Medical Malpractice Actions Based on Lack of Informed Consent in "Full-Disclosure" Jurisdictions: The Enigmatic Affirmative Defense

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Occasionally, I find myself confronted with a legal conclusion that is enigmatic to me. I don’t mean simply a conclusion with which I happen to disagree. Nor do I mean a conclusion with whose underlying rationale I happen to disagree. Rather, I mean a legal conclusion that makes me wonder why any court would fashion such a result. This is one of those occasions.

Those jurisdictions that require the physician to disclose to the patient all material risks incident to proposed therapy as a condition precedent to securing the patient’s informed consent to that therapy simultaneously afford the physician the affirmative defense that disclosure of the risk that eventuated would have had an adverse effect on the patient’s physical or emotional well-being and, therefore, nondisclosure of that risk was consistent with the professional standard of disclosure.¹ Why do those “full-disclos-

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¹ I have combined compliance with the professional standard of disclosure and the "therapeutic privilege" because I believe that in reality the two constitute a unitary defense. If called upon to defend withholding of information [based on the therapeutic privilege] in a legal action, the [medical care] provider must prove not only the factual element of the patient’s sensitivity but also that other practitioners would have done the same under the circumstances involved. Thus, the therapeutic privilege defense may need the support of expert medical testimony, a requirement that most physicians should not find difficult to satisfy.


In Canterbury [v Spence], Dr. Spence claimed that “communication of that risk (paralysis) to the patient is not good medical practice because it might deter patients from undergoing needed surgery and might produce adverse psychological reactions which could preclude the success of the operation.” Such claims will almost invariably be raised by physicians since they are derived from deeply held tenets of medical practice. Judge Robinson’s enigmatic phrase of “just due” certainly suggests that the medical professional standard would be applicable in such a case, raising profound questions about the extent to which the novel legal standard has been swallowed up by the traditional and reasonable medical standard.

In fact, medical judgment was given its “just due” twice. It could also be invoked under the “therapeutic privilege” not to disclose, which Judge Robinson retained as a
"Jurisdictions permit that affirmative defense? That's what puzzles me. Perhaps a little background will demonstrate the reason for my puzzlement.

In medical malpractice actions brought on a theory of lack of informed consent, the states divide into two major camps: those that judge the adequacy of the physician's disclosure to the patient by the professional standard of disclosure and those that repudiate the professional standard of disclosure and compel disclosure of all material risks. Those in the first camp justify the use of the professional standard of disclosure in terms of encouraging the physician to utilize his professional judgment, in keeping with the professional standard, to determine which risks to disclose and which to withhold in order to avoid an adverse effect on the patient's physical or emotional well-being.

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.

In those jurisdictions, the plaintiff, in order to make a legally sufficient case against the physician, must present expert medical testi-

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The therapeutic privilege not to disclose is merely a procedurally different way of invoking the professional standard of care.


2. In David E. Seidelson, Medical Malpractice: Informed Consent Cases in "Full-Disclosure" Jurisdictions, 14 Duquesne L R 309-11, n.1 and n.2 (1976), I indicated those states that judge the adequacy of the disclosure by the professional standard of disclosure and those that compel disclosure of all material risks, along with appropriate citations. A more current "State-by-State Analysis" may be found in Rosoff, Informed Consent at 75 (cited in note 1).

3. See note 2. A few notable changes in pre-existing law should be cited. Maryland, which at one time apparently judged the adequacy of the disclosure by the professional standard, Kruszewski v Holz, 265 Md 434, 290 A2d 534 (1972) (without specific decision, trial court's use of professional standard referred to), subsequently compelled disclosure of all material risks. Sard v Hardy, 281 Md 432, 379 A2d 1014 (1977). Oklahoma, which apparently permitted the plaintiff to proceed under either standard, Martin v Stratton, 515 P2d 1366 (Okla 1973) (but evidence insufficient as to both), subsequently adopted the standard requiring disclosure of all material risks. Scott v Bradford, 606 P2d 554 (1979). Texas, which at one time judged the adequacy of the disclosure by the professional standard of disclosure, Karp v Cooley, 349 F Supp 287 (S D Tex 1972), aff'd 493 F2d 408 (5th Cir), cert denied, 419 US 845 (1974), applying Wilson v Scott, 412 SW2d 299 (Tex 1967), subsequently concluded that, where the Texas Medical Disclosure Panel has not determined what risks must be disclosed with regard to a particular procedure, the physician has the duty "to disclose all risks or hazards which could influence a reasonable person in making a decision to consent to the procedure." Peterson v Shields, 652 SW2d 929, 931 (Tex 1983).

mony to the effect that the professional standard of disclosure mandated disclosure of the eventuated risk, complemented by additional evidence that the defendant failed to disclose that risk and, had the risk been disclosed, consent to the proposed therapy would not have been forthcoming.\(^5\)

Those states that require disclosure of all material risks - the "full-disclosure" jurisdictions - do so for the purpose of preserving the patient’s right of self-determination.

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.\(^6\)

Those full-disclosure jurisdictions apparently have concluded that, as between protecting the physician’s exercise of professional judgment and preserving the patient’s right of self-determination, the latter concern is paramount. In those jurisdictions, the plaintiff, in order to make a legally sufficient case against the physician, is required to present expert medical testimony only to the effect that there existed a medically cognizable risk of the eventuated injury, complemented by additional evidence that the risk was material and, had it been disclosed, consent to the therapy would not have been forthcoming.\(^7\)

The full-disclosure jurisdictions are themselves divided into two camps: those that judge materiality and consent by an objective standard and those that judge materiality and consent subjectively.\(^8\) The former insist that application of an objective standard is compelled by considerations of fairness to the physician and of protecting the integrity of the judicial process.

