.*, 211 N.Y. at 129, 105 N.E. at 93).

167. 434 So. 2d at 1046 ("Materiality is, in essence, the product of the risk and its chance of occurring.').

168. The *LaCaze* court applied the objective standard of reasonableness rather than the subjective standard, thereby vitiating the individual's freedom of choice by substituting for it the standard of what a reasonable patient would have done.

169. See *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979).

170. *Karp v. Cooley*, 493 F.2d at 423.

171. *LaCaze*, 434 So. 2d at 1048.

172. *Id.* at 1044.

v. *Cooley*,¹⁷³ which bases the physician's duty to disclose on medical custom and practice, and stated that the entirety of the physician's duty to provide his patient with information under the doctrine of informed consent is subsumed by Louisiana Revised Statutes 40:1299.40.¹⁷⁴ The opinion continued: "R.S. 40:1299.40 has, therefore, superseded in Louisiana, the jurisprudential rules defining 'consent to medical treatment'. A patient's consent to treatment must be measured by the standards contained in Subsection A or Subsection C of the statute."¹⁷⁵ The effect of this step, since the statute does not require that the patient be informed of alternative forms of treatment, is to exclude any duty on the part of the physician to suggest alternative therapy in the informed consent document.

Justice Blanche, in his concurring opinion,¹⁷⁶ stated that the view that R.S. 40:1299.40 supersedes the jurisprudential standards for informed consent is incorrect. He characterized the jurisprudence as imposing

an affirmative duty on the physician to provide his patient with sufficient information to enable that patient to intelligently decide, by balancing probable risks against probable benefits, whether to undergo the proposed treatment, select an alternative process, or refuse treatment altogether. Accordingly, the information typically required to be disclosed included the proposed diagnostic, therapeutic or surgical procedures contemplated, the material risks involved, and the alternatives available, if any.¹⁷⁷

Justice Blanche argued that the statute was intended to provide physicians with the protection of an evidentiary rule creating a presumption of valid consent and was not intended to create a cause of action against physicians for failure to comply with its disclosure requirements. Furthermore, Subsections A and B of the statute, when read together, are rules of evidence and do not purport to confer substantive rights to the patient nor do they purport to be the exclusive means for obtaining a valid consent.

In short, the majority's position that the Uniform Consent Law supersedes the prior jurisprudence on informed consent is simply not supported by a careful reading of the statute. The jurisprudence is superseded only in the sense that now a valid consent may be obtained 'notwithstanding' the jurisprudence. The opposite is not true, i.e. that an invalid consent is obtained if the statute is not complied with. By its express provisions, the

173. 493 F.2d at 423.

174. 434 So. 2d at 1046.

175. *Id.*

176. *Id.* at 1050 (Blanche, J., concurring).

177. *Id.* (citing *Perle v. St. Paul Fire & Marine Ins. Co.*, 349 So. 2d 1289 (La. App. 1st Cir. 1977)).

Uniform Consent Law deals only with valid consents, not invalid ones. There is nothing in the statute to indicate that compliance with the statute is the exclusive means of obtaining a valid consent.¹⁷⁸

Justice Blanche would also allow the physician the option of utilizing the "therapeutic privilege" of not informing the patient of some information which, in the physician's professional opinion, would be harmful for the patient to know.¹⁷⁹

Justice Dennis, in his concurring opinion, disagreed with the majority's construction of Louisiana Revised Statutes 40:1299.40 as a comprehensive restatement of the informed consent doctrine, and argued that future cases falling outside the confines of the present statute should continue to be governed by the jurisprudence.¹⁸⁰ He noted that the statute "satisfies only one duty of the physician to his patient during the course of treatment and does not supplant his obligation to fulfill his other duties contemplated by the doctrine of informed consent."¹⁸¹ Some of the other duties which Justice Dennis stated might be required of the physician in fulfilling "his basic duty of due care" would be "to inform his patient of an alternative treatment promising greater benefit than that being pursued, to alert him of a bodily abnormality, or to apprise him of an ailment's lack of response to treatment"¹⁸²

Impact and Critique of Pizzalotto and LaCaze

In *Pizzalotto*, the court recognized that the elements necessary to the cause of action for lack of consent are the same as those in battery.¹⁸³ Therefore, an attorney should plead the battery theory of recovery: (1) when the physician fails to obtain any consent to perform an operation, or (2) when the physician obtains consent to perform an operation, but either exceeds the scope of the consent, misrepresents the severity of the operation, or performs an operation of a substantially different nature. Under the battery theory, the burden of proof is not as onerous as in an action for lack of informed consent because the plaintiff only has to show that the operation was performed without his consent. This criterion is satisfied where the patient either never consented to medical treatment or where consent to medical treatment was vitiated by an inadequate disclosure. This writer agrees with the majority opinion's application of the battery theory of recovery to these situations.

