2002

Practice Makes Perfect: Experience-Related Information Should Fall within the Purview of Pennsylvania's Doctrine of Informed Consent

Brad M. Rostolsky

Follow this and additional works at: https://dsc.duq.edu/dlr

Part of the Law Commons

Recommended Citation
Available at: https://dsc.duq.edu/dlr/vol40/iss3/6

This Comment is brought to you for free and open access by Duquesne Scholarship Collection. It has been accepted for inclusion in Duquesne Law Review by an authorized editor of Duquesne Scholarship Collection.
Practice Makes Perfect: Experience-Related Information Should Fall Within the Purview of Pennsylvania's Doctrine of Informed Consent

INTRODUCTION

When illness and disease enter our lives, we call upon physicians and their years of training and experience to guide us through some of the more frightening and helpless moments of life. In these moments of life and death, patients, armed with an understandably unsophisticated knowledge of medical science, believe that physicians will decipher for them the Latin terminology and scientific intricacies associated with their ailments. Patients assume that physicians will explain the potential risks and benefits of medical treatment. Given the degree to which a patient relies on a physician's medical advice, is it reasonable for a patient to be concerned with the extent of training and practical experience that a physician has with respect to his proposed treatments? Answering this question for the first time, the Supreme Court of Pennsylvania, in Duttry v. Patterson, said no.

Although the factors relevant to a patient's informed consent decision have not traditionally included a physician's practical experience or level of training, recent advances in the gathering and comparing of physician-performance data in connection to probable patient outcomes have become central to the debate concerning the modern application of the doctrine of informed consent. Only the Supreme Court of Wisconsin, however, has embraced the idea that a patient's treatment decision is reasonably affected by his perception of a physician's skill in performing a

---

2. Id.
4. Aaron D. Twerski & Neil B. Cohen, The Second Revolution in Informed Consent: Comparing Physicians to Each Other, 94 Nw. U. L. Rev. 1, 1-5 (1999). "With the advent of more extensive gathering and comparison data, it has become possible to provide information to patients not only about the risks associated with the procedures for which consent was sought, but also about the relative risks associated with the medical providers who would perform those procedures." Id. at 3. Examples of studies supporting the use of physician-performance data may be found infra at note 70.

543
recommended surgery.\(^5\)

That lone decision, *Johnson v. Kokemoor*,\(^6\) provides the basic framework upon which the doctrine of informed consent should be applied in Pennsylvania.\(^7\)

I. THE DOCTRINE OF INFORMED CONSENT

Since the 1914 decision in *Schloendorff v. Society of New York Hospital*,\(^8\) the principle that patients, not physicians, have the right to determine what is done to their bodies has governed the interaction between physicians and patients.\(^9\) In *Schloendorff*, Justice Cardozo articulated the premise that has become known as the doctrine of informed consent:

Every human being of adult years and sound mind has a right to determine what is done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. This is true, except in cases of emergency where the patient is

5. *Id.* at 6-7. As argued by Professor Twerski, a patient's informed consent embraces more than the hypothetical risks of a surgical procedure performed by a hypothetical surgeon:

When the omitted information concerns risks associated with the particular provider . . . the question is not whether the patient would have consented to the procedure in question (as opposed to some other procedure with a different risk matrix, or as opposed to the risk of undergoing no procedure at all). Rather, the question is whether the patient would have consented to the procedure to be performed by this provider with this provider's level of risk, as opposed to being performed by another provider with that provider's lower level of risk.

*Id.* at 12.

6. 545 N.W.2d 495 (Wis. 1996).

7. Although the superior court's decision in *Duttry v. Patterson*, 741 A.2d 199 (Pa. Super. Ct. 1999) embraced the analysis provided in *Johnson*, the Pennsylvania Supreme Court was content to give *Johnson* only cursory mention in a footnote while deciding the issue. *Duttry*, 771 A.2d at 1259 n.2.