[Judging materiality subjectively] 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.\(^9\)

And:

5. See for example, \textit{Wilson v Scott}, 412 SW2d 299, 301-02 (Tex 1967).
8. See for example, \textit{Canterbury v Spence}, cited in note 6 (objective standard); \textit{Scott v Bradford}, 606 F2d 554, 557-58 (Okla 1979) (subjective standard). In adopting the subjective standard, the Supreme Court of Oklahoma was apparently influenced by Seidelson, 14 Duquesne L Rev 309 (cited in note 2).
[The subjective] method of dealing with the issue of causation [or consent] 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.\(^{10}\)

In those full-disclosure jurisdictions, the plaintiff must present evidence sufficient to persuade a reasonable jury that a reasonable person in patient's circumstances would have considered the undisclosed risk significant in deciding whether or not to undergo the proposed therapy and that, apprised of the risk, a reasonable person in patient's circumstances would not have consented to the therapy.\(^{11}\)

The latter class of full-disclosure jurisdictions believes that determining materiality and consent subjectively is essential in order to preserve the particular patient's right of self-determination, the basic rationale for utilizing a full-disclosure approach. This class recognizes that, if materiality and consent are judged objectively, the particular patient's right of self-determination will be lost, to the extent that the patient's views of materiality and consent might have differed from those of a reasonable person in like circumstances.

Although the Canterbury rule is probably that of the majority, its "reasonable man" approach has been criticized by some commentators as backtracking on its own theory of self-determination. The Canterbury view certainly severely limits the protection granted an injured patient. To the extent the plaintiff, given an adequate disclosure, would have declined the proposed treatment, and a reasonable person in similar circumstances would have consented, a patient's right of self-determination is irrevocably lost. This basic right to know and decide is the reason for the full-disclosure rule.

\(^{10}\) Id at 790-91. In my opinion, when the court decides to judge materiality and consent objectively, it actually imposes on the plaintiff a dual burden: "demonstrating that both he and a reasonable person in like circumstances would have considered the risk significant, and, apprised of the risk, neither he nor a reasonable person in like circumstances would have consented." David E. Seidelson, Lack of Informed Consent in Medical Malpractice and Product Liability Cases: The Burden of Presenting Evidence, 14 Hofstra L Rev 621, 626 (1986) (emphasis added) (footnote omitted). See, Haven v Randolph, 342 F Supp 538 (D D C 1972), aff'd on other grounds per curiam, 494 F2d 1069 (D C Cir 1974); Henderson v Milobsky, 595 F2d 654 (D C Cir 1978) (opinion by the same judge who authored Canterbury v Spence cited in note 6). But see, Hartke v McKelway, 707 F2d 1544 (D C Cir 1983), cert denied, 464 US 983.

Applying an objective, rather than a subjective, standard to materiality and consent may facilitate a matter-of-law determination that the medically cognizable risk was not material. See Pauscher v Iowa Methodist Medical Center, 408 NW2d 355 (Iowa 1987).

\(^{11}\) See for example, Canterbury v Spence, 464 F2d 772, 787, 790-91 (D C Cir 1972).
Accordingly, we decline to jeopardize this right by the imposition of the "reasonable man" standard.\(^2\)

In those full-disclosure jurisdictions, the plaintiff must present evidence sufficient to persuade a reasonable jury that the patient would have considered the undisclosed risk significant in deciding whether or not to undergo the proposed therapy and that, apprised of the risk, the patient would not have consented to the proposed therapy.\(^3\) Yet, all of the full-disclosure jurisdictions, whether judging materiality and consent objectively or subjectively, afford the physician the affirmative defense that his nondisclosure of the material, eventuated risk was consistent with the professional standard of disclosure and the product of his professional judgment that disclosure would have had an adverse effect on the patient’s physical or emotional well-being.\(^4\) Why?

\(^{12}\) Scott v Bradford, 606 P2d at 559 (footnotes omitted).

\(^{13}\) See for example, Scott v Bradford, 606 P2d 554, 558-59 (Okla 1979).

\(^{14}\) The second exception [emergency being the first] obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. Where that is so, the cases have generally held that the physician is armed with a privilege to keep the information from the patient, and we think it clear that portents of that type may justify the physician in action he deems medically warranted. The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient’s well-being.

Canterbury v Spence, 464 F2d at 789 (footnotes omitted).

[T]he primary duty of a physician is to do what is best for his patient and where full disclosure would be detrimental to a patient’s total care and best interests a physician may withhold such disclosure, for example, where disclosure would alarm an emotionally upset or apprehensive patient.

Scott v Bradford, 606 P2d at 558 (footnote omitted).

Situations may be envisioned where the disclosure of a risk to a patient would be detrimental to the patient. The existence of such a situation is a matter of defense for the doctor. The doctor may present evidence to justify the failure to disclose by his own testimony or by the testimony of other lay or expert witnesses. The doctor may establish the existence of a standard of nondisclosure by medical experts in his field or practice. . . .

Miller v Kennedy, 11 Wash App 272, 288, 522 P2d 852, 863 (1974), aff’d per curiam, 85 Wash 2d 151, 530 P2d 334 (1975): “We can add nothing constructive to the well considered opinion of [the] court and, accordingly, approve and adopt the reasoning thereof.” 85 Wash 2d at 151, 530 P2d at 334.

