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Medical Malpractice: Informed Consent Cases in “Full-Disclosure” Jurisdictions

David E. Seidelson*

I trust that the current controversy over the premium rates charged physicians for professional liability insurance will become the subject of a political resolution which will permit the practice of medicine to continue to be an economically feasible activity. I hope that that resolution will not emasculate either the existing or the emerging body of decisional law governing medical malpractice actions. On the basis of that trust and that hope, I would like to undertake an examination of some of the problems which exist in that decisional law as it applies to informed consent.

There is a marked divergence of opinion among the various jurisdictions as to the extent of disclosure which a physician must make to a patient as a condition precedent to securing the patient’s informed consent to a contemplated therapeutic procedure. Two basically different views emerge from the existing opinions: (1) the extent of disclosure required will be determined by the application of a professional standard, or (2) all material risks incident to the

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1. The following jurisdictions apparently judge the adequacy of the disclosure by the professional standard.
The proposed treatment must be revealed. The first view, currently the

Missouri: Aiken v. Clary, 396 S.W.2d 668 (Mo. 1965).

2. The following jurisdictions apparently require disclosure of all material risks.

Because there is very little Louisiana jurisprudence on the subject of informed consent, plaintiff cites many decisions from other jurisdictions which state that the physician has a duty to warn of dangers lurking in proposed treatment and to impart information which the patient has a right to expect. We agree that a physician does have a duty to disclose material facts reasonably necessary to allow the patient to form the basis of an intelligent consent.

294 So. 2d at 620.

"Informed consent" means for the purposes of this act and of any proceedings arising under the provisions of this act, the consent of a patient to the performance of health care services by a physician or podiatrist: Provided, That prior to the consent having been given, the physician or podiatrist has informed the patient of the nature of the
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prevailing one, is predicated upon a judicial conclusion that the degree of revelation in each case is a matter to be determined by proposed procedure or treatment and of those risks and alternatives to treatment or diagnosis that a reasonable patient would consider material to the decision whether or not to undergo treatment or diagnosis. No physician or podiatrist shall be liable for a failure to obtain an informed consent in the event of an emergency which prevents consulting the patient. No physician or podiatrist shall be liable for failure to obtain an informed consent if it is established by a preponderance of the evidence that furnishing the information in question to the patient would have resulted in a seriously adverse effect on the patient or on the therapeutic process to the material detriment of the patient's health.


Washington: Miller v. Kennedy, 11 Wash. App. 272, 522 P.2d 852 (1974), aff'd per curiam, 85 Wash. 2d 151, 530 P.2d 334 (1975): "We can add nothing constructive to the well considered opinion of that court and, accordingly, approve and adopt the reasoning thereof." 85 Wash. 2d at 151, 530 P.2d at 334. This resulted in rejection of the professional standard earlier applied in ZeBarth v. Swedish Hosp. Medical Center, 81 Wash. 2d 12, 499 P.2d 1 (1972). See Young v. Group Health Cooperative, 85 Wash. 2d 332, 534 P.2d 1349 (1975): "This case was brought to trial prior to our decision in Miller v. Kennedy . . . which abandoned the ZeBarth case in this regard." Id. at 336 n.1, 534 P.2d at 1352 n.1.


The following jurisdictions appear to have idiosyncratic or unclear (to this author) conclusions.

Idaho: Riedinger v. Colburn, 361 F. Supp. 1073 (D. Idaho 1973). In this diversity case, after concluding that "[t]here is no case law in Idaho establishing the principle of informed consent or the standard to be applied if, in fact, such a principle should exist," id. at 1076, the court predicted that Idaho would require "as a rule of disclosure the medical community standard for general procedures, but when relatively complicated surgery is involved, a doctor must, in addition, disclose known risks of death or serious bodily injury." Id. at 1077.

Maine: Downer v. Veilleux, 322 A.2d 82 (Me. 1974). After concluding that plaintiff's evidence failed to satisfy either standard, the court stated, "The decision as to whether the duty to disclose is governed by medical or by legal standards will be made when the facts of a particular case so require." Id. at 92.

Minnesota: Bang v. Charles T. Miller Hosp., 251 Minn. 427, 88 N.W.2d 186 (1958) (implies full disclosure but conclusion not clear, in part because of battery characterization).


Oklahoma: Martin v. Stratton, 515 P.2d 1366 (Okla. 1973) (plaintiff may proceed under either standard but evidence in case insufficient as to both).


3. See notes 1 & 2 supra.
medical judgment, taking into account not only the risks incident to the proposed procedure but, as well, the adverse effects on the patient's physical or emotional well-being which might result from a full disclosure. The second view, presently the minority conclusion but apparently attracting new adherents, is based on judicial recognition of the patient's right of self-determination in regard to what is to be done with or to his body. Because my own inclination is toward the "self-determination" or "full-disclosure" rule, and because there already exists a substantial literature, consisting of judicial opinions and scholarly articles, precisely identifying and carefully weighing the legitimate and persuasive reasons underlying each of the two approaches, it is the purpose of this article not to

4. See, e.g., Aiken v. Clary, 396 S.W.2d 668, 674 (Mo. 1965):

The question is not what, regarding the risks involved, the juror would relate to the patient under the same or similar circumstances, or even what a reasonable man would relate, but what a reasonable medical practitioner would do. Such practitioner would consider the state of the patient's health, the condition of his heart and nervous system, his mental state, and would take into account, among other things, whether the risks involved were mere remote possibilities or something which occurred with some sort of frequency or regularity. This determination involves medical judgment as to whether disclosure of possible risks may have such an adverse effect on the patient as to jeopardize success of the proposed therapy, no matter how expertly performed.

5. "We note the trend is to approach the problem from the standpoint of the patient and his interests—requiring the physician to disclose all risks and material facts to the patient . . . ." Holt v. Nelson, 11 Wash. App. 230, 238, 523 P.2d 211, 217 (1974). Examination of the cases cited in notes 1 and 2 supra indicates that where a recent change of judicial view has occurred, as in Washington, the change is from the professional standard to full disclosure.

6. "In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice." Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972). "Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves." 464 F.2d at 784.


8. See, e.g., Plante, An Analysis of "Informed Consent," 36 Ford. L. Rev. 639 (1968); Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw. U.L. Rev. 628 (1969) (perhaps the single most influential article on the subject); Comment, Informed Consent in Medical Malpractice, 55 Calif. L. Rev. 1396 (1967) (with varying standards applied to a hypothetical case); Comment, Valid Consent to Medical Treatment: Need the Patient Know?, 4 Duq. L. Rev. 450 (1966).
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attempt to demonstrate which view is preferable but rather, to attempt to identify and resolve some of the difficulties which the full-disclosure view has generated.

It should be noted that, although some of the courts which have adopted the full-disclosure rule may have been influenced toward that conclusion by the "conspiracy of silence," their adoption of that rule is not likely to obviate the plaintiff's need for expert medical testimony. There is some irony in that conclusion. To some extent, and, arguably, to a rather substantial extent, the theory of liability predicated on the absence of patient's informed consent was a product of the efforts of plaintiffs' counsel to avoid nonsuits or directed verdicts in medical practice actions due to the absence of expert medical testimony establishing the appropriate professional standard by which defendant physicians' conduct was to be judged. For example, if a patient died as a consequence of a surgeon's decision to anesthetize the patient while the patient was weakened by the recent ingestion of a substantial quantity of alcohol, a wrongful death action against the surgeon would surely fail unless plaintiff introduced expert medical testimony that surgeon's decision to operate in those circumstances violated the professional standard. However, if the wrongful death action could be couched in terms of the absence of an informed consent, and if the jurisdiction applied the full-disclosure rule, evidence that the surgeon had failed to apprise patient of the material risk of administering the anesthesia in such circumstances would constitute a legally sufficient action even absent expert medical testimony. At least that was

9. "[A]s a practical matter, we must consider the plaintiff's difficulty in finding a physician who would breach the 'community of silence' by testifying against the interest of one of his professional colleagues." Cooper v. Roberts, 220 Pa. Super. 260, 267, 286 A.2d 647, 650 (1971).

In speaking of the reluctance of one professional to testify against another, we are aware that in Coleman v. McCarthy, 53 R.I. 266, 165 A. 900 (1923), this court thought this difficulty was more apparent than real because of the Superior Court's statutory power to appoint expert witnesses who may subsequently testify at trial . . . . This observation was made in a day when malpractice suits were a rarity. Today, we think it is obvious that while the court can appoint an expert, there is no compulsion on the part of the appointee to serve, particularly if he thinks his court appearance may jeopardize the renewal of his malpractice insurance or result in an increase in the premium paid by his colleagues.


the anticipation of counsel representing plaintiffs in such cases. But it didn’t work out quite that way.