8. 105 N.E. 92 (N.Y. 1914). In *Schloendorff*, a patient was operated on while unconscious and without having given consent to an operation. *Schloendorff*, 105 N.E. at 93.

9. *Id.* The requirement of physicians to obtain a patient's informed consent, however, is often limited by three exceptions:

(1) an emergency exception, which applies when the patient is incapable of consenting and the imminent harm from forgoing treatment outweighs the harm threatened by the proposed treatment; (2) a "therapeutic privilege," which applies when the disclosure of risks would present such a threat of harm to the patient that it is medically contraindicated; and (3) an exception for risks that ought to be known by everyone, or that are already known by the particular patient.

Krause, *supra* note 1, at 279 n.29. Although the emergency exception is also reflected in Pennsylvania's informed consent statute (the statute begins with the admonition "[e]xcept in emergencies") the application of these exceptions to the general requirement of informed consent is outside the scope of this comment. 40 PA. CONS. STAT. § 1301.811-A (1998).
This demand on physicians to obtain a patient's informed consent before performing an operation is rooted in the idea that a patient can make a knowledgeable decision about what happens to his body only when he is first presented with the material information, the benefits and risks, about the proposed surgical procedure.11

Application of the doctrine of informed consent varies by jurisdiction.12 Historically, courts have framed their analyses of informed consent under legal theories sounding in battery, negligence, contract, or the fiduciary nature of the doctor/patient relationship.13 Although the doctrine of informed consent was originally developed under the rubric of battery,14 the negligence standard has emerged as the preferred standard by which courts apply the doctrine of informed consent.15 Beyond the differences in

10. Schloendorf, 105 N.E. at 93.
11. E.g., Richard A. Heinemann, Note, Pushing the Limits of Informed Consent: Johnson v. Kokemoor and Physician-Specific Disclosure, 1998 Wis. L. Rev. 1079, 1089. "Traditional informed consent law was designed to ensure that patients understand the benefits and risks of proposed treatments." Id. In the first Supreme Court of Pennsylvania decision to adopt the doctrine of informed consent, Justice O'Brien wrote, "for there to be a valid consent it must be clear that both parties understand the nature of the undertaking and what the possible as well as expected results might be." Gray v. Grunnagle, 223 A.2d 663, 674 (Pa. 1966).
14. Joan P. Dailey, Comment, The Two Schools of Thought Doctrine and Informed Consent Doctrines in Pennsylvania: A Model for Integration, 98 DICK. L. REV. 713, 726 (1994). Under a medical battery theory, the elements for a cause of action for battery require the patient to prove that "(1) the physician performed a procedure or treatment beyond the scope of the patient's consent; (2) the treatment provided was substantially different from that to which the patient agreed; and (3) the physician intentionally deviated from the care to which the patient agreed." Id.
15. Id. at 732. "[T]he great majority of jurisdictions recognize negligence as the proper basis for an informed consent action." Id. at 729-30. E.g. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972); Natanson v. Kline, 350 P.2d 1093 (Kan. 1960); Sard v. Hardy, 379 A.2d 1014 (Md. 1977); Wilkinson v. Vesey, 295 A.2d 676 (R.I. 1972). Under the negligence standard, a patient must show that a physician's failure to disclose information material to a treatment decision has caused the patient's injury. Shugrue, supra note 12, at 893. Key to the difference between the application of the informed consent doctrine under the battery and negligence standard is that only under the battery standard are physicians exposed to liability regardless of whether the patient incurs a physical injury as a result of the procedure to which he did
applying the doctrine that rests in choosing a negligence or battery standard, courts have wrestled with choosing the appropriate standard by which to prove that consent was or was not given by a patient.\textsuperscript{16}

When evaluating whether a patient was provided the material information adequate to secure his patient's informed consent, the courts have applied two differing legal standards: (1) the traditional "professional community" standard; and (2) the "reasonable patient" standard.\textsuperscript{17} Under the "professional community" standard, a physician must disclose to the patient all information that a reasonable and minimally competent physician would reveal in the same situation.\textsuperscript{18} The "reasonable patient" standard, however, is growing in popularity among the courts.\textsuperscript{19} In applying this patient-oriented approach to informed consent, the court considers whether a physician has provided to the patient all material information that a reasonable patient would have deemed necessary to making his treatment decisions.\textsuperscript{20} It has been


17. \textit{Id.} at 886.