[T]he physician retains a qualified privilege to withhold information on therapeutic grounds, as in those cases where a complete and candid disclosure of possible alternatives and consequences might have a detrimental effect on the physical or psychological well-being of the patient. . . .

To add to the enigma, we should note that, while all of the full-disclosure jurisdictions afford the physician that affirmative defense, it is treated differently in different states. Some of the full-disclosure jurisdictions apparently treat that affirmative defense as other such defenses are treated: if the jury accepts the evidence underlying the defense, the jury must find for the defendant. In this particular context, that means, if the jury accepts the physician's evidence that nondisclosure was consistent with the professional standard of disclosure and the product of the physician's professional judgment that disclosure would have had an adverse effect on the patient's physical or emotional well-being, the jury must find for the defendant. Other full-disclosure jurisdictions give that particular affirmative defense an idiosyncratic treatment: even if the jury accepts the physician's evidence that nondisclosure was consistent with the professional standard of disclosure and the product of the physician's professional judgment that disclosure would have had an adverse effect on the patient's physical or emotional well-being, the jury may still find for the plaintiff if the jury concludes that no standard of nondisclosure should deprive a patient of the right of self-determination.

Now we are confronted with two enigmas. First, why should a full-disclosure jurisdiction, already having determined that the patient's right of self-determination is paramount, permit the physician an affirmative defense based on the professional standard of disclosure and the physician's professional judgment? It seems fairly apparent that that affirmative defense is inherently inconsistent with the court's basic rationale for imposing the full-disclosure standard, a judicial determination that the patient's right of self-determination is of greater moment and more deserving of judicial protection than a concern with encouraging the physician to exercise his professional judgment to withhold disclosure of those

15. For example, the opinions in *Canterbury v Spence*, cited in note 8, and *Scott v Bradford*, cited in note 8, suggest such a traditional treatment.

16. The doctor may establish the existence of a standard of nondisclosure by medical experts in his field or practice, but it is for the jury to accept or reject whether any standard of nondisclosure should deprive a patient of his right of self-determination.


As in every informed consent case, the physician is free to introduce evidence of his compliance with the prevailing medical standard of care to explain his failure to disclose. But such proof is not conclusive; it is still for the jury to decide whether adherence to the professional standard should deprive a patient of his right of self-determination.

*Sard v Hardy*, 281 Md at 445, 379 A2d at 1023.
risks that the physician believes will have an adverse effect on the patient’s well-being. In those full-disclosure jurisdictions where the affirmative defense is treated in the same manner as other affirmative defenses, that defense seems to have the potential of negating the basic rationale for judicial imposition of the full-disclosure standard: preserving the patient’s right of self-determination.17

Second, in those full-disclosure jurisdictions where the affirmative defense is afforded an idiosyncratic treatment, the jury is told, in effect, that two standards exist for judging the physician’s conduct and the jury is to determine which of those standards to utilize. Normally, of course, it is a judicial function to determine and then instruct the jury as to the appropriate standard by which a defendant’s conduct is to be judged, leaving to the jury the factual determination of whether or not the defendant’s conduct was consistent with that prescribed standard. Why the abdication of that usual judicial responsibility in those full-disclosure jurisdictions giving the affirmative defense that idiosyncratic treatment?

Let us take up first the primary question: Why do full-disclosure jurisdictions permit the physician to avoid liability by demonstrating that nondisclosure was consistent with the professional standard of disclosure and the product of a professional judgment that disclosure would have had an adverse effect on the patient’s physical or emotional well-being? Perhaps some insight can be gained by examining other defenses available to the physician in a full-disclosure jurisdiction. In Canterbury v Spence,18 the affirmative defense of compliance with the professional standard of disclosure is coupled with another defense, the existence of an emergency.19 In Scott v Bradford,20 the affirmative defense of compliance with the professional standard is joined with emergency and risks already known to the patient.21 Does the rationale underlying those

17. In Canterbury, Dr. Spence claimed that “communication of that risk (paralysis) to the patient is not good medical practice because it might deter patients from undergoing needed surgery and might produce adverse psychological reactions which could preclude the success of the operation.” Such claims will almost invariably be raised by physicians since they are derived from deeply held tenets of medical practice. Judge Robinson’s enigmatic phrase of “just due” certainly suggests that the medical professional standard would be applicable in such a case, raising profound questions about the extent to which the novel legal standard has been swallowed up by the traditional and venerable medical standard.
20. See note 8.
21. Scott, 606 P2d at 559.
other defenses apply to compliance with the professional standard? The emergency defense is fairly straightforward: if the medical exigencies preclude an opportunity for the physician to afford the patient a full disclosure, the physician may avoid liability for his failure to disclose the eventuated risk. Of course. No rational court would subject the physician to liability for a failure to disclose where the time necessary for such a disclosure would have transformed patient into cadaver.