Since the gravamen of plaintiff’s complaint in an informed consent case in a jurisdiction requiring full disclosure is that defendant failed to advise the patient of all material risks incident to the treatment, plaintiff’s case-in-chief must present appropriate evidence of those material risks. And, generally, only a duly qualified expert medical witness can identify those material risks. While it may be true that some risks are so patently incident to a given medical procedure that they would constitute an appropriate subject for judicial notice, that same conclusion would foreclose the possibility that nondisclosure of those risks was culpable. Even the full-disclosure rule requires disclosure only of those risks unknown to the patient. If a particular risk is so generally well known in the community that it may be judicially noticed, it is not likely to have been unknown to the patient. At a somewhat diminished level of certainty of knowledge, it is conceivable that a judge could conclude that, as to a particular risk, a jury of laymen, even absent expert medical testimony, could determine that it was incident to a particular procedure. Again, however, it seems likely that, if laymen are competent to recognize a risk as incident to a medical procedure, so too should plaintiff patient have recognized the risk even absent disclosure by defendant physician. Consequently, the full-disclosure rule is not calculated to eliminate the need for expert medical testimony in plaintiff’s case-in-chief; rather, it changes the thrust of such testimony from the establishment of a professional standard which differs from defendant’s conduct to the identification of material risks incident to the particular procedure. That change in content may diminish somewhat the reluctance of a physician to testify for plaintiff in a medical malpractice action, but it does not eliminate the need for expert medical testimony.

11. "There are obviously important roles for medical testimony in such cases, and some roles which only medical evidence can fill. Experts are ordinarily indispensable to identify and elucidate for the fact-finder the risks of therapy and the consequences of leaving existing maladies untreated." Canterbury v. Spence, 464 F.2d 772, 791-92 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

12. In the new Federal Rules of Evidence, judicial notice of an adjudicative fact is permitted when the "judicially noticed fact" is "not subject to reasonable dispute in that it is either (1) generally known within the territorial jurisdiction of the trial court or (2) capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b).
Assuming that the plaintiff is able to secure an expert medical witness willing to so testify, may that witness identify certain medically cognizable risks as "material risks"? The objection likely to be asserted by defendant to the use of that phrase in the testimony of plaintiff's expert is that it goes to an ultimate issue in the case, i.e., which, if any, of the cognizable risks were material. The "ultimate issue" objection to expert testimony did enjoy a period of favor in American jurisprudence. Those courts which sustained such an objection generally explained that decision in terms of an apprehension that receiving expert testimony stated in terms of the ultimate issue would usurp the jury's fact-finding function. Implicit in that rationale was a judicial belief that jurors would unquestionably embrace the testimony offered by a duly qualified expert witness. Today that judicial concern seems almost unbelievably naive. Jurors tend to be zealous protectors of their fact-finding function and, typically, possess a healthy skepticism of expert testimony, which is regularly nurtured by counsel's cross-examination of hostile experts. Moreover, in virtually every case in which expert testimony is appropriate, the conclusions and opinions offered by plaintiff's experts and defendant's experts are likely to be dramatically inconsistent. In an informed consent case in a full-disclosure jurisdiction, for example, the conclusions of plaintiff's expert as to which risks were material may well be controverted by the testimony of defendant's expert. In the face of such controverted and inconsistent expert opinions, the jury, even discounting its fervor in retaining its legitimate functions, could hardly embrace unquestioningly the testimony of either expert.

Judicial recognition of the reluctance of jurors to surrender their

13. But until about twenty-five years ago, a very substantial number of courts had gone far beyond this commonsense reluctance to listen to the witness's views as to how the judge and jury should exercise their functions and had announced the general doctrine that witnesses would not be permitted to give their opinions or conclusions upon an ultimate fact in issue. McCORMICK'S HANDBOOK OF THE LAW OF EVIDENCE 27 (2d ed. E. Cleary 1972) [hereinafter cited as McCormick].

14. The reason was sometimes given that such testimony "usurps the function" or "invades the province" of the jury. Obviously these expressions were not intended to be taken literally, but merely to suggest the danger that the jury might forego independent analysis of the facts and bow too readily to the opinion of an expert or otherwise influential witness. Id.
fact-finding obligation to any witness and of the likelihood of conflicting expert testimony in most cases probably explains the current general rejection of the ultimate issue objection.\textsuperscript{15} There does continue to exist, however, one area in which the objection retains viability. When the ultimate issue consists of words or phrases of legal art, courts continue to be reluctant to permit expert testimony in those specific terms.\textsuperscript{16} That reluctance is probably well founded. Even "the world's foremost authority" in some science or art (other than law) is unlikely to be competent to testify in words or phrases of legal art. Where an offered will is challenged on the ground of absence of "testamentary capacity," for example, neither testator's lifelong treating physician nor a world renowned medical specialist in that infirmity which allegedly deprived testator of the necessary legal capacity should be deemed competent to testify to the presence or absence of "testamentary capacity."\textsuperscript{17} There would seem to be no reason for indulging in the assumption that either of those medical experts is sufficiently qualified as a legal expert to conclude that testator had or lacked testamentary capacity. Obviously, that doesn't mean that their relevant, conceivably critical, medical testimony should be excluded or even diminished in significance. It means only that neither should be permitted to offer his opinion of testator's condition in the precise terminology of the law when that

\textsuperscript{15} Although the rule had been followed in many states prior to 1942, there has been a trend since then to abandon or reject it with the result that now in a majority of state courts an expert may state his opinion upon an ultimate fact, provided that all other requirements for admission of expert opinion are met. 
\textit{Id. Accord, FED. R. EVID. 704: "Testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact." }

\textsuperscript{16} \textbf{FED. R. EVID. 704, 28 U.S.C.A. App. (1975)} (Notes of Advisory Committee on Proposed Rules) provides: 

The abolition of the ultimate issue rule does not lower the bars so as to admit all opinions. Under Rules 701 and 702, opinions must be helpful to the trier of fact, and Rule 403 provides for exclusion of evidence which wastes time. These provisions afford ample assurances against the admission of opinions which would merely tell the jury what result to reach, somewhat in the manner of the oath-helpers of an earlier day. They also stand ready to exclude opinions phrased in terms of inadequately explored legal criteria. Thus the question, "Did T have capacity to make a will?" would be excluded, while the question, "Did T have sufficient mental capacity to know the nature and extent of his property and the natural objects of his bounty and to formulate a rational scheme of distribution?" would be allowed. 

\textit{Id. (citation omitted). }

See also MCCORMICK, supra note 13, at 28 & n.55.

\textsuperscript{17} See note 16 supra.
nomenclature is a phrase of legal art. Rather, counsel, whether proponent or opponent, should elicit answers in lay (from a legal point of view) language which is synonymous with the legal art phraseology. Such synonymous lay language exists for every phrase of legal art; if it did not, the legal esoterica would be devoid of intelligible meaning and wholly without efficacy in every case in which a jury trial is possible, for a significant portion of a trial judge's obligation in instructing a jury is to explain in language comprehensible to the jury each of the legal art phrases which the jury will be required to utilize.

It becomes necessary, then, to determine whether or not "material risks," when used to describe certain medically cognizable risks incident to a particular therapeutic procedure, constitutes a phrase of legal art. One is virtually compelled to an affirmative answer, for several reasons. First, it seems fair to assume that various physicians would have various and probably inconsistent views about which cognizable risks were material, if each were free to make his own determination of "material risk." Second, those jurisdictions which have embraced the full-disclosure rule have imparted to the phrase "material risk" relatively precise definitions which may differ considerably from a layman's conclusion as to the legal meaning of the phrase. For example, a layman might well conclude that a risk was material, for purposes of the full-disclosure rule, if knowledge of that risk would have dissuaded the patient from consenting to the proposed medical procedure. Another layman might conclude that a risk was material if knowledge of that risk would have dissuaded him from consenting to the procedure. And a medical expert—lay in a legal sense—might conclude that only those risks which would have dissuaded him from consenting to the procedure were material. Each of these lay conclusions might be significantly different from the others and each, apparently, differs from the legal meaning intended for "material risks" in full-disclosure jurisdictions. Therefore, the phrase should be considered one of legal art and, for that reason, inappropriate for testimonial use by either side's experts in an informed consent case in a full-disclosure jurisdiction. As a consequence, and as a means of retaining the greatest utility for appropriate expert testimony in informed consent cases,
counsel on both sides should put to the experts questions calculated to elicit ultimate responses in that lay language which is synonymous with "material risks."

That, in turn, raises the question of what constitutes a "material risk" in an informed consent case being tried in a full-disclosure jurisdiction. One of the earliest and perhaps one of the most influential of the full-disclosure cases is *Canterbury v. Spence*. In *Canterbury*, the court adopted the following language as determinative of the materiality of a risk:

[A] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.

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20. Id. at 787, quoting Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U.L. Rev. 628, 640 (1970). Here and at other points in this article, I have excerpted language from *Canterbury* for the purpose of examining the court's rationale and indicating my own agreement or disagreement with that rationale and the conclusion supported by it. The *Canterbury* opinion was selected from among those cases rejecting the professional standard and requiring full disclosure, not because I consider *Canterbury* a vulnerable "whipping boy" but rather because (1) it has been uniquely influential and (2) it is, in my opinion, one of the most thoughtfully considered and precisely written of the judicial opinions adopting the full-disclosure rule.

At one point in its opinion, the *Canterbury* court states:

Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision. These conspicuous examples of permissible uses of nonexpert testimony illustrate the relative freedom of broad areas of the legal problem of risk nondisclosure from the demands for expert testimony that shackle plaintiffs' other types of medical malpractice litigation.

464 F.2d at 792.

At another point, the court notes:

Of necessity, the content of the disclosure rests in the first instance with the physician. Ordinarily it is only he who is in position to identify particular dangers; always he must make a judgment, in terms of materiality, as to whether and to what extent revelation to the patient is called for. He cannot know with complete exactitude what the patient would consider important to his decision, but on the basis of his medical training and experience he can sense how the average, reasonable patient expectably would react. Indeed, with knowledge of, or ability to learn, his patient's background and current condition, he is in a position superior to that of most others—attorneys, for example—who are called upon to make judgments on pain of liability in damages for unreasonable miscalculation.