20. The following cases employed the "reasonable patient" approach: \textit{Canterbury}, 464 F.2d 772; Logan v. Greenwich Hosp. Ass'n, 465 A.2d 294 (Conn. 1983); Revord v. Russell, 401
observed, however, that the "reasonable patient" standard has been "difficult to apply in practice."\(^2\) Commentators have begun to focus on the possible ineffectiveness of the traditional objective application of this standard and have given consideration to what information the actual patient involved in the decision-making process desires.\(^2\)

II. INFORMED CONSENT IN PENNSYLVANIA

Although the Pennsylvania legislature recently enacted 40 PA. CONS. STAT. § 1301.811-A (1998), a codification of the law of informed consent, there has yet to be any interpretation in case law or scholarly writing regarding the statute's impact on whether a physician's training or personal experience is relevant to an informed consent analysis.\(^2\) Therefore, prior caselaw must be

---


21. Heinemann, supra note 11, at 1083. Traditionally, the "reasonable patient" approach has focused on an objective measure of what a theoretical patient, not the actual patient in question, would objectively require in order to make treatment decisions. \textit{Id.}

22. \textit{Id.} A problem with applying a the objective approach to the "reasonable patient" standard involves the "virtual impossibility to determine what a hypothetical, 'reasonable' patient would have done in similar circumstances." \textit{Id.} at 1084. \textit{See also infra} notes 64-68 and accompanying text.

23. The decision in Duttry did not involve an analysis of the statute because Duttry's surgery was performed long before the statute was enacted. Duttry, 771 A.2d at 1258 n.1. Pennsylvania's informed consent statute reads as follows:

(a) Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient's authorized representative prior to conducting the following procedures:

(1) Performing surgery, including the related administration of anesthesia.

(2) Administering radiation or chemotherapy.

(3) Administering a blood transfusion.

(4) Inserting a surgical device or appliance.

(5) Administering an experimental medication, using an experimental device or using an approved medication or device in an experimental manner. (b) Consent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure. The physician shall be
examined to carve out the doctrine of informed consent in Pennsylvania.

Despite the national trend of applying a negligence standard to informed consent analyses, the courts of Pennsylvania have held close to its battery-based approach to the doctrine of informed consent.\textsuperscript{24} Even within the framework of battery, however, Pennsylvania implemented the more progressive "reasonable patient" standard during a time when most jurisdictions employed the "professional community" standard.\textsuperscript{25} From its 1971 inception into Pennsylvania jurisprudence, the "reasonable patient" standard has been viewed by Pennsylvania courts to provide more equitable relief than the "professional community" standard to patients bringing suits under the doctrine of informed consent.\textsuperscript{26} The Pennsylvania Superior Court, in \textit{Cooper v. Roberts},\textsuperscript{27} found that:

\begin{quote}
the standard of disclosure exercised by the medical community [on which the "professional community" standard is based] was inequitable for two reasons: (1) the standard failed to consider the amount of knowledge a particular patient may require to make an informed consent, and (2) the patient's expense and suffering should not be subordinated to the self-imposed standards of a medical community whose
\end{quote}

\begin{quote}
entitled to present evidence of the description of that procedure and those risks and alternatives that a physician acting in accordance with accepted medical standards of medical practice would provide. (c) Expert testimony is required to determine whether the procedure constituted the type of procedure set forth in subsection (a) and to identify the risks of that procedure, the alternatives to that procedure and the risks of these alternatives. (d) A physician is liable for failure to obtain the informed consent only if the patient proves that receiving such information would have been a substantial factor in the patient's decision whether to undergo a procedure set forth in subsection (a).
\end{quote}