How about pre-existing knowledge of the risk? If the eventuated risk was already known to the patient, it would have been feckless for the physician to have disclosed it and irrational for a court to impose liability on the physician for a failure to disclose. In those circumstances, the patient’s right of self-determination would not have been violated; he knew of the risk when he consented. But neither of those rationales seems applicable to permitting the affirmative defense of compliance with the professional standard of disclosure. Moreover, neither of those defenses, emergency or already known risk, wholly negates the physician’s legal obligation to disclose all material risks. The first defense is limited to circumstances where no opportunity for disclosure existed and the second to risks already known by the patient. Neither of those defenses approves of the physician’s substituting his judgment for the informed judgment of the competent patient. Each is therefore quite different from compliance with the professional standard of disclosure. That defense is inherently inconsistent with the obligation to disclose all material risks. Neither the rationale underlying the emergency defense nor that underlying already known risks is applicable to or seems to justify the existence of the defense of compliance with the professional standard of disclosure. Is there some other explanation for the retention of that defense by full-disclosure jurisdictions?

I suspect that, in part, the answer may be judicial habit. In medical malpractice actions predicated on allegedly negligent performance, courts almost invariably judge the physician’s conduct by the professional standard of performance.\(^22\)\(^23\) When the theory of liabil-
ity is shifted from negligent performance to negligent disclosure, many courts opt to judge the adequacy of the disclosure by the professional standard of disclosure. In addition to the stated rationale of thereby encouraging physicians to utilize their professional judgment in deciding which risks, if disclosed, would have an adverse effect on patients, I suspect those courts were influenced as well by the firmly entrenched habit of judging physicians by a professional standard. And when some courts elected to impose a judicially fashioned standard requiring disclosure of all material risks, thereby protecting the patient's right of self-determination, they saw fit to afford the physician the affirmative defense of compliance with the professional standard of disclosure, perhaps out of the same habit and perhaps not fully appreciating that the affirmative defense was inherently inconsistent with the full-disclosure rule.

There is nothing innately wrong with habit. We all do many things out of habit and, frequently, compliance with habit produces an efficient and nearly unthinking method of accomplishing a number of simple, though important, tasks. Before I retire for the night, I lock the front door, check the kitchen to be sure that all of the jets on the gas range are off, that the faucet is not leaking, and that the doors to the refrigerator and freezer are fully closed. I check the utility room to be sure that the door to the full-sized freezer is fully shut, that there is no water leaking into the stationary tubs, and that the water heater is functioning properly. Then I set the thermostat for the night and go upstairs. And I do all of that in less time than it took to write it down, simply because it's all a matter of rote requiring virtually no intellectual effort.

But sometimes unthinking compliance with habit can produce unfortunate results. When a full-disclosure jurisdiction permits the physician the affirmative defense of compliance with the professional standard of disclosure, the court affords the physician the capacity to negate the judicially-fashioned standard requiring disclosure of all material risks and, in the process, to override the patient's right of self-determination, the basic rationale for the full-disclosure rule. That affirmative defense may lead to the ultimate conclusion that protecting the physician's right to exercise professional judgment is superior to preserving the patient's right of self-determination. If habit is the explanation for permitting that af-


firmative defense, it is an inadequate reason.

There may be an additional explanation for full-disclosure jurisdictions’ permitting that affirmative defense. To some extent, the genesis of the lack of informed consent theory of liability may lie in the efforts of plaintiffs’ counsel to circumvent the “conspiracy of silence,”25 the reluctance or outright refusal of physicians to testify that a professional colleague, the defendant, had acted in a negligent manner. As noted earlier, in malpractice actions based on negligent performance, plaintiffs’ counsel are almost invariably required to present expert medical testimony establishing a professional standard of conduct inconsistent with the defendant’s performance. Given the reluctance or outright refusal of physicians to provide such testimony, plaintiffs’ counsel often found themselves stymied, irrespective of the merits of the cases. It may well have been in an effort to circumvent that problem that plaintiffs’ counsel first began to articulate the theory of lack of informed consent as a different or alternative theory of liability, in the hope that judicial acceptance of the theory might obviate the need for, or shift the thrust of, any expert medical testimony. That hope was realized only in part.

In those jurisdictions that judge the adequacy of the physician’s disclosure exclusively by the professional standard, the plaintiff, in order to reach the jury, must present expert medical testimony that the defendant’s disclosure was not consistent with the professional standard of disclosure.26 Plaintiff's expert must testify that the professional standard of disclosure mandated revelation of the risk that ultimately eventuated and caused the plaintiff’s injuries. In short, the plaintiff’s expert medical witness must offer explicit testimony that the defendant’s disclosure was negligent. In those jurisdictions applying the full-disclosure rule, expert medical testi-


26. A number of cases in other jurisdictions hold that the plaintiff, in an action against a physician for failure to disclose hazards, must prove a medical standard by expert medical evidence. . .

We conclude therefore that the plaintiff had the burden to prove by expert medical evidence what a reasonable medical practitioner of the same school and same or similar community under the same or similar circumstances would have disclosed to his patient about the risks incident to a proposed diagnosis or treatment, that the physician departed from that standard, causation, and damages. The action is one of malpractice for a physician’s failure to conform to medical standards in obtaining the patient’s consent.