*Id.* at 787.

Those two excerpts are logically reconcilable. The second recognizes the initial obligation of
Rather clearly, that language contemplates an objective, rather than a subjective, standard for determining materiality. A risk is material only if it would be likely to affect the decision of a reasonable person in the patient's circumstances. Thus, to avoid an appropriate ultimate issue objection to a medical opinion couched in terms of legal art and, simultaneously, to preserve the greatest efficacy for his expert's testimony, proponent should have the expert witness identify those risks incident to the therapeutic procedure which, in the witness' opinion, would affect the decision of a reasonable person in the patient's circumstances to undergo or forego the proposed procedure.

While that may take care of the ultimate issue objection, it seems to create an even more basic problem. Those courts which have embraced the full-disclosure rule have done so because of their recognition that, in the words of the Canterbury opinion, "[r] espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves."2 If full disclosure is mandated by the patient's right of self-determination but materiality is to be determined by the reasonable person standard, an inherent inconsistency arises. It is quite possible that the patient's decision to undergo the proposed medical procedure would have been affected, even converted into a decision to decline the procedure, by disclosure of a particular incident risk which would not have affected the decision of a reasonable person (as determined by expert witness or jury) in like circumstances. To the extent that, given a particular revelation, patient would have declined the procedure and a reasonable person in like circumstances would have undergone the procedure, patient's right of self-determination is lost. That conclusion necessarily impels one to inquire why a full-disclosure court, sensitive to a patient's right of self-determination, would determine the materiality of medical risks by the application of an objective rather than a subjective standard. Even the Canterbury court conceded that "[o]ptimally for the patient, expo-

the physician to disclose material risks and the first the capacity of a layman to determine materiality. Still, it would be a foolish plaintiff's counsel who would forego the opportunity of having a duly qualified expert identify as material that undisclosed risk which occasioned plaintiff's injury, especially since the adequacy of defendant's disclosure is to be judged by an objective standard under the Canterbury formulation. See also note 11 supra.

21. 464 F.2d at 784.
sure of a risk would be mandatory whenever the patient would deem it significant to his decision, either singly or in combination with other risks." Then why not use the subjective standard? The *Canterbury* answer is:

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.

Apparently, the *Canterbury* court concluded that it would be "legally" and "morally" unjustifiable to permit the imposition of liability on a physician for his failure to apprise the patient of those risks which the patient would have considered critical in deciding whether or not to undergo the proposed therapy; rather, such liability is to be permitted only if the non-disclosure would have affected the decision of a fictitious "reasonable patient," even though the actual patient would have elected to forego the therapy had he been fully informed. And the detrimental impact on the patient's right of self-determination, presumably the *raison d'être* for the full-disclosure rule, is explained away in terms of fairness to the physician. To determine the legal, logical and equitable propriety of that "bargain," it becomes necessary to examine the persuasiveness of the court's stated concern over unfairness to the physician were a subjective standard to be utilized.

It should be recalled that the full-disclosure rule is an alternative to the professional-standard rule. Under the professional-standard rule, the treating physician and the expert medical witnesses purport to be able to determine (1) the totality of the substantial risks

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22. *Id.* at 787.
23. *Id.*
involved, (2) those risks which might dissuade the patient from consenting to the proposed therapy, and (3) that bundle of risks from (1) and (2) which, if revealed to the patient, would have an adverse effect on his physical or emotional well-being. Therefore, they assert, the patient should be apprised of those risks in categories (1) and (2) less those in category (3). It would seem that to assert the capacity to determine those factors necessary to establish a professional standard by which to judge the scope of disclosure asserts a capacity even greater than that which would be required to make a full disclosure satisfactory to a particular patient. The professional standard imputes to the physician both the capacity to determine which risks might affect the patient’s decision and which risks might adversely affect the patient if revealed to him. That imputed capacity rests on a professionally asserted unique insight into the physical and emotional condition of the particular patient. Reduced to its most essential and simplest form, the underlying foundation for use of the professional standard is: The doctor knows best. Why in the world disregard that asserted professional insight simply because the test for determining the adequacy of the disclosure shifts from the professional standard to the full-disclosure rule? Certainly the formulation and utilization of the latter test does nothing in fact to diminish the unique insight into patients’ needs which the medical profession regularly purports to possess in informed consent cases in jurisdictions which retain the professional standard rule. To conclude that the same insight into the informational needs of a particular patient exists in an informed consent case in a jurisdiction which utilizes the full-disclosure rule would impute to the treating physician no greater insight or foresight than his professional colleagues regularly purport to possess in professional-standard jurisdictions. Indeed, even in full-disclosure jurisdictions, the physician may offer evidence tending to justify an apparently inadequate disclosure on the grounds that “risk-disclosure [posed] such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view.” It would seem, then, that to test the adequacy of the disclosure in a full-disclosure jurisdiction by the needs of the particular patient, rather than by an objective standard utilizing a fictitious

24. See note 4 supra.
25. 464 F.2d at 789.
reasonable-person patient, would not constitute an inappropriate imposition on the treating physician.

It is true, of course, as the Canterbury opinion indicates, that in negligence actions generally the reasonable person standard is the rule. Whether or not that general rule should be considered inexorably applicable to the alleged negligence of the physician in an informed consent case in a full-disclosure jurisdiction should depend, in substantial measure, on the similarities or disparities between the typical negligence action and the informed consent case.

Let's examine a typical negligence action. If defendant's alleged negligence was in the manner of operation of his automobile, which collided with plaintiff's car, defendant's conduct will indeed be judged by the reasonable person standard. Certainly one reason for that legal conclusion is that plaintiff had no right to expect more of the defendant. Defendant's operation of his car did not constitute any representation, express or implied, that defendant possessed any skills or capacities beyond those of a reasonable person. A second and intimately related reason for application of the reasonable person standard in such a case is the absence of any conduct on the part of defendant which induced plaintiff to undertake a course of action which plaintiff might otherwise have avoided. Presumably, plaintiff would have been driving his car at the same time and place absent any conduct at all on the part of defendant. Absent any such inducement on the part of defendant, plaintiff cannot assert successfully that he was enticed into an expectation of conduct on the part of defendant different from that of a reasonable person. And, finally, there is a plaintiff-protecting reason for the application of a reasonable person standard by which to judge defendant's conduct. If defendant driver were to be judged by a subjective rather


[It is a mistake to say, as the petitioner does, that if the man on the spot, even an expert, does what his judgment approves, he cannot be found negligent. The standard of conduct, whether left to the jury or laid down by the court, is an external standard, and takes no account of the personal equation of the man concerned. The notion that "it should be coextensive with the judgment of each individual" was exploded, if it needed exploding, by Chief Justice Tindal, in Vaughan v. Menlove.]

The court in Vaughan v. Menlove, 132 Eng. Rep. 490, 493 (C.P. 1837) had stated:

Instead, therefore, of saying that the liability for negligence should be co-extensive with the judgment of each individual, which would be as variable as the length of the foot of each individual, we ought rather to adhere to the rule which requires in all cases a regard to caution such as a man of ordinary prudence would observe.
than an objective standard, the ultimate "logical" conclusion would be that defendant's conduct would be judged by defendant's standard; in most cases, conduct and standard would coincide, defendant would be deemed non-negligent and plaintiff would be denied a recovery.

Now consider the relationship between physician and patient. Clearly, the physician holds himself out as possessing superior knowledge and skill in regard to the object of the professional relationship, and, just as clearly, patient implicitly recognizes and accepts that representation. Who in all the world would be better equipped to guide, counsel and treat the patient medically than the treating physician? And to whom, in all the world, would plaintiff more naturally look for such guidance, counseling and treatment than the treating physician? Their professional relationship is based on the physician's implied representation of superior knowledge and skill and the patient's reliance on that representation. Moreover, the physician, unlike defendant driver, does induce the plaintiff to undertake a course of action he otherwise might have avoided. That inducement occurs in two ways. First, it seems fair to conclude that, absent the professional relationship, patient would not have undergone the particular therapeutic treatment involved. Second, and, simultaneously more specific and cogent to the issue, one of the principal reasons for the relationship is plaintiff's desire to receive adequate guidance and counsel in determining which course to follow by way of treatment. Inherent in the inducement which flows from the physician's disclosure of information is the patient's reliance upon that information in determining whether or not to acquiesce in a particular course of proposed treatment. Finally, use of a subjective standard in judging the adequacy of physician's disclosure—subjective in the sense of requiring disclosure of those factors material to the particular patient—certainly would not lead to nearly total immunity from liability for the physician. On the contrary, it would tend to be more plaintiff-protecting than the objective standard. Therefore, to the extent that utilization of the objective standard in the vehicle case is impelled by a plaintiff-protecting desire, that same desire in an informed consent case would point toward the utilization of a subjective standard. And, not just incidentally, use of the subjective standard in the informed consent case would be plaintiff-protecting not only in the general sense of providing a meaningful opportunity for recovery but, as well, in the more
specific sense of preserving the particular patient's right of self-determination, which perfectly complements the basic reason for requiring full disclosure. That compination of (1) superior knowledge impliedly asserted by the physician and implicitly accepted by the patient, (2) the inducement and reliance by physician and patient, respectively, inherent in the professional relationship, and (3) a desire to protect the plaintiff, in the general sense of making recovery feasible and in the specific sense of preserving his right of self-determination, dramatizes the patent distinctions between that professional relationship and the roles of two automobile operators using a public highway. Those distinctions, in turn, tend to support the conclusion that use of the objective standard in negligence actions generally does not justify its use in determining the adequacy of physician's disclosure to patient.