\textsuperscript{24} Dailey, \textit{supra} note 14, at 733. "Despite the nationwide trend toward establishing a negligence standard for informed consent actions, Pennsylvania courts have stubbornly refused to forsake the battery standard. \textit{Id.} See Bryan J. Warren, Comment, Pennsylvania Medical Informed Consent Law: A Call to Protect Patient Autonomy Rights by Abandoning the Battery Approach, 38 Duq. L. Rev. 917 (2000) for a detailed discussion of the history of informed consent in Pennsylvania, as well as a persuasive argument that Pennsylvania should adopt the negligence standard in informed consent analyses.


\textsuperscript{26} \textit{Id.} In \textit{Cooper}, the superior court compared the more traditionally employed "professional community" standard to the newly adopted "reasonable patient" standard and ruled that the more patient oriented "reasonable patient" approach was more equitable. \textit{Id.} at 650.

\textsuperscript{27} \textit{Id.} at 647.
conspiracy of silence is notoriously difficult to overcome.28

Pennsylvania courts have often addressed the nature of "material information" in the context of a physician’s duty to obtain a patient’s informed consent.29 It was only in the recently decided Duttry v. Patterson,30 however, that the Supreme Court of Pennsylvania considered whether the material information relevant to a patient’s ability to give his informed consent includes a "surgeon’s personal qualifications and experience" in performing a medical procedure.31 Overruling the superior court’s decision,32 Justice Cappy wrote that the “information personal to the physician, whether solicited by the patient or not, is irrelevant to the doctrine of informed consent.”33

---

28. Dailey, supra note 14, at 731 n.133 (discussing the impact of the Cooper decision).
29. When interpreting the doctrine of informed consent, the Pennsylvania courts have consistently held that the material information on which a patient’s informed consent is predicated must enable the patient to make reasonable health care decisions. Cosom v. Marcotte, 760 A.2d 886, 892 (Pa. Super Ct. 2000). “The primary focus of Pennsylvania law with respect to informed consent is to guarantee that a patient is supplied with all the material facts from which an intelligent choice as to medical attention may be reached, regardless of whether the patient chooses rationally.” Id. at 892. The courts have described material information in the following ways:

Our conclusion does not require a physician to apprise [sic] a patient of every minute detail concerning the surgical implantation of a medical device. Rather, the patient need only be apprised [sic] of such material information as is necessary to determine whether to proceed with the surgical or operative procedure or remain in the present condition.


We have held that a physician or surgeon who fails to advise a patient of material facts, risks, complications and alternatives to surgery which a reasonable [person] in the patient’s position would have considered significant in deciding whether to have the operation is liable for damages which ensue, and the patient need not prove that a causal relationship exists between the physician’s or surgeon’s failure to disclose information and the patient’s consent to undergo surgery.


We do not believe that requiring physicians and surgeons to communicate material facts, risks, complications and alternatives to their patients creates an unduly burdensome requirement. A physician or surgeon need not disclose all known information; however, the physician or surgeon is required to advise the patient of those material facts, risks, complications and alternatives to surgery that a reasonable person in the patient’s situation would consider significant in deciding whether to have the operation. Thus, the patient is assured that he will be provided with "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."

31. Id. at 1257.
33. Duttry, 771 A.2d at 1259.
The issue decided by the Supreme Court of Pennsylvania in *Duttry* required a determination of whether information about a surgeon's experience in performing a specific operation is "material" to the patient's ability to make an informed treatment decision. In *Duttry*, Mrs. Cloma Duttry ("Duttry") sought medical care from Dr. Lewis T. Patterson ("Patterson") after being diagnosed with esophageal cancer. After discussing treatment options with Patterson, Duttry consented to Patterson's performance of a surgical procedure in which part of Duttry's esophagus and stomach were to be resected. Because of complications resulting from the surgery, Duttry required additional, emergency surgery. Duttry alleged that she developed Adult Respiratory Disease Syndrome ("ARDS") as a result of the surgical complications and the need for emergency surgery. The ARDS left Duttry with permanent damage to her lungs, which prohibited her from continuing to work.