178. Id. at 1051.

179. Id. at 1052.

180. 437 So. 2d 869 (Dennis, J., concurring).

181. Id. at 870.

182. Id.

183. 437 So. 2d at 862.

In *LaCaze*, the court held that the Uniform Consent Law superseded the prior informed consent jurisprudence. It recognized that the patient's understanding of the risks and treatment is necessary before a valid informed consent can be given. The court then applied the objective (reasonable man) test as the standard of patient understanding. The physician's duty is to comply with the requirements of Subsections A and C of the statute.¹⁸⁴ Subsection A requires the physician to inform the patient in writing of the following information: (1) the surgical procedure or course of procedures to be followed as well as the purpose of the procedure; (2) the risks, if any, associated with the particular procedure to be performed; and (3) the risks, if any, of death, brain death, quadriplegia, paraplegia, the loss or loss of function of any organ or limbs, and disfiguring scars. Subsection A also requires the physician to obtain an acknowledgement from the patient that disclosure of the information listed above has been made, and that all questions which the patient has asked have been answered satisfactorily. The consent form then must be signed by the patient or someone who has legal authority to consent on his behalf. If these requirements have been met without a misrepresentation of material fact, then the consent is presumed to be valid and effective, and the physician's duty regarding consent is presumed to be fulfilled.

If, however, the informed consent is not reduced to writing, Subsection C of the statute would allow the consent to be valid if the physician can prove that all the other requirements in Subsection A have been met. At trial it would be the physician's word against the patient's.

If the statutory guidelines of Louisiana Revised Statutes 40:1299.40 are met, the question remains whether the physician has fulfilled his duty to the patient with regard to informed consent even though additional duties are imposed by the jurisprudence. These duties include informing the patient of alternative forms of therapy, or referring him to a specialist or another medical facility where more sophisticated equipment is available for diagnosis and treatment. This writer agrees with Justices Blanche and Dennis in their concurring opinions in *LaCaze*¹⁸⁵ in which they argue that compliance with the Uniform Consent Law is neither the exclusive means of obtaining a valid consent nor, necessarily, fulfillment of the physician's duties under the doctrine of informed consent. Additionally, the physician still has an affirmative duty to the patient to insure that he receives the best available treatment and care. Failure of the physician to consider all medical benefits and risks of treatment and then disclose them to the patient might not be a breach of the statutory duty of informed consent, but arguably it would still be a deviation from the accepted standard of medical care and, therefore, constitutes medical negligence on the part

184. La. R.S. 40:1299.40 (1977).

185. 434 So. 2d at 1050 (Blanche, J., concurring); 437 So. 2d 869 (Dennis, J., concurring).

of the health care provider.¹⁸⁶ The doctrine of informed consent should change the medical decision-making process from a consensual one, in which the physician obtains the acquiescence of the patient, to a participatory one, in which the patient plays an active role. The patient's participation in the process should include considering information, weighing alternative courses of treatment, balancing medical risks against benefits, and considering the financial costs of treatment.