There is, in addition, an innate mechanical awkwardness in using an objective rather than a subjective standard to test the adequacy of the disclosure. In most instances in which the reasonable person standard is used to judge a defendant's conduct, the standard and the conduct are compared by the jury with its attention focused primarily on the defendant and the circumstances in which he acted; reference to the plaintiff, while relevant, tends to be of only secondary significance. For example, in the case of the allegedly negligent automobile operator, the jury would judge his conduct as it compared with what a reasonable person in like circumstances would have done. Consideration of plaintiff driver would tend to be limited to his presence on the scene as one of the circumstances to be considered. In such a case, defendant's conduct is judged by a standard uniquely attuned to a defendant-analog: a reasonable person in like circumstances. But in an informed consent case, the adequacy of defendant physician's disclosure can be judged only with primary and critical attention focused upon the recipient of the information offered. Where the actual recipient (the patient) is supplanted by a reasonable person in like circumstances (the objective standard), the jury is required to judge the adequacy of defendant's conduct by a plaintiff-analog, the reasonable person in circumstances similar to those of the patient. That subtle shift in standard

27. Actually, what the objective standard requires is what the reasonable physician would know about the "informational needs" of the reasonable patient in circumstances similar to those of the patient. Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972). That creates
personification, from defendant-analog to plaintiff-analog, imposes on the jury the wrong exemplar by which to judge the defendant's conduct; it requires the jury to determine the propriety of defendant's conduct by an objective standard attuned primarily to the plaintiff.

That mechanical awkwardness, in turn, gives rise to this paradox: the more precisely the reasonable person in like circumstances resembles the particular plaintiff patient, the more inappropriate the objective standard would become for imposition on the defendant physician; and the less distinctly the reasonable person in like circumstances resembles the particular plaintiff patient, the greater would be the loss of the patient's right of self-determination. To the extent that virtually all of the patient's idiosyncrasies are taken into account in the jury's formulation of a reasonable person in like circumstances, the resulting standard to be imposed on the defendant will be uniquely identical to the plaintiff. A standard so carefully tailored to fit the patient simply will not fit comfortably when draped on the physician. To the extent that the particular patient's idiosyncrasies, especially those possessing a substantial capacity for affecting his decision of whether to accept or reject the proposed therapy, are ignored in the jury's formulation of a reasonable person in like circumstances, the patient's acknowledged (at least, in full-disclosure jurisdictions) right of self-determination will be sacrificed. Once it is recognized that the adequacy of the physician's disclosure can be tested sensibly only with primary and critical attention focused upon the patient, the mechanical awkwardness of imposing on the jury an objective plaintiff-analog for application to the defendant's conduct, and the unfortunate paradox which that imposition creates, can be eliminated simply and sensibly by permitting the jury to follow the dictates of common sense and logic and determine the adequacy of the disclosure by determining if it apprised the particular patient of all material risks.

Finally, the Canterbury desire to achieve fairness to the physician seems hardly likely to be realized in fact by judging the adequacy of physician's disclosure by an objective standard which consists of
two creatures of fiction: the objective physician and the objective patient. It seems fair to conclude, as the text does, that, given those two "reasonable persons," the jury, in determining the adequacy of the disclosure, would look primarily to the analog of the recipient of the information, the reasonable person in circumstances similar to those of the patient.
a reasonable person in circumstances similar to those of the patient. No matter how precisely that objective standard takes into account the idiosyncrasies of the particular patient, it will at best mirror a flawed perception of the actual patient. So long as the jury has imposed upon it a "reasonable person" patient, it will be required to apply a standard distinguishable to some extent from the actual patient. Necessarily, then, the jury's ultimate reasonable person will be a creature of fiction. The physician will have had no professional relationship with that fictitious being, no opportunity to observe it, no opportunity to talk with it, and no opportunity to assess its comprehension of and reaction to the physician's disclosure. What reason is there to assume that the physician's disclosure would have been more likely to reveal all of the material risks to this creature of fiction than to the actual patient? The *Canterbury* answer presumably would be that the actual patient's "ideas on materiality could hardly be known to the physician," and that "the physician's liability for nondisclosure is to be determined on the basis of foresight, not hindsight." In effect, the *Canterbury* court decided that the physician would be better able to determine and predict the ideas on materiality of a reasonable patient as ultimately defined by a jury than the ideas on materiality of the actual and conceivably unreasonable patient. I find that decision lacking in persuasiveness. Given the professional relationship which existed between physician and patient, and the opportunity afforded physician by that relationship to explore the idiosyncrasies and even the irrationalities of the patient, I would be inclined to believe that physician would be at least as competent to discern the ideas on materiality of the particular and potentially unreasonable patient as he would be to determine the ideas on materiality of the fictitious reasonable patient ultimately fashioned by a jury.

It would seem that preservation of the patient's right of self-determination, the touchstone of the full-disclosure rule, is better served by use of a subjective standard to test the adequacy of the physician's disclosure and that use of such a subjective standard would not impose unduly on the physician. Consequently, I would amend the language of *Canterbury*,

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28. *Id.*
29. *Id.*
[A] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.\textsuperscript{30}

to read:

A risk is material when the patient would attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.\textsuperscript{31}

\textsuperscript{30} Id.

\textsuperscript{31} There is an additional “fringe benefit” in rejecting Canterbury’s objective standard and embracing a subjective standard for judging the adequacy of defendant physician’s disclosure. If defendant’s conduct is judged, as Canterbury says it should be, by a standard which contemplates what “the physician knows or should know,” the standard begins with a “reasonable physician.” If the standard includes, as Canterbury says it should, what a reasonable person in the plaintiff’s position would consider significant, it ends with a reasonable patient. One would think that the most qualified witness in the world to testify to what a reasonable physician in circumstances like the defendant’s would reveal to a reasonable patient in circumstances like the plaintiff’s would be a physician practicing in the same medical speciality as the defendant. And that comes so very close to paralleling the professional standard that it imperils the very existence of the full-disclosure rule. Even if plaintiff is not required to introduce expert medical testimony as to the professional standard of disclosure, it seems a virtual certainty that defendant will and that defendant’s experts will establish a standard entirely consistent with defendant’s disclosure. If, after hearing defendant’s experts establish a standard which perfectly reflects defendant’s disclosure, the jury is instructed to judge the adequacy of that disclosure by an objective standard, \textit{i.e.}, what a reasonable physician would have taken to be the informational needs of a reasonable patient, it seems very likely that the jury, if it believes the testimony of defendant’s experts, will find that testimony to be dispositive of the issue. To the extent that that occurs, the full-disclosure rule will have been supplanted by the ostensibly rejected professional standard.

On the other hand, if the adequacy of defendant’s disclosure is judged by a subjective standard—revelation of all risks to which the particular patient would attach significance—the testimony of defendant’s experts, though still relevant, would be much less likely to be determinative. None of those experts could state conclusively what the defendant in fact knew or should have known of his patient and none could state conclusively what the particular patient considered material. Consequently, the jury would be free to accept the totality of the testimony of defendant’s experts without, simultaneously, tacitly applying the professional standard in a jurisdiction which has rejected that standard and embraced the full-disclosure rule.

At times, language appears in judicial decisions which implies a subjective test for determining the adequacy of the disclosure but the implication seems blunted or wholly overcome by the totality of the opinion. See, \textit{e.g.}, Cobbs v. Grant, 8 Cal. 3d 229, 245, 502 P.2d 1, 11, 104 Cal. Rptr. 505, 515 (1972):

In sum, the patient’s right of self-decision is the measure of the physician’s duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician’s communica-
Closely allied to the question of which standard should be used to judge the adequacy of physician's disclosure, an objective or a subjective one, is the question of which standard should be used to determine whether or not, had an adequate disclosure been made, consent would have been forthcoming. Consistent with its adoption of an objective standard for measuring the adequacy of the disclosure, *Canterbury* adopts an objective standard for determining if consent would have been extended or withheld, had an adequate disclosure been made. Just as use of an objective standard to measure the adequacy of disclosure diminishes the patient's right of self-determination, so too, the use of an objective standard to decide the consent issue has precisely the same effect for precisely the same reason. If the jury concludes that defendant physician's disclosure

...
was inadequate, it must then decide whether or not an adequate disclosure would have elicited consent. Under the Canterbury formulation, the jury is to resolve that issue by determining whether or not, had an adequate disclosure been provided, a reasonable person in the patient's circumstances would have acquiesced. To the extent that plaintiff patient, given an adequate disclosure, would have declined the proposed treatment and a reasonable person in similar circumstances, as determined by the jury, would have consented, patient's right of self-determination is irrevocably lost. Still bearing in mind that that basic right of self-determination is the essential reason for the full-disclosure rule, one is compelled to ask why that basic right is to be jeopardized by the imposition of an objective standard in determining the consent issue. The Canterbury answer is that the subjective method of dealing with the issue of causation [i.e., whether or not consent would have been forthcoming had an adequate disclosure been made] comes in second-best. It places the physician in jeopardy of the patient's hindsight and bitterness. It places the factfinder in the position of deciding whether a speculative answer to a hypothetical question is to be credited. It calls for a subjective determination solely on testimony of a patient-witness shadowed by the occurrence of the undisclosed risk.