Wilson v Scott, 412 SW2d 299, 301-02 (Tex 1967).
mony may still be required, but the plaintiff's expert will not be required to present explicit inculpating evidence. Rather, the plaintiff will be required to present expert testimony that the eventuated risk was a medically cognizable risk incident to the proposed therapy.\textsuperscript{27} From that expert testimony, complemented by the patient's testimony, a reasonable jury might be able to conclude that the physician failed to disclose a medically cognizable risk, the undisclosed and eventuated risk was material, and, if disclosed, would have precluded consent. Under the full-disclosure rule, that would constitute a legally sufficient case. Thus, while the hope of plaintiffs' counsel that the lack of informed consent theory would eliminate the need for expert medical testimony was never realized, in full-disclosure jurisdictions at least the thrust of the required expert testimony was changed considerably. Plaintiff's expert is not required to give explicit testimony that the defendant's disclosure was negligent. Instead, plaintiff's expert is required only to offer the more benign testimony that the eventuated risk was a medically cognizable risk incident to the procedure performed, even when that procedure is performed properly. That shift in the thrust of the required expert testimony might make it easier for the plaintiff to secure a willing expert medical witness. And, indeed, some of the courts that adopted the full-disclosure rule may have been influenced in part by their realization that the judicially-fashioned standard requiring disclosure of all material risks would diminish the plaintiff's problem of securing the required expert medical testimony and thus facilitate the plaintiff's presenting a legally sufficient case.\textsuperscript{28}

If the physician in the defense case then offers expert medical testimony (including his own) that nondisclosure of the risk was consistent with the professional standard of disclosure predicated on the avoidance of adverse impact on the patient, such defense

\textsuperscript{27} 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 factfinder the risks of therapy and the consequences of leaving existing maladies untreated.

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. 


\textsuperscript{28} Finally, as 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.

evidence will not retroactively destroy the sufficiency of the plaintiff's case. Plaintiff will still reach the jury. It is just that the jury, instructed by the court as to the affirmative defense of compliance with the professional standard of disclosure, may find for the defendant, even though the jury finds that the eventuated risk was material, undisclosed, and, if disclosed, would have precluded consent. The plaintiff still would have reached the jury and the jury could have found for the plaintiff, either because it did not accept the defendant's evidence (in some full-disclosure jurisdictions) or because, although accepting that evidence, the jury concluded that no standard of nondisclosure should deprive a patient of the right of self-determination (in other full-disclosure jurisdictions). What could be fairer than that? Plaintiff's burden of presenting expert medical testimony is eased because of the more benign thrust of that testimony and, therefore, the plaintiff's ability to make a legally sufficient case is enhanced. And, once reaching the jury, the plaintiff could prevail. At the same time, the physician's right to rely on the professional standard of disclosure and his medical judgment is not wholly eliminated. Instead, the full-disclosure court repudiates the professional standard only for the limited purpose of ruling on the legal sufficiency of the plaintiff's case. That serves the litigation interests of both the patient and the physician. Is that an acceptable reason for permitting the physician the affirmative defense?

Despite its surface appeal, that rationale, it seems to me, is not an acceptable basis for affording the physician the affirmative defense of compliance with the professional standard of disclosure, for several reasons. First, the language used by virtually all of the full-disclosure courts is emphatic with regard to the preservation of the patient's right of self-determination.29 That is the asserted

29. The root premise is the concept, fundamental in American jurisprudence, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible.

It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a fact of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which
reason for the judicially fashioned standard compelling the physi-

traditionally has exacted obligations beyond those associated with arms-length trans-
actions. His dependence upon the physician for information affecting his well-being,
in terms of contemplated treatment, is well-nigh abject.

Nor can we ignore the fact that to bind the disclosure obligation to medical usage is to
arrogate the decision on revelation to the physician alone. 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.

Canterbury, 464 F2d at 780, 782, 784 (footnotes omitted).
The doctrine of informed consent. . . follows logically from the universally recognized
rule that a physician, treating a mentally competent adult under non-emergency cir-
cumstances, cannot properly undertake to perform surgery or administer other ther-
apy without the prior consent of his patient. . . In order for the patient’s consent to
be effective, it must have been an “informed” consent, one that is given after the
patient has received a fair and reasonable explanation of the contemplated treatment
or procedure. . .
The fountainhead of the doctrine of informed consent is the patient’s right to exer-
cise control over his own body, at least when undergoing elective surgery, by deciding
for himself whether or not to submit to the particular therapy. . . As Judge Car-
dozo said [.]. . . “[e]very human being of adult years and sound mind has a right to
determine what shall be done with his own body.” Other courts have bottomed the
physician’s duty to disclose on the fiducial quality of the physician-patient relation-
ship. . . Whatever its source, the doctrine of informed consent takes full account of
the probability that unlike the physician, the patient is untrained in medical science,
and therefore depends completely on the trust and skill of his physician for the infor-
mation on which he makes his decision. . .
Simply stated, the doctrine of informed consent imposes on a physician, before he
subjects his patient to medical treatment, the duty to explain the procedure to the
patient and to warn him of any material risks or dangers inherent in or collateral to
the therapy, so as to enable the patient to make an intelligent and informed choice
about whether or not to undergo such treatment. . .

In recent years . . . an ever-expanding number of courts have declined to apply a
professional standard of care in informed consent cases, employing instead a general
or lay standard of reasonableness set by law and independent of medical custom.
These decisions recognize that protection of the patient’s fundamental right of physi-
cal self-determination — the very cornerstone of the informed consent doctrine —
mandates that the scope of a physician’s duty to disclose therapeutic risks and alter-
natives be governed by the patient’s informational needs. Thus, the appropriate test
is not what the physician in the exercise of his medical judgment thinks a patient
should know before acquiescing in a proposed course of treatment; rather, the focus is
on what data the patient requires in order to make an intelligent decision.