The guidelines suggested by the *LaCaze* court, its interpretation of Louisiana Revised Statutes 40:1299.40 and its requirements for a valid informed consent provide substantial guidance to the physician as to what and how much to say to the patient. However, since *LaCaze* adopted the objective standard of causation, the question of whether a particular patient would have refused medical treatment is irrelevant because the objective standard allows the admission at the trial of only that evidence probative of whether a reasonable patient would have accepted the treatment. If the patient does have the right to do with his body as he wishes¹⁸⁷ and if the patient even has the right to refuse medical treatment and die,¹⁸⁸ then the *LaCaze* court was inconsistent in adopting the objective test which disregards the patient's right of self-determination and requires that his decision be "reasonable." Additionally, the *LaCaze* objective standard of causation deprives the jury of its traditional function of assessing the plaintiff's credibility under oath when he testifies that his decision to undergo treatment would have been different if he had been aware of the risks involved. Since the physician knows that the patient is held to an objective standard of disclosure, then, to avoid civil liability, he need not disclose any more information to the patient than would be required to cause a "reasonable person" to undergo treatment. Information of unique significance to the patient's decision may thus be denied the patient, while the physician escapes liability because the jury will be denied the opportunity to hear the testimony of the patient's desires and wishes. Instead, the jury will hear expert medical testimony from physicians who will tell them how a reasonable patient would have reacted under the circumstances. Under the subjective test, the physician and the patient would both be allowed to testify. The physician would tell the jury what he told the patient, then the patient would tell the jury whether he would have refused the treatment or if he understood the physician's explanation. The jury would then be given the opportunity to assess the credibility of both

186. See generally Baudry & Wiener, Preoperative Preparation of the Surgical Patient, 63 *Surgery* 885 (1968); Capron, Informed Consent in Catastrophic Disease Research and Treatment, 123 *U. Pa. L. Rev.* 349, 413-14 (1974); Rockwell & Pepitone-Rockwell, The Emotional Impact of Surgery and the Value of Informed Consent, 63 *Medical Clinics N. Am.* 1341 (1979).

187. 434 *So. 2d* at 1043; see *supra* note 19 and accompanying text.

188. See *supra* notes 125-133 and accompanying text.

witnesses. If the subjective standard of disclosure were adopted in Louisiana, then physicians would have to establish a dialogue with each of their patients. To insure that he meets the individual's needs for information, the physician would have to follow a set of disclosure checklists or guidelines for each patient.

LaCaze's effect on patients' participation in the medical decision-making process is not limited to its imposition of the objective or reasonable man standard of disclosure. In *LaCaze*, the court also adverted to the physician's right to exercise the "therapeutic privilege."¹⁸⁹ The physician's invocation of the "therapeutic privilege" is, of course, subject to judicial scrutiny. But the question of whether the patient was so ill or distraught that the disclosure would have been hazardous to him is primarily a medical question, and the physician defending the earlier decision not to disclose risk information can usually sway the jury by introducing an impressive group of experts to agree with the defendant's position. Therefore, although *Pizzalotto* and *LaCaze* do answer some of the questions which attorneys and physicians have had about the doctrines of lack of consent and lack of informed consent, the *LaCaze* court's adoption of the "objective reasonable man view" and its favorable reference to the physician's "therapeutic privilege" in informed consent cases have vitiated the patient's right to determine his fate over his body and life.¹⁹⁰ On the other hand, the subjective standard of disclosure recognizes the patient's rights and should, therefore, be adopted either judicially or legislatively.

Liberative Prescription for Patient Consent and Other Consent Statutes

Gunter v. Plauche involved a malpractice cause of action in which the plaintiff alleged that the defendant negligently performed two operations on his knee. In *Gunter's* petition he alleged that he was operated on by Dr. Plauche on July 1, 1976 and September 7, 1977 and that both operations were unsuccessfully and negligently performed. On August 31, 1978 Mr. Gunter filed suit and on September 4, 1980 (with the leave of court), filed a "supplemental and amending petition" alleging that the treatment and two operations were performed without the defendant's properly informing him of alternatives to and risks of the treatment performed.¹⁹¹ The trial court directed a verdict against *Gunter*, but the court of appeal reversed and remanded. The court held that reasonable jurors might conclude that *Gunter* was denied the right to informed

189. 434 So. 2d at 1045.

190. *Id.* at 1043 (citing *Schloendorff v. Society of New York Hosps.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914)).

191. 439 So. 2d at 438.

consent.¹⁹² At the second trial the jury held for the defendant on the issue of negligence but granted damages of \$175,000 on Gunter's informed consent claim.

During the course of the second trial, the defendant filed a peremptory exception of prescription as to the original petition and, in the alternative, as to the amending petition. After the verdict was rendered, the trial judge refused to sign the judgment and set a hearing on the exception. The judge maintained the exception and dismissed the plaintiff's suit. The court of appeal affirmed¹⁹³ and the Louisiana Supreme Court granted certiorari¹⁹⁴ to review the lower court's judgment.