Better it is, we believe, to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance. If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not. The patient's testimony is relevant on that score of course but it would not threaten to dominate the findings. And since that testimony would probably be appraised congruently with the factfinder's belief in its reasonableness, the case for a wholly objective standard for passing on causation is strengthened. Such a standard would in any event ease the fact-finding process and better assure the truth as its product.33

Viewed in its totality, that explanation for the adoption of an objec-

33. *Id.* at 790-91 (footnotes omitted).
tive, rather than a subjective, standard for determining this causa-
tion issue comes down to one essential judicial recognition and con-
cern. In virtually every such case, plaintiff patient will testify that, 
given adequate disclosure, he would not have consented, and the 
plaintiff's right to recover and the defendant physician's vulnerabil-
ity to liability should not be made dependent on that self-serving 
testimony of the plaintiff. How persuasive is that explanation?

It should be conceded immediately that indeed plaintiff will tes-
tify that, adequately informed, he would not have consented. To do 
otherwise, would require the granting of defendant's motion for non-
suit or directed verdict, and would make one wonder why plaintiff 
and his lawyer had invested all of the time, effort and money neces-
sary for the preparation for and the participation in the trial. 
Whether a subjective or an objective standard is utilized, plaintiff's 
case will fail if plaintiff concedes that, given an adequate disclosure, 
he would have consented. If a subjective standard is used, that 
concession would be determinative of the standard and defendant 
would prevail as a matter of law. Were an objective standard uti-
lized, while plaintiff's concession would not be determinative of the 
standard, it would nonetheless be conclusive as a matter of law 
because, even given the objective standard, a sine qua non to a 
legally sufficient plaintiff's case is evidence that the particular pa-
tient would not have consented. In reality, the objective standard 
requires evidence from the plaintiff which would justify affirmative 
determinations that neither the particular plaintiff patient nor a 
reasonable person in like circumstances would have consented. 
Thus, whichever standard is employed, plaintiff's testimony that he 
would not have consented, given an adequate disclosure, should be 
contemplated. But does it necessarily follow that the jury will be-
lieve that testimony? The concern implicit in the above quotation 
from Canterbury suggests, unpersuasively, an affirmative answer. 
Surely the jury will recognize the apparent self-interest underly-
ing that testimony of the plaintiff. And, just as surely, counsel for 
the defendant, in summation, will underscore that self-interest as a 
critical factor to be considered by the jury in determining the credi-
bility to be extended the plaintiff and the weight to be given his 
testimony. In all likelihood, that portion of defendant's summation 
will be contemplated by an instruction from the court to the jury 
to take self-interest into account in determining matters of credibil-
Moreover, the jury is likely to realize that, self-interest aside, the plaintiff may find it difficult to know factually whether or not he would have consented, given an adequate disclosure, before suffering the ultimate adverse consequences. That, too, seems calculated to affect the jury's determination of whether or not to credit plaintiff's testimony that he would have withheld consent. And, finally, it should be emphasized that, even assuming the use of an objective standard, the jury's acceptance of plaintiff's testimony that he would not have consented is a prerequisite to a verdict for the plaintiff. It is difficult to understand why that jury determination would become less reliable if the subjective standard were employed.

Since jury acceptance of plaintiff's testimony that, given an appropriate disclosure, he would have withheld consent is a legal requirement for a verdict for the plaintiff, whichever standard is employed, the essential difference resulting from the selection of either standard becomes clearer. If the objective standard is used, jury acceptance of plaintiff's testimony is but one of two necessary factual determinations preceding a verdict for the plaintiff; there would remain the necessity of an affirmative jury determination that a reasonable person in plaintiff patient's circumstances likewise would have withheld consent. On the other hand, if the subjective standard is used, jury acceptance of plaintiff's testimony would be dispositive of the consent issue. It is that consequence which seems to have disturbed the Canterbury court. Why?

The above quoted excerpt from Canterbury suggests two reasons. First, "[i]t places the factfinder in the position of deciding whether a speculative answer to a hypothetical question is to be credited." 35

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34. E.g., District of Columbia Standardized Jury Instruction No. 31 (rev. ed. 1968) provides:

In reaching a conclusion as to the credibility of any witness, and in weighing the testimony of any witness, you may consider any matter that may have a bearing on the subject. You may consider the demeanor and the behavior of the witness on the witness stand; the witness' manner of testifying; whether the witness impresses you as a truthful individual; whether the witness impresses you as having an accurate memory and recollection; whether the witness has any motive for not telling the truth; whether the witness had full opportunity to observe the matters concerning which he has testified; whether the witness has any interest in the outcome of this case, or friendship or animosity toward other persons concerned in this case.

Id. (emphasis added).

35. 464 F.2d at 791.
However, as already indicated, the jury would be required to decide whether or not to credit that "speculative" answer even if an objective standard were employed. And, were an objective standard used, would not the jury's determination of whether or not a reasonable person in like circumstances (that purely fictitious creature of the law) would have consented impose upon the jury an additional and perhaps even more "hypothetical question"? Second, the quoted language above indicates that to treat plaintiff's testimony, if believed, as determinative of the consent issue would place "the physician in jeopardy of the patient's hindsight and bitterness." So far as that "hindsight and bitterness" are concerned, we have already noted that the jury, in deciding credibility and weight, is certain to take into account, along with plaintiff's self-interest, the fact that his testimony that he would have withheld consent is an after-the-fact declaration made subsequent to his having endured the adverse consequences of the medical procedure. That should alleviate adequately any judicial concern that the jury, without appropriate reflection and discrimination, will accept plaintiff's testimony. The only remaining objection to use of the subjective standard implied in Canterbury is general unfairness to the physician. Presumably, that feared unfairness is of the same nature and quality as the feared unfairness arising from the utilization of a subjective, rather than an objective, standard to judge the adequacy of the disclosure. Obviously, the two issues are intimately related. For precisely the same reasons stated earlier in support of the use of a subjective standard in determining the adequacy of the disclosure, and in negating that expressed unfairness to the physician, it is submitted that use of the subjective standard in determining whether or not consent would have been forthcoming, given an adequate disclosure, would impose no unfairness on the physician. On the contrary, it would reflect accurately the implicit representation of superior knowledge by the physician and the tacit acceptance of that representation by the patient, preserve the essential reason for adoption of the full-disclosure rule—patient's right of self-determination—and afford the physician a meaningful opportunity during the professional relationship to determine the enlightened sincerity of the particular patient's consent rather than compel the physician to predict (at his potential peril) whether or not that ultimate creature

36. Id. at 790-91.
of the jury's fashioning (a reasonable person in circumstances like those of the plaintiff) would consent. Consequently, I would amend the Canterbury language,

Better it is, we believe, to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance. If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not.\(^\text{37}\)

to read:

If adequate disclosure would have caused the patient to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown.

There is lurking in both the excerpt quoted from Canterbury and in my own suggested amendment a delicate problem not merely of causation but of proximate cause as well. That latent proximate cause problem was not specifically before the court in Canterbury but it could arise in almost any informed consent case in a full-disclosure jurisdiction.\(^\text{38}\) Let's fashion a hypothetical set of facts which will focus attention on and require resolution of the problem. Having dealt with the methods of judging the adequacy of disclosure and for determining if consent would have been forthcoming, given an adequate disclosure, assume now (1) an inadequate disclosure, (2) a determination that consent would not have been forthcoming

\(^{37}\) Id. at 791 (footnotes omitted).
\(^{38}\) See, e.g., Bowers v. Garfield, 382 F. Supp. 503 (E.D. Pa.), aff'd without opinion, 503 F.2d 1398 (3d Cir. 1974), wherein the district court stated:

Both at trial and on the present appeal, plaintiffs have contended that a causal relationship between failure to disclose and the injury complained of is unnecessary and irrelevant. This stance is clearly contra to the weight of modern authority in the area of informed consent.

382 F. Supp. at 505 n.3 (citations omitted).

In Bowers, the court rejected as well plaintiff's assertion (and the suggestion contained in this article) that whether or not consent would have been forthcoming, given an adequate disclosure, "should [be] decided on a subjective basis, that is, would Mrs. Bowers herself have undergone the hysterectomy if Dr. Garfield advised her of the risk of a vesicovaginal fistula." \(^\text{Id.}\) at 505. Relying in part on "[t]he preeminent federal case in point," Canterbury, the Bowers court applied "the objective 'reasonable woman' test." \(^\text{Id.}\) at 506.
had an adequate disclosure been made, (3) adverse consequences suffered by the patient as a result of the therapeutic measure utilized, but (4) adverse consequences resulting from a medically cognizable but non-material risk incident to the therapy. To become somewhat more specific, but to avoid that degree of specificity which would arouse more disagreement over medical opinion than consideration of the legal problem, let's assign basic symbols to the factors involved. The particular therapy gives rise to a number of medically cognizable risks, a through d. Risks a through c are material. Physician discloses only risks a and b to patient and, given that inadequate disclosure, patient consents to the therapy. Had disclosure of risk c been made, consent would not have been given. As a result of the treatment, patient suffers adverse consequences produced by risk d, but not caused by any failure in administering the therapy. Should physician be liable for these adverse consequences?