Duttry brought suit against Patterson alleging claims of medical malpractice and a lack of informed consent. Critical to the decisions made by both the Pennsylvania Supreme Court and superior court was Duttry's claim that during her discussion with Patterson about the operation she asked the physician about his prior experience in performing the operation he recommended. Although Patterson allegedly assuaged Duttry's concerns by telling her that he had "performed this particular procedure approximately once every month," Duttry attempted to introduce evidence at trial to establish that Patterson had, in fact, only performed the type of surgery performed on Duttry "nine times in the preceding five years."

34. *Id.* at 1257. "The question with which we are presented is whether the superior court erred as a matter of law when it determined that information concerning a surgeon's personal qualifications and experience is relevant to an informed consent claim." *Id.*
35. *Duttry*, 771 A.2d at 1256.
36. *Id.*
37. *Id.* Three days after the surgery was performed a leak, which had developed at the site of the surgery, grew and became a rupture. *Id.*
38. *Id.*
40. *Duttry*, 771 A.2d at 1257. In addition to naming Patterson in the suit, Duttry named Patterson Surgical Associates and the Polyclinic Medical Center. *Duttry*, 741 A.2d at 200. Prior to a decision in the case, the parties agreed to dismiss the Polyclinic Medical Center. *Id.*
41. *Duttry*, 771 A.2d at 1256.
42. *Id.* at 1257. The trial court, however, would not allow Duttry to introduce this
Though Duttry found momentary reprieve from the superior court's reversal of the jury's decision in favor of Patterson, the Supreme Court of Pennsylvania reversed the superior court's decision.43 In contrast to the results in Duttry, Ms. Donna Johnson ("Johnson"), a patient who brought an informed consent action against her physician in Johnson v. Kokemoor,44 found ultimate relief from the Supreme Court of Wisconsin's reversal of the Wisconsin Court of Appeals' decision for the physician. In Johnson, the Supreme Court of Wisconsin considered the issue of whether a physician failed to obtain Johnson's informed consent prior to surgery when the physician failed to divulge his true level of experience in performing the type of operation he recommended to her, as well as having failed to compare the rates of patient survival and success regarding the performance of this operation by experienced and inexperienced surgeons.45

After being diagnosed with an enlarging brain aneurysm, Johnson sought the medical advice and care of Dr. Richard Kokemoor ("Kokemoor").46 When Kokemoor recommended to Johnson that she undergo surgery to clip the aneurysm, Johnson agreed, but only after asking the physician about his experience in performing the surgery.47 The surgery performed by Kokemoor left Johnson an incomplete quadriplegic,48 and she brought suit against Kokemoor for overstating his surgical experience during doctor-patient consultations.49 At trial, Johnson introduced evidence that Kokemoor, in response to her questions about his experience in performing the recommended surgery, told Johnson that he had performed the surgery "dozens" of times.50 The physician had

evidence, ruling that it was "not relevant to the issue of informed consent." Id. Foreshadowing the sentiments of the Pennsylvania Supreme Court, the trial court "reasoned that the only information that a physician must impart to a patient to obtain informed consent is information relative to the risks of the procedure itself." Id. As evidenced by the trial court's ruling, "information regarding the personal skills and abilities of the physician is not relevant to understanding the risks of the procedure itself." Id.

43. Id.
44. 545 N.W.2d 495 (Wis. 1996).
45. Id. at 497. Although not relevant to this discussion, the Johnson court also considered whether the physician violated the doctrine of informed consent when he failed "to refer the plaintiff to a tertiary care facility staffed by physicians more experienced in performing the same surgery." Id.
46. Id. at 499.
47. Id.
48. Id. Johnson "remains unable to walk or to control her bowel or bladder movements . . . [and] her vision, speech and upper body coordination are partially impaired." Id.
49. Johnson, 545 N.W.2d at 499.
50. Id.
actually performed