Sard v Hardy, 281 Md at 438-39, 442, 379 A2d at 1019-20, 1021 (footnotes omitted).
The scope of the duty to disclose information concerning the treatment proposed,
other treatments and the risks of each course of action and of no treatment at all is
measured by the patient’s need to know. The inquiry as to each item of information
which the doctor knows or should know about the patient’s physical condition is,
“Would the patient as a human being consider this item in choosing his or her choice
of treatment?” . . .
Indeed, it is the prerogative of the patient to choose his treatment. A doctor may not
withhold from the patient the knowledge necessary for the exercise of that right.
cian to disclose all material risks. None of those full-disclosure courts (to my knowledge) has asserted that that judicially-fashioned standard exists for the sole or even primary purpose of striking a litigation compromise between patient and physician, one easing the patient's burden of presenting a legally sufficient case while simultaneously preserving the physician's right to rely on the professional standard of disclosure. That may indeed be the ultimate result achieved by a full-disclosure court's permitting the physician the affirmative defense of compliance with the professional standard. But that result is so directly at odds with the avowed purpose of fashioning and imposing the full-disclosure rule - preserving the patient's right of self-determination - that to accept that result as the rationale for affording the physician the affirmative defense would be to impute to the full-disclosure courts a distressing level of disingenuousness.

Second, to accept that result as an appropriate rationale for permitting the affirmative defense would be to mislead the patient with regard to his expectations concerning the doctor-patient relationship. The explicit language of the full-disclosure courts informs the patient that, in that relationship, he has the right to anticipate revelation of all material risks incident to any proposed therapy. Without it, the prerogative is valueless.

Miller v Kennedy, 11 Wash App at 282-83, 522 P2d at 860-61 (footnotes omitted).

A patient's right to make up his mind whether to undergo treatment should not be delegated to the local medical group. What is reasonable disclosure in one instance may not be reasonable in another. We decline to adopt a standard based on the professional standard. We, therefore, hold the scope of a physician's communications must be measured by his patient's need to know enough to enable him to make an intelligent choice. In other words, full disclosure of all material risks incident to treatment must be made. . . . A risk is material if it would be likely to affect patient's decision.

Scott v Bradford, 606 P2d at 558.

30. Even in Cooper v Roberts, 220 Pa Super 260, 286 A2d 647 (1971), where the court noted that, "as 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," 220 Pa Super at 267, 286 A2d at 650, that consideration was only the "final[]," id, one in support of repudiating the professional standard of disclosure.

[T]he primary interest of Pennsylvania jurisprudence in regard to informed consent is that of having the patient informed of all the material facts from which he can make an intelligent choice as to his course of treatment, regardless of whether he in fact chooses rationally. Although we have high regard for the professionalism of the medical community, the standard of disclosure exercised therein bears no inherent relationship to the amount of knowledge that any particular patient might require in order to make an informed choice.

220 Pa Super at 266, 286 A2d at 650.

31. See note 29.
To assert simultaneously as a rationale for the affirmative defense that, as the result of a litigation compromise, the doctor has the right to rely on the professional standard of disclosure, would be to mislead or confuse the patient perhaps as profoundly as any physician's disclosure that withheld material risks. It is damaging enough to the patient's expectations that that result obtains under the existing law. To attempt to justify that result in terms of a tacit judicially-effected litigation compromise would be an added affront to every layman who is party to a doctor-patient relationship in a full-disclosure jurisdiction.

Finally, that litigation compromise is based on a tacit quid pro quo. The patient will be afforded some relief from the conspiracy of silence and the adverse impact that has on his ability to make a legally sufficient case, by amending the thrust of the required expert medical testimony; the physician, in exchange, will be afforded the legal right to rely on the professional standard of disclosure. There are two things wrong with that bargain. The first is that the conspiracy of silence was a conspiracy among physicians. To ameliorate the plight of the patient occasioned by that conspiracy at the price of affording the physician the right to rely on the professional standard would be to reward physicians for having successfully conspired not to testify. That's hardly an elegant bargain for any court to strike. Second, the conspiracy of silence, awesomely successful until perhaps the mid-1960s, has lost much of its clout. Thanks to the growing number of physicians willing to testify for plaintiffs in medical malpractice actions,\(^3\) judicial willingness to permit a physician in one specialty to testify in an action against a physician in another specialty,\(^3\) and judicial repudiation

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32. I confess that I do not know why, starting in the mid-1960s, there emerged physicians who were willing to testify for plaintiffs in medical malpractice actions. Purely as a matter of speculation, it may have been because a number of those physicians, while in medical school, took courses in Forensic Medicine and came face-to-face with the conspiracy of silence. Some of them may have found that confrontation unpalatable. Apparently, some risk may still attach to the physician who testifies for plaintiffs in medical malpractice actions. See Kiepfer v American Physicians Ins. Exch., No. 5A-85-CA-3140 (W D Tex, May 31, 1989), reported at 32 ATL A L Rep 471 (Dec 1989) (boycott of testifying physician).