The supreme court, through Justice *Pro Tem*. Bailes, reasoned that the amended claim for the breach of duty by the physician in failing to obtain an informed consent to medical treatment was governed by the standards set forth in Louisiana Revised Statutes 40:1299.40 and cited *LaCaze* with approval.¹⁹⁵ The court acknowledged that the informed consent claim is different from the claim for the negligent performance of surgery. However, the court held that since the facts of the informed consent arose from the same medical negligence action, the defendant received sufficient notice to interrupt prescription for the negligence cause of action which was filed within the one year prescriptive period. Since the original petition was filed timely, the amendment to the pleading was also timely; therefore, the trial court erred in sustaining the defendant's exception of prescription.¹⁹⁶ According to plaintiff's attorney, Gunter settled in February of 1984 for \$260,000. Justice Blanche dissented on the grounds that the "lack of informed consent to surgery and negligence in the performance of surgery are two entirely different causes of action arising out of two separate events, and the filing of suit on one would not constitute fair notice of the other."¹⁹⁷

One of the problems physicians sometimes encounter in obtaining an informed consent from a patient involves the capacity of the patient to give an informed consent. The question of who can consent to treatment for whom is clearly indicated in Louisiana Revised Statutes 40:1299.53. The statute indicates that a consent can be given by any adult, for himself; any parent, whether an adult or a minor, for his minor child; any married person, whether an adult or a minor, for himself, and for his spouse;

192. *Gunter v. Plauche*, 399 So. 2d 727 (La. App. 1st Cir. 1981).

193. *Gunter v. Plauche*, 428 So. 2d 1094 (La. App. 1st Cir. 1983).

194. *Gunter v. Plauche*, 434 So. 2d 1099 (La. 1983).

195. 439 So. 2d 437, 440. Another case citing *LaCaze* and the causation test for informed consent is *Doss v. Hartford Fire Insurance Co.*, 448 So. 2d 813 (La. App. 2d Cir. 1984).

196. *Id.* at 441.

197. *Id.*

any person temporarily standing *in loco parentis* whether formally serving or not, for the minor under his care and any guardian for his ward; any female regardless of age or marital status, for herself when given in connection with pregnancy or childbirth; and in the absence of a parent, any adult, for his minor brother or sister; in the absence of a parent, any grandparent for his minor grandchild. In addition to this statute and Louisiana Revised Statutes 40:1299.55,¹⁹⁸ two Attorney General's opinions state that minors are allowed to give consent for themselves when none of the authorized persons of legal age are available.¹⁹⁹ In emergency situations, a consent may be implied under Louisiana Revised Statutes 40:1299.54.²⁰⁰

Information Which Physicians Should Convey to Encourage Patients to Participate in the Medical Decision-Making Process

Even if the physician follows the statutory and jurisprudential standards, he apparently has little guarantee that the patient understands and remembers what the physician has told him. One study revealed that even when "risk information" was presented in a concise, intelligible manner, patients averaged only a seventy percent rate of comprehension.²⁰¹ Another study revealed that even when patients fully understand the information concerning their medical treatment, they are frequently unable to remember that information for any significant period of time.²⁰² Tape recording the

198. La. R.S. 40:1299.55 (1977) ("Any person acting in good faith shall be justified in relying on the representations of any person purporting to give such a consent, including, but not limited to his identity, his age, his marital status, his emancipation, and his relationship to any other person for whom the consent is purportedly given.').

199. 1975 La. Op. Att'y Gen. 1740 (Jan. 22, 1976) (allowing minors to consent in emergencies); 1979 La. Op. Att'y Gen. 1051 (Sept. 26, 1979) (allowing schools to give consent for minors in emergencies).

200. See *supra* note 147. Other informed consent requirements covered by statute, but which will not be discussed in this article, include blood donations, La. R.S. 40:1097 (1978), venereal disease treatment, La. R.S. 40:1065.1 (1977), drug abuse treatment, La. R.S. 40:1096 (1977), treatment for the mentally ill and retarded, La. R.S. 40:1299.58 (1978), sterilization and abortions, La. R.S. 40:1299.35.5 & 1299.35.6 (1981), and parental care of infants, La. R.S. 40:1299.36.2 (1982). Consent under these special circumstances is regulated by specific statutes rather than by the general guidelines regulating consent and informed consent. See La. R.S. 40:1299.36.2 (1982) (governing parental refusal to give consent for care and treatment of minors).