The issue presented is a "proximate cause" problem and may be stated in the following manner: Should physician's failure to have made an adequate disclosure be deemed the proximate cause of patient's injury? To help resolve that issue, some legal history may be appropriate. There was a time when the typical judicial characterization of an informed consent case involving an inadequate disclosure and adverse consequences was that of a "technical battery."

Absent an adequate disclosure, patient's express or implied consent was not an informed consent. Absent an informed consent, physician's contact with patient's body was a harmful or offensive contact inflicted upon the person of another without that other's consent and without legal privilege. Since these italicized words constitute a nearly perfect hornbook description of a battery,

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39. A discussion of the judicial transition of informed consent cases from battery through technical battery to negligence may be found in Trogun v. Fruchtman, 58 Wis. 2d 596, 207 N.W.2d 297 (1973).

40. See e.g., Restatement (Second) of Torts § 13 (1965), which states:

Battery: Harmful Contact

An actor is subject to liability to another for battery if

(a) he acts intending to cause a harmful or offensive contact with the person of the other or a third person, or an imminent apprehension of such a contact, and

(b) a harmful contact with the person of the other directly or indirectly results.

See also M. Hill, H. Rosser, W. Sogg, Smith's Review Legal Gem Series Torts (3d ed. 1975), which reads:

LEGAL GEMS - Battery

1. The essential elements of a battery at common law are these:

(a) The defendant must intentionally by an act set in motion a force towards
courts utilized that nomenclature. Probably two complementary factors contributed to judicial utilization of the battery characterization of informed consent cases: a typical judicial impulse toward stare decisis and the natural favor of plaintiffs' counsel in representing clients' causes. From the point of view of plaintiff's counsel, hardly anything could be more appealing than an approach which invited a potential characterization of defendant's conduct in a manner synonymous with an intentional wrong. From the point of view of the court, the invitation was an enticing one because it permitted the use of a familiar legal theory in dealing with the then novel concept of "informed consent malpractice actions." Since, as noted above, there is an apparent, if somewhat simplistic, analogy between the absence of informed consent prior to the application of the therapy and the intentional tort of battery, courts recognized the similarities and embraced the familiar language of a battery. But it wasn't an entirely open-armed embrace. Courts were sensitive to a critical distinction between the classic battery and the informed consent case. The former required an intentionally harmful or offensive contact; the latter almost invariably involved conduct lacking that degree of culpability and intended to be healing rather than harmful—thus the phrase "technical battery." An immediate consequence of judicial use of the adjective "technical" was preclusion of punitive damages, an element of recovery appropri-

the plaintiff, or a third person.
(b) The force must be wrongful, not justified by the usages of men.
(c) The force directed towards the plaintiff must be without his consent and against his will.
(d) The force must cause physical contact with the person of the plaintiff.
2. The gist of the offense in battery is the unpermissible touching of the person of the plaintiff without his consent.
41. "These essentially negligence cases do not fit the traditional mold of situations wherein punitive damages can be awarded." Trogun v. Fruchtman, 58 Wis. 2d 596, 614, 207 N.W.2d 297, 313 (1973).
As one commentator stated:
What appears to distinguish the case of the unauthorized operation from traditional assault and battery cases is the fact that in almost all of the cases, the doctor is acting in relative good faith for the benefit of the patient. It is true that in some cases the results are not in fact beneficial, but the courts have stated repeatedly that doctors are not insurers. The traditional assault and battery, on the other hand, involves a defendant who is acting for the most part out of malice or in a manner which is generally considered as "anti-social." And in general the assaulter and batterer is not seeking to confer any benefit upon the plaintiff. . . . This leads to the conclusion that there is some basis for separating most of the [malpractice] cases discussed in this paper from the traditional assault and battery.
McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment, 41 MINN. L. REV.
ate in cases involving intentional wrongs.

This early judicial recognition that, even assuming an inadequate disclosure by defendant physician, his conduct was not intentionally wrongful but, rather, inadvertent or negligent, remains a critical factor in resolving our proximate cause issue. Given intentionally wrongful conduct on the part of a defendant, a court is likely to impose liability for the totality of the adverse consequences produced by that conduct, however novel the actual injury or extraordinary the manner of injury may be. But where defendant's conduct does not exceed that level of culpability embraced by the word negligence, his liability is likely to be limited by the scope of reasonable foreseeability. Thus, in our hypothetical case against defendant physician in which plaintiff patient seeks to recover for adverse consequences produced by risk d, the liability issue is likely to be resolved by determining whether or not such injury was reasonably foreseeable.

The court may very well approach the reasonable foreseeability question in a two-step process, asking, first whether injury of any kind to the plaintiff was reasonably foreseeable at the time of defen-

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381, 424 (1957).

In Gill v. Selling, 125 Ore. 587, 267 P. 812 (1928), the court concluded that punitive damages were legally inappropriate where defendant physicians performed a spinal puncture on plaintiff as a result of mistaking her for another patient.

42. There is a definite tendency to impose greater responsibility upon a defendant whose conduct has been intended to do harm, or morally wrong. More liberal rules are applied as to the consequences for which he will be held liable, the certainty of proof required, and the type of damage for which recovery is to be permitted, as well as the measure of compensation. The defendant's interests have been accorded substantially less weight in opposition to the plaintiff's claim to protection when moral iniquity is thrown into the balance. Apparently the courts have more or less unconsciously worked out an irregular and poorly defined sliding scale, by which the defendant's liability is least where his conduct is merely inadvertent, greater when he acts in disregard of consequences increasingly likely to follow, greater still when he intentionally invades the rights of another under a mistaken belief that he is committing no wrong, and greatest of all where his motive is a malevolent desire to do harm.


Informed Consent

Dant's negligence (his failure to provide an adequate disclosure) and, second, whether the manner of injury which occurred (injury produced by risk d) was within the general manner of injury reasonably foreseeable.\(^4\)

The first question would seem to require an affirmative answer. When defendant failed to provide an adequate disclosure, one that apprised the patient of medically cognizable and material risk c, it was reasonably foreseeable that the treatment might result in injury produced by that material risk.

The second question is considerably more difficult to answer. Presumably, plaintiff's assertion would be a two-pronged argument leading to an affirmative answer to the question. First, since defendant's inadequate disclosure vitiates plaintiff's consent, any injury resulting from the legally unconsented-to procedure utilized by defendant should be considered reasonably foreseeable.\(^6\) Second, since risk d was a medically cognizable (albeit not material) risk incident to the procedure utilized by defendant, injury from that risk was reasonably foreseeable in fact.

To some extent, the first argument would be more appropriate were the defendant's conduct intentionally wrongful rather than merely negligent. While it may be true that the inadequate disclosure vitiates the consent, damages should be limited to compensation for reasonably foreseeable injuries. Mere absence of a legally sufficient consent, significant as that absence may be both from the perspective of the patient and the law, should not result in the imposition of damages wholly disproportionate to the degree of culpability of the defendant. That same admonition would serve to negate the efficacy of the implied assertion that the imposition of damages for all adverse consequences would serve the desirable purpose of dissuading the defendant and others similarly situated from utilizing inadequate disclosures in the future. Presumably, that deterrent effect, however desirable, would be served adequately by limiting liability to those injuries reasonably foreseeable.

Plaintiff's second argument is considerably more persuasive and

\(^{44}\) In re Arbitration Between Polemis and Furness, Withy & Co., Ltd., [1921] 3 K.B. 560 (C.A.). In Polemis the court applied only this first step and rejected the second.

\(^{45}\) See note 43 and accompanying text supra.

\(^{46}\) In effect, this was the assertion of plaintiffs which was rejected in Bowers v. Garfield, 382 F. Supp. 503 (E.D. Pa.), aff'd without opinion, 503 F.2d 1398 (3d Cir. 1974).
requires rather careful attention. It is true, of course, that once risk
\( d \) is defined as a medically cognizable risk incident to the procedure
utilized, injury produced by that risk tends to be reasonably foreseeable,
even by the simple application of a priori logic. Acceptance of
that logic would lead inexorably to the conclusion that the specific
manner of injury was, indeed, within the general manner of injury
reasonably foreseeable. But there is a problem in accepting without
serious challenge that "logical" conclusion. That aspect of defend-
ant's conduct which made it culpable was the absence of disclosure
of risk \( c \); the injury resulted not from undisclosed material risk \( c \) but
from undisclosed non-material risk \( d \). Thus it could be asserted that
there was an absence of a legal cause and effect relationship between
that aspect of defendant's conduct which made it culpable (failure
to warn of risk \( c \)) and the injury sustained (produced by risk \( d \)); put
another way, it could be said that the culpability did not produce
the injury. There are then coinciding divergent factors which must
be considered to resolve the proximate cause issue: the injury re-
sulted from a medically cognizable risk incident to the procedure,
as to which procedure plaintiff's consent was uninformed, but the
injury-producing risk was not one which the defendant was required
to reveal.