33. "While the court may rule that a certain subject of inquiry requires that a member of a given profession, as a doctor, . . . be called [,] usually a specialist in a particular branch within a profession will not be required." Edward W. Cleary, ed, McCormick on Evidence 34 (3d ed 1984) and see note 10. In addition, see Baerman v Reisinger, 363 F2d 309 (D C Cir 1966) (general practitioner competent to establish standard for cardiologist in diagnosing hypothyroidism); Radman v Harold, 279 Md 167, 367 A2d 472 (1977), aff'd, 31 Md App 184, 355 A2d 477 (1976) (internist competent to establish standard for gynecologist in performing hysterectomy); Kosberg v Washington Hospital Center, 394 F2d 947 (D C Cir 1968) (treating internist competent to establish standard for psychiatrist in deciding patient's
of the "community standard," the conspiracy of silence no longer possesses its one-time capacity to stifle malpractice actions irrespective of their merits. Consequently, for a contemporary court to afford the patient partial relief from the conspiracy by altering the thrust of the required expert testimony at the cost of negating the patient's right of self-determination by allowing the physician the defense of compliance with the professional standard of disclosure is hardly a fair bargain for the patient. For all of those reasons, the litigation compromise is not a persuasive rationale for affording the physician the affirmative defense of compliance with the professional standard in a full-disclosure jurisdiction.

Is there some additional reason that has impelled full-disclosure courts to recognize compliance with the professional standard as an affirmative defense? Dr. Jay Katz has written:

The history of the doctrine of informed consent illuminates the difficulties of resolving the conflicting tensions that judges were confronted with when they attempted to extend patients' rights to self-determination. Judges perceived the conflict to be one between liberty and caring custody.

Perhaps that judicially perceived tension is the explanation for recognition of the affirmative defense by full-disclosure courts. While motivated to preserve the patient's right of self-determination, the courts have not been prepared to eliminate entirely the physician's caring professional judgment that certain risks, if disclosed, would adversely affect the patient's physical or emotional well-being. Thus, the courts may have concluded that they were affording the patient the best of both worlds: the right to be apprised of all material risks except those that, if disclosed, would harm rather than help him. That humanistic rationale has enor-

34. Formerly it was generally held that allowance must be made for the type of community in which the physician carries on his practice, and for the fact, for example, that a country doctor could not be expected to have the equipment, facilities, libraries, contacts, opportunities for learning, or experience afforded by large cities. Since the standard of the "same" locality was obviously too narrow, this was commonly stated as that of "similar localities," thus including other towns of the same general type. Improved facilities of communication, travel, availability of medical literature, and the like, have led some courts to abandon a fixed locality rule in favor of treating the community as one factor to be taken into account in applying the general professional standard. In other jurisdictions the "locality rule" has been discarded outright, and a general national standard applied in all cases, especially in the case of medical specialists.

Prosser & Keeton, Torts 187-88. See also, Morrison v MacNamara, 407 A2d 555 (D C 1979) (national standard applied to method of administering urethral smear test).

mous appeal. It implies the existence not only of a caring physician but of a caring judiciary as well. The patient, already discomposed by the actual or feared illness or injury, should enjoy the right to be apprised of all material risks incident to the proposed procedure or therapy, excepting those risks that in the caring professional judgment of the physician, corroborated by the professional standard of disclosure, would, if disclosed, exacerbate the patient’s discomposure to the point of adversely affecting his physical or emotional well-being. Even if those latter risks were to be disclosed, the patient, now all the more disturbed, could hardly be expected to make a dispassionate decision. And even if he should acquiesce in the proposed procedure or therapy after being informed of that latter class of particularly disconcerting risks, the contemplated beneficial effects of the proposed procedure or therapy could be diminished. Only an inhumane physician would reveal that latter class of risks and only an inhumane court would compel such disclosure. That, I think, may be the most likely and perhaps the most compelling reason for full-disclosure courts to continue to afford the physician the affirmative defense of compliance with the professional standard of disclosure.

Now we must determine if that reason is an appropriate rationale for affording that defense. When a court determines to embrace the full-disclosure rule, a judicially fashioned standard compelling disclosure of all material risks, that court has concluded that the patient’s right of self-determination is paramount. The court has opted to preserve that right of patient autonomy over the competing rationale underlying the decision of those other courts that judge the disclosure exclusively by the professional standard of disclosure: protecting the physician’s exercise of his professional judgment. The full-disclosure courts have elected to favor an approach that makes the patient the master of his own fate over the competing paternalistic approach that suggests “the doctor knows best.” That preference inherently acknowledges that, as between the patient and the physician, it is the former who should decide what is or is not to be done to the patient and that the patient’s decision must be an informed one. Logically, that conclusion cannot coexist with a rule allowing the physician a defense based on a professional judgment as to which risks are to be disclosed and which concealed. Beyond pure logic, the judicial standard requiring the disclosure of all material risks recognizes the patient as being capable of making decisions, properly informed. Presumably, that recognition of patient capacity extends not only to the easy deci-
sions but to the difficult ones as well. Indeed, if it did not, the patient's right of self-determination would be nearly meaningless. To conclude that the patient somehow loses that capacity when the decisions become difficult imputes to the patient an absence of capacity inimical to autonomy. Yes, it's true that some risks, if disclosed, may exacerbate the patient's already discomposed condition. It may even be true that that exacerbation may diminish the efficacy of the proposed procedure or therapy. While that may make it difficult for the physician to disclose, and difficult even for a full-disclosure court to compel disclosure, both should realize that the difficulty is inherent in the basic determination that it is the patient, not the physician, who is to make the decision. The shibboleth that "I'm doing this for your own good," when applied to a competent adult, even one discomposed by concern, is generally most appropriately met with the response, "Thanks, but no thanks."