201. Epstein & Lasagna, Obtaining Informed Consent: Form or Substance, 123 *Archives Internal Medicine* 682, 684 (1969) (reporting that subjects who read the short form of a protocol exhibited a recall rate of 70% and those who read the longer version only remembered 35%).

202. Robinson & Merav, Informed Consent: Recall by Patients Tested Postoperatively, 22 *Annals Thoracic Surgery* 209 (1976) (After a full disclosure of risks to patients undergoing heart surgery, patients were tested 4 to 6 months later for their memory of the elements of the disclosure. Even with prompting, the average cumulative recall score was only 42%). Bailey, Informed Consent, 1978 *Legal Medicine Annual* 273, cites the Robinson and Merav

risk information and reviewing it in a number of disclosure sessions would help the patient better assimilate and recall the information so as to be able to make an informed choice, particularly if the doctor were to give the patient a duplicate tape of the sessions.

Unless requirements for a comprehensive, subjective patient standard can be set forth in a relatively detailed checklist which physicians would routinely use to brief their patients about surgical or medical procedures, physicians will continue to lack sufficient guidance to meet the requirements of an informed consent doctrine which would actively involve both the patient and physician in the decision-making process. Some organizations such as the American Hospital Association,²⁰³ the federal government,²⁰⁴ and the Joint Commission for Accreditation of Hospitals²⁰⁵ have promulgated guidelines which give physicians and patients some degree of certainty about whether there has been compliance with the requirements of informed consent. The statutory requirements that the information should be in writing and signed by the patient should not hinder the physician from adopting the checklist approach, because that method would insure that the physician had covered all of the necessary information for a valid informed consent. In addition, since all of the necessary information would be on the document after the patient signs it, the requirements of the Louisiana informed consent statute would be met and the informed consent would be presumed to be valid.

It is suggested the physician should use the following checklist in obtaining an informed consent from a patient:

1. The physician should describe, in detail, the proposed treatment including the actual procedures to be followed in layman's language. The physician should also explain why the patient's physical condition necessitates the treatment as well as the relative benefits of the proposed treatment.

2. The physician should describe all risks of treatment that the patient would consider material, including whether the risks of the procedure include death, brain damage, quadriplegia, paraplegia, loss or loss of function of any organ or limb, or disfiguring scars; a disclosure of the probable complications; and a description of the risks to be encountered from

study as support for his contention that physicians should, for their own protection, document disclosure sessions by use of tape recorders. Repetition of risk information over a number of disclosure sessions would serve to strengthen the patient's comprehension of the treatment and its risks, enabling a strengthening of physiological and psychological defenses against the approaching stress of treatment.

203. American Hospital Ass'n, *A Patient's Bill of Rights* (1972).

204. See, e.g., FDA Regulations for New Drugs, 21 C.F.R. § 310 (1984); HHS Regulations for Protection of Human Subjects, 45 C.F.R. § 46 (1983).

205. Joint Comm'n on the Accreditation of Hosps., *Accreditation Manual for Hospitals* 85 (1983).

a failure to undergo the proposed treatment. The measure of what risks to disclose to the patient should be a subjective one based upon the patient's understanding of what he is being told, even though at trial the court would apply an objective standard. The physician should then describe the risks which he believes the patient would consider relevant in deciding whether to undergo treatment, regardless of the importance that a reasonable person would attach to these risks.

3. The physician should offer to give a more exhaustive disclosure of risks which would include the more remote risks of treatment. This guideline insures that the patient will be informed of all the risks that might be relevant to his or her decision and acts as a check against physician error concerning the degree of disclosure under the pending guideline. In making the offer of more exhaustive disclosure, the physician should state the factors which he used in determining which risks to disclose.

4. The physician should describe the potential benefits of the treatment and explain the treatment's efficacy in bringing about these benefits.

5. The physician should describe the alternative methods of treating the patient's condition, including in the discussion the risks and potential benefits of those alternatives as well as the relative costs of the treatment.

6. The physician should explain why he thinks the proposed treatment would be more beneficial to the patient than alternative methods of treatment.