The late Dean Prosser, in discussing the legal inefficacy of a con-
sent produced by mistake or ignorance in the context of a battery
action, wrote:

\[ \text{[T]he mistake must extend to the essential character of the act itself, which is to say that which makes it harmful or offensive, rather than to some collateral matter which merely operates as an inducement . . . .} \]

The question sometimes has arisen in cases involving medi-
cal or surgical treatment, where the defendant is aware that the
patient does not understand the nature of the operation, or the
risk of undesirable consequences involved in it. Where there is
active misrepresentation, this has been held to invalidate the
consent, so that there is a battery; and the same has been held
where there has been mere nondisclosure of consequences
which the surgeon knew to be certain to follow. Beyond this,
there have been few decisions finding battery where there was
failure to disclose only a known risk of the treatment.

The greatest number of decisions now regard the failure to
disclose a mere risk of treatment as involving a collateral mat-
ter, and negligence rather than intent, and so have treated the question as one of negligent malpractice only, which brings into question professional standards of conduct. The matter is therefore more fully considered in connection with negligence.\textsuperscript{47}

That fuller consideration is:

A considerable number of late cases have involved the doctrine of "informed consent," which concerns the duty of the physician or surgeon to inform the patient of the risk which may be involved in treatment or surgery. The earliest cases treated this as a matter of vitiating the consent, so that there was liability for battery. Beginning with a decision in Kansas in 1960, it began to be recognized that this was really a matter of the standard of the professional conduct, since there will be some patients to whom disclosure may be undesirable or even dangerous for success of the treatment or the patient's own welfare; and that what should be done is a matter of professional judgment in light of the applicable medical standards. Accordingly, the prevailing view now is that the action, regardless of its form, is in reality one for negligence in failing to conform to the proper standard, to be determined on the basis of expert testimony as to what disclosure should be made. The factors to be considered by the physician or surgeon include the likelihood and seriousness of the bad result, the feasibility of alternative methods, the interest of the patient, knowledge of his past history, his emotional stability, the necessity of treatment, and the existence of an emergency.\textsuperscript{48}

Unfortunately, neither of those excerpts comes to grips with our specific problem. The first excerpt, directed at the intentional tort of battery, indicates that mistake or ignorance as to a "collateral matter" will not vitiate a consent, but directs our attention to the second excerpt as providing a "more fully considered" discussion of informed consent cases considered as negligence actions. The second excerpt evidences Dean Prosser's preference for the negligence characterization over the battery characterization\textsuperscript{49} and, as well perhaps, his preference for the professional-standard rule over the full-

\textsuperscript{47} Prosser, supra note 42, § 18 at 105-06 (footnotes omitted).

\textsuperscript{48} Id. § 32 at 165-66 (footnotes omitted).

\textsuperscript{49} For a judicial discussion of the two characterizations see Trogun v. Fruchtman, 58 Wis. 2d 596, 207 N.W.2d 297 (1973), in which the court, like Dean Prosser, expressed its preference for the negligence theory.
Disclosure rule, but does not confront our proximate cause problem. In our case, the non-disclosure cannot be characterized as going only to a "collateral matter" since the revelation failed to disclose material risk c; it was that inadequacy which compels a finding of culpability. Yet it was the medically cognizable but non-material risk d which produced the injury. In our case, causation in fact exists because (1) the procedure did cause the injury and (2) plaintiff's consent to the procedure was uninformed (3) due to defendant's inadequate disclosure. Had an adequate disclosure been given, consent would have been withheld, the procedure would not have been employed and the injury would not have occurred. Still, there remains the troubling fact that the inadequacy of the disclosure lay in the failure to warn of material risk c and the injury was the realization of non-material, albeit medically cognizable, risk d.

In his chapter on proximate cause, Dean Prosser wrote:

It is quite possible, and often helpful, to state every question which arises in connection with "proximate cause" in the form of a single question: was the defendant under a duty to protect the plaintiff against the event which did in fact occur? Such a form of statement does not, of course, provide any answer to the question, or solve anything whatever; but it does serve to direct attention to the policy issues which determine the extent of the original obligation and of its continuance, rather than to the mechanical sequence of events which goes to make up causation in fact. The question becomes particularly helpful in cases where the only issue is in reality one of whether the defendant is under any duty to the plaintiff at all—which is to say, whether he stands in any such relation to the plaintiff as to create any legally recognized obligation of conduct for his benefit. Or, reverting again to the starting point, whether the interests of the plaintiff are entitled to legal protection at the defendant's hands against the invasion which has in fact occurred. Or, again reverting, whether the conduct is the "proximate cause" of the result. The circumlocution is unavoidable, since all of these questions are, in reality, one and the same.\footnote{Prosser, supra note 42, § 42 at 244-45 (footnotes omitted).}

Several caveats about our consideration of this excerpt are appropriate. First, it was written, not with specific attention to informed consent cases or even medical malpractice actions generally but,
rather, for general application to proximate cause problems. Yet, at

times, reversion to basic principles can be uniquely helpful in re-
solving specific issues in particularized circumstances. Second, by

its own terms, the excerpt's suggested question is "particularly

helpful in cases where the only issue is in reality one of whether the
defendant is under any duty to the plaintiff at all." In our case, the

physician clearly owed a duty to the patient: the legally imposed
obligation to proffer an adequate disclosure. By hypothesis, physi-
cian violated that duty. But, as the excerpt indicates, the suggested
question may have relevance in other circumstances and, indeed, all
of the stated circumstances are intimately related.

Raising the suggested question in our specific context, was the
physician under a duty to protect the patient against injury from

risk d? In attempting to answer that question, we should recognize

that the word duty is, in reality, a loaded word. A duty exists if a
court deems it appropriate to impose such a duty; it does not, if the
court deems it inappropriate. Duty, then, is a legal conclusion
rather than a self-apparent concept. Consequently, the question
may be rephrased as whether a legal duty should be imposed on the
physician to protect the patient from risk d. The answer is no.51

Had the physician disclosed to the patient all of the material
risks, a, b and c, before receiving patient's consent, and had patient
then suffered adverse consequences from non-material but
medically cognizable risk d, of course no liability would be imposed
on physician. I think there are two basic reasons why that is so.
First, by definition, physician's conduct would not have been culpa-
ble; by revealing all material risks to the patient, physician pro-
vided a legally sufficient disclosure. Second, physician owed no duty
to patient to "protect" him from non-material risk d; physician was
not required to disclose that risk and the adverse consequences pro-
duced by it were not caused by any negligent performance of the
therapy by the physician. The most damning characterization
which can be made of physician's legally inadequate disclosure is
that it induced the patient to consent to a form of therapy which
patient would have eschewed had he been apprised of material risk

51. This conclusion would be consistent with the court's conclusion in Bowers v. Garfield,
382 F. Supp. 503 (E.D. Pa.), aff'd without opinion, 503 F.2d 1398 (3d Cir. 1974), rejecting
plaintiffs' assertion that "a causal relationship between failure to disclose and the injury
complained of is unnecessary and irrelevant."
While it is factually true that, had patient chosen to forego the therapy he would have avoided the consequences produced by risk, there is the absence of an appropriate legal relationship between the sole aspect of physician’s conduct which was culpable (failure to disclose risk c) and the adverse consequences suffered by patient (produced by risk d). Imposition of liability on the physician for those adverse consequences might be appropriate if physician’s conduct had been intentionally wrongful or wholly lacking in social utility. But we have noted the judicial recognition that informed consent cases involve alleged negligence, not intentional wrongs, and certainly no one would doubt that physician’s principal purpose was to heal rather than harm the patient. The physician’s conduct, though culpable because of the inadequacy of the disclosure, seems not to require judicial deterrence beyond that which would be effected by the prospect of liability for adverse consequences produced by undisclosed material risk c. And patient, never entitled by law to a disclosure of non-material risk d, hardly could argue successfully that his reasonable expectations were frustrated by a judicial determination that he could not recover damages for the adverse consequences produced by that risk. Therefore, I would conclude that the formulation suggested earlier for resolving the consent issue—“[i]f adequate disclosure would have caused the patient to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown”—should be read with the understanding that the italicized words are intended to be dispositive of the proximate cause issue.

One final problem must be examined. Early in the article, reference was made to the case in which a surgeon caused a general anesthesia to be administered to a patient weakened by the recent ingestion of a substantial quantity of alcohol and patient died as a result of that administration. Then we noted the differing roles of expert medical witnesses called by plaintiff in a wrongful death action against surgeon, depending on whether the action was couched in terms of a negligent decision by defendant or the absence of an informed consent by the now deceased patient. The present inquiry will be limited to the informed consent theory of liability.

Assume that, despite his alcohol-weakened physical condition, patient was fully capable of comprehending an adequate disclosure

52. See text accompanying note 10 supra.
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of the particular material risk of administering the anesthesia to him and that plaintiff in the wrongful death action alleges that (1) no such disclosure was made and (2) had it been made, patient would not have consented. Assume, too, 'that at the time surgeon and patient discussed the proposed procedure (repair of a fractured arm), no one else was present. What happens to plaintiff's informed consent case? Under existing law, it would fail as a matter of law because of plaintiff's inability to present evidence that an adequate disclosure had not been made. That inability would exist because of patient's death during surgery. And, rather obviously, a similar inability may exist in every informed consent case in which the patient dies during or shortly after the therapeutic procedure. Is that an acceptable legal conclusion?