Let us consider a rather dramatic hypothetical case. Patient is afflicted with a serious illness. Procedures and therapies are available. If utilized they may ameliorate or even cure the illness. But their utilization is attended with significant, medically cognizable risks. The physician, deeply committed to ameliorating or curing illness, believes strongly that the procedures will accomplish that end and, therefore, should be utilized. The physician also believes that, if the patient is informed of the attendant risks, the patient may suffer serious emotional repercussions perhaps triggering impaired cardiac functioning or even a heart attack. Let us assume that in such circumstances the professional standard of disclosure would mandate withholding disclosure of those risks. It is not difficult to imagine the physician's reluctance to disclose those risks or even a full-disclosure court's reluctance to compel disclosure. The former, a healer by vocation, wishes to do nothing to harm the patient. The latter, although committed to a patient's right of self-determination, may feel that to deny the physician the legal right to withhold such risks from the patient might result in a compelled disclosure resulting in detriment to the patient. Should the physician in those circumstances be deemed to have the right not to make a full disclosure?

If that question is answered affirmatively, the ineluctable result is that it is the physician, not the patient, who becomes the ultimate decision-maker. And if the medically cognizable risks incident to the proposed procedure are such that their mere disclosure may trigger emotional repercussions, impaired cardiac functioning,
or even a heart attack, those risks must be grave. To conclude that their gravity justifies nondisclosure would be to deny the patient his right of self-determination where that right is most important. To leave the patient to decide whether or not to undergo the proposed procedure ignorant of the gravest risks incident to that procedure would be to sacrifice the patient’s right of self-determination when the medically cognizable risks incident to the proposed procedure pose the greatest peril to the patient. That result would be contrary to the basic rationale underlying the full-disclosure standard both in terms of logic and humanism.

Let us fashion another dramatic hypothetical case. Patient is afflicted with a terminal illness. Procedures and therapies are available. If utilized, they may extend the patient’s life. But their utilization is attended with medically cognizable risks that may seriously and adversely affect the quality of that extended life. The physician, deeply committed to extending human life, believes strongly that the procedures and therapies will accomplish that end and therefore should be utilized. The physician also believes that, if the patient is informed fully as to the likelihood and term of extended life, the nature and extent of the medically cognizable risks, and the prognosis absent such procedures and therapies, the patient will not consent to those procedures. The physician believes too that such a full disclosure would have an adverse effect on the patient’s physical and emotional well-being and might even diminish the efficacy of those procedures if performed. Let us assume as well that, in such circumstances, the professional standard of disclosure would mandate something considerably less than a full disclosure. Should the physician be deemed to have the legal right to withhold a full disclosure?

Once again, if that question is answered affirmatively, the result is that it becomes the physician, not the patient, who assumes the role of the ultimate decision-maker. That conclusion is so inherently at odds with preservation of the patient’s right of self-determination, the basic reason for the full-disclosure rule, that the two cannot coexist, not as a matter of logic and not as a matter of humanism. Acquisition of information, bad news as well as good, is a necessary concomitant of decision-making. When the physician is the only practical source of that information, he should be compelled to disclose it; otherwise the patient’s right of self-determination is more illusory than real. In humanistic terms, to deprive the terminally-ill patient of the opportunity to make an informed choice from among the available alternatives is nearly impossible
to justify. It would treat the terminally-ill patient as something less than a competent adult. It would strip him of his ability to decide his own destiny from among the limited, unpleasant available alternatives. It would deny him the ability to weigh the relative advantages and disadvantages of each course in an informed, meaningful manner. In short, it would be grossly inappropriate.

If, even in those dramatic situations, fashioned to create the most appealing cases for recognition of a right of non-disclosure, such a right is not persuasively supported, and I think it is not, that right has no legitimate role to play in a full-disclosure jurisdiction. Even the most likely and compelling reason for full-disclosure courts to permit the physician the affirmative defense of compliance with the professional standard is not persuasive. In negating the patient’s right of self-determination, the defense violates both a sense of logic and a humanistic view of the patient. It should not be allowed.

There remains one additional question: Why do some of the full-disclosure courts, while allowing the defense, treat it in an idiosyncratic manner, permitting the jury to find for the plaintiff even if the jury accepts the evidence underlying the defense? It could be argued, I suppose, that that idiosyncratic treatment reflects a judicial determination that the jury, serving as a microcosm of society, should make the ultimate determination of which should prevail, the patient’s right of self-determination or the physician’s right to rely on professional judgment. Such an argument would rest on the predicate that, in resolving that tension, society’s representative, the jury, rather than the court, should be the final arbiter. The jury, representing society, is better able to strike the appropriate balance. I confess that I find the argument wanting, for a couple of reasons. First, the same thing could be said of every case in which an affirmative defense exists. Yet, in virtually all other cases, the court will instruct the jury that, if it accepts the evidence underlying the affirmative defense, it must find for the defendant. Second, I am just cynical enough to disbelieve that the idiosyncratic treatment is the product of a judicial conclusion that society’s representative should decide. Rather, I believe it is the result of a particular full-disclosure court’s tacit recognition of the impropriety of the affirmative defense coupled with a judicial reluctance to eliminate the professional standard entirely, whether that reluctance is the product of habit, an awkward litigation compromise, or a misguided sense of humanism. More directly stated, I believe that idiosyncratic treatment is the product of a judicial effort to fop off on
the jury what is more properly a judicial function: to decide whether the affirmative defense can coexist with a full-disclosure standard based on the patient's right of self-determination. The responsibility for making that decision rests with the court. And the court should make it consistently with logic and humanism (as well as the court’s tacit recognition that the two standards cannot coexist) and eliminate that affirmative defense. Only then will the patient's right of self-determination truly be preserved.