7. The physician should offer to answer any questions the patient may have concerning the proposed treatment, its risks, or alternatives. In view of the general reluctance of patients to ask questions, physicians should make special effort to encourage the patient's inquiries. Specifically, the physician should offer to answer the patient's questions several times during the disclosure session, expressly inquiring as to whether the patient has any further questions. For example, he should state, "I am available to answer questions at any time that you may have about what I have told you" or ask "Do you have any questions now that I can answer for you?." In connection with this offer to answer the patient's question, the physician should also offer to repeat or supplement the relevant risk information at a later time. The patient may not have particular questions concerning the treatment, but may still desire to hear the relevant information again to assimilate it more fully. The patient should, therefore, be informed that the physician stands ready to review the information with him if the patient believes that it is necessary, and that the patient should jot down questions to ask so that he will not forget them.

8. The physician should ask, and this should be part of the informed consent in writing, whether or not the patient understands the information conveyed. The questions should be: "Do you understand what I have

told you?" and "Do you have any other questions about this?" The physician should then write down that the patient has understood the information and whether he asked questions. If the patient did ask questions, the physician should take note of them and of his answers to them. Therefore, when the patient signs he will read and be reminded of the informed consent, he then will review "that he did not have any questions or that his questions were answered" and either ask the questions at that time or by his silence and signature agree to the statement.

9. The physician should inform the patient that he has the right to refuse treatment or to choose one of the alternatives which have been discussed at the session. The physician should convey his willingness to perform any alternative treatment that the patient chooses, or to help the patient find a specialist qualified to perform the chosen alternative. Compliance with this guideline should alert the patient to his full freedom to choose one of the alternatives discussed at the session, without having to rely solely upon his resources in locating a physician willing to perform the preferred alternative.

10. The patient should be informed of the right to withdraw consent at any time before the procedure or, if circumstances permit, during the course of treatment.

11. The physician should inform the patient of the risks of not taking a diagnostic test or of refusing treatment. For instance, if a physician recommends a pap smear test and the patient refuses, the physician should tell the patient that by refusing the test to detect cancer,²⁰⁶ an undetected case of cancer might kill her.

12. Although not a requirement for a patient's consent, the physician should document the amount of time spent with the patient, and the number of sessions in which he discussed the consent considerations. He could even tape record the disclosure sessions and give the patient a duplicate of the tape. This would allow the patient to review the tape under less stressful conditions and enable him to consider his options in a more objective frame of mind.

CONCLUSION

The Supreme Court of Louisiana in *LaCaze v. Collier*, *Pizzalotto v. Wilson*, and *Gunter v. Plauche* has determined that an action for lack of informed consent sounds in negligence, that an action for lack of consent sounds in the intentional tort of battery, and that both causes of action are separate from traditional medical malpractice or negligence causes of action. Under a negligence cause of action for lack of informed

206. See *supra* notes 81-94 and accompanying text.

consent, the patient must prove that the doctor failed to disclose statutorily-required information regarding the proposed treatment, that the procedure caused the injury, and that a reasonable person in the patient's situation would not have undergone the procedure had he been fully informed. Under a battery cause of action for lack of consent, the patient must prove only that the physician operated without procuring an "informed consent" and that the procedure caused the injury. Generally, when a patient suffers a bad result and cannot prove that the physician was negligent, if he is able to show that the informed consent does not follow the guidelines of Louisiana Revised Statutes 40:1299.40, then not only will the informed consent allegation fortify a weak case, it may guarantee that the case will reach the jury. Judges, in deciding such cases, should carefully separate these issues at trial, because the cause of action for lack of consent or lack of informed consent arises from the risk of harm in a non-negligently performed medical procedure or treatment. Generally in such cases, the surgery was done correctly with the results being exactly as the doctor expected. It is the patient who did not desire or expect the results obtained, and from that unexpected result is born the dissatisfaction which gives rise to many a medical malpractice lawsuit. Although informed consent is a very lethal weapon in the plaintiff's arsenal and the informed consent doctrine seems to greatly favor the patient's rights, the Louisiana Supreme Court's use of the objective standard of what a reasonable patient would have done under the circumstances in determining causation, instead of using the subjective standard, does not recognize the individual patient's right to exercise complete control over his medical destiny.