It is true that in negligence actions generally the plaintiff bears the burden of persuasion and suffers the consequence of a failure to adduce evidence necessary to make out a legally sufficient case. For example, if an automobile collision results in the death of one driver and a wrongful death action against the other, plaintiff will be required to present evidence demonstrating the negligence of defendant or suffer the legal consequences, probably the granting of defendant's motion for a nonsuit or a directed verdict. If there were no witnesses to the collision other than the drivers, and no other witnesses, lay or expert, who can testify that the collision was the result of defendant's negligence, plaintiff has two alternatives, neither very satisfactory. Plaintiff can suffer the granting of defendant's nonsuit or directed verdict motion or plaintiff can summon the defendant to the stand as on cross-examination and hope that defendant's testimony will demonstrate his own culpability. Rather clearly, that second alternative rests on a hope not likely to be realized in very many cases. A combination of factors, including defendant's recognition of his own self-interest, defendant's adequate preparation for trial by his counsel and defendant's conceivably firmly based belief in his own freedom from fault, suggest that

53. An exception to that general conclusion occurred in Wilson v. Scott, 412 S.W.2d 299 (Tex. 1967). There plaintiff, in an effort to establish the professional standard for disclosure, called defendant physician to the stand as on cross-examination. Defendant "testified that standard medical practice would have included advice about the chance of Scott's total loss of hearing" incident to the proposed stapedectomy. Id. at 303. Plaintiff testified that defendant had failed to reveal that risk to him; defendant testified that he had. The defendant's testimony as on cross-examination made the plaintiff's case legally sufficient.
defendant's testimony is more likely to be exculpating than inculpating. Thus, in most such cases, plaintiff is unlikely even to reach the jury. And, as unsatisfactory as that may seem to the plaintiff, generally it is a legally palatable result flowing from plaintiff's inability to present inculpating evidence against the defendant, even where that inability flows directly from the death of the plaintiff's testate or intestate.

But there are certain characteristics which distinguish substantially the abortive wrongful death action against defendant motorist and the wrongful death action brought against defendant physician and resting on the asserted absence of patient's informed consent. To a substantial extent, those distinctions were noted earlier in this article to support the suggested conclusions that in informed consent cases both the adequacy of physician's disclosure and the determination of whether or not patient would have consented, given an adequate disclosure, should be judged by a subjective standard attuned to the particular patient.

The physician-patient relationship necessarily implies a tacit representation of superior knowledge on the part of the physician and an implicit reliance on that superior knowledge by the patient. Neither exists in the usual motor vehicle collision case. The existence of the professional relationship results in an inducement to undergo a particular course of treatment. No such inducement exists in the motor vehicle case. Moreover, where physician and patient discuss the desirability of a proposed therapeutic procedure, there necessarily arises a feasible opportunity for creating some evidence of the nature or substance of that discussion, which would subsist even after patient’s death. Obviously, no similar opportunity exists in the factual setting of most motor vehicle collisions. One thing which both wrongful death actions—that against defendant motorist and that against defendant physician—would have in common is the unlikelihood that the defendant, called to the stand as on cross-examination, would sufficiently inculpate himself to convert the plaintiff's potentially insufficient case into a legally sufficient cause of action—and for precisely the same reasons. Therefore, in the informed consent case, plaintiff's right to summon the defendant to the stand is about as unlikely to avoid a nonsuit or a directed verdict as it would be in the collision case.

54. For the exception to the rule, see note 53 supra.
In light of the distinctions between the physician-patient relationship and the relationship between two motor vehicle operators, it seems inappropriate to maintain a legal theory which virtually assures the failure of a wrongful death against a physician, based on the absence of patient’s informed consent, in those cases where patient dies during or shortly after the therapeutic procedure—even accepting the propriety of a similar result in the motor vehicle case. In recognition of the unlikelihood that defendant physician, called as on cross-examination, will save the legal sufficiency of plaintiff’s case, some other method must be employed if the undesirable legal consequence of patient’s death is to be avoided. Since the professional relationship provides an opportunity for creating subsisting evidence of the physician’s disclosure and the patient’s reaction thereto, and because the physician “controls” both the relationship and the opportunity, I find myself inclined toward a method which would encourage the physician to take appropriate advantage of both. That encouragement would arise out of a rule of law that, in those informed consent cases in which patient dies during or shortly after and as a result of the therapeutic procedure utilized, the burden of presenting evidence of an informed consent should be on the physician and that burden should not be deemed satisfied by the uncorroborated testimony of the physician.

Given such a rule of law, it seems fair to conclude that physicians would utilize the opportunity presented by the professional relationship with their patients to fashion some form of continuing evidence of an informed consent. Since no physician could predict with certainty which patients would die during or shortly after the therapeutic procedure, each physician would tend to utilize the opportunity with every patient. That, in turn, would tend toward not only the elimination of the present almost certain legal insufficiency of plaintiff’s wrongful death action flowing from patient’s death but would, as well, tend toward providing defendant physician with more specific evidence of an informed consent in all cases. And, ultimately, such a rule would have the effect of sensitizing physicians generally to the significance of assuring adequate disclosures which are properly comprehended by their patients. Presumably, that ultimate consequence would be entirely consistent with, and effectively complementary to, the basic rationale for the full-disclosure rule: patient’s right of self-determination.
The method of creating such subsisting evidence should be left to the physician. He should be permitted to determine the most appropriate method of the several which suggest themselves: recordings (effected with the patient’s acquiescence) of the disclosure and patient’s knowing consent, a written disclosure and a written consent, a disclosure and a consent made in the presence of appropriate third parties, either other professionals or immediate members of the patient’s family. In deciding which alternative to employ from among these or as many others as may occur to the physician, the physician can be counted on to be appropriately sensitive both to the patient’s right of self-determination and the ultimate legal efficacy of the evidence created. Each of those considerations should tend to emphasize to the physician the significance of the other in a mutually nurturing manner.

In those jurisdictions having Dead Man’s Acts which would

55. For a statute providing that a written consent immunizes the physician from liability in certain circumstances, see Ga. Code Ann. tit. 88, § 2906 (1971):

A consent to medical and surgical treatment which discloses in general terms the treatment or course of treatment in connection with which it is given and which is duly evidenced in writing and signed by the patient or other person or persons authorized to consent pursuant to the terms hereof, shall be conclusively presumed to be a valid consent in the absence of fraudulent misrepresentations of material facts in obtaining the same.

The statute is set forth for the reader’s general information. I would not propose the general enactment of such statutes or approve of this specific one. The statutory approval of a disclosure “in general terms” seems to me too vague and evidences a predictable legislative difficulty in attempting to contemplate the kind of disclosure required in a particular factual setting.

56. See, e.g., Ohio Rev. Code tit. 23, § 2317.03 (1955), which provides:

A party shall not testify when the adverse party is . . . an executor or administrator . . . of a deceased person except:

(A) As to facts which occurred . . . after the time the decedent . . . died . . .

See also Pa. Stat. Ann. tit. 28, § 325 (1958), which provides:

[I]n any civil proceeding . . . although a party to a thing or contract in action may be dead . . . nevertheless any surviving . . . party to such thing or contract . . . whose interest is adverse to the . . . right of such deceased . . . party, shall be a competent witness to any relevant matter, although it may have occurred before the death of said party . . . if and only if such relevant matter occurred between himself and another person who may be living at the time of trial and may be competent to testify, and does so testify upon the trial against such surviving . . . party . . . or if such relevant matter occurred in the presence or hearing of such other living or competent person.

The Federal Rules of Evidence provide for the applicability of Dead Man’s Acts in non-federal causes of action tried in federal courts:

Every person is competent to be a witness except as otherwise provided in these rules. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the competency of a witness shall be determined in accordance with State law.

Fed. R. Evid. 601.
“seal the lips” of the defendant physician in plaintiff’s wrongful death action, that effect should be avoided either by judicial construction of the statute or by legislative amendment. Permitting the physician to testify would serve not only as a quid pro quo for imposing upon him the burden of producing evidence of an informed consent but, as well, as an assurance that physician would be able to offer that testimonial foundation which might be required as a prerequisite to admissibility of the subsisting evidence of patient’s informed consent. Recognition that such a testimonial foundation may be required, suggests the propriety of shifting the burden of presenting evidence onto the physician only in those wrongful death actions in which defendant physician survives. And shifting the burden of adducing evidence is all that I suggest; I would retain the usual burden of persuasion imposed on the plaintiff, once defendant physician has presented appropriate evidence of patient’s informed consent.

Because it would (1) eliminate the apparent unfairness of the virtually certain legal insufficiency of a wrongful death action based on an absence of informed consent, (2) accurately reflect the reality of the professional relationship and its opportunity for creating subsisting evidence of patient’s informed consent, (3) nurture the physician’s sensitivity to the patient’s right of self-determination, and (4) tend to provide more specific evidence of informed consent in all cases, I would suggest that courts in full-disclosure jurisdictions fashion a rule of law which would impose upon surviving defendant physician the burden of adducing evidence, beyond the wholly uncorroborated testimony of the defendant, of patient’s informed consent in those cases in which patient dies during or shortly after the therapeutic procedure utilized as a result of the procedure, and that in such cases defendant physician be considered a fully competent witness notwithstanding the death of patient.

The suggestions contained in this article are not likely to arouse unanimous approbation; they may very well stimulate agitated rejection by many of those who read the article. Perhaps the most assuaging single comment I can make about them is that they seem to me to be calculated to produce a desirable physician-patient relationship and to achieve realization of the patient’s right of self-determination, the essence of the full-disclosure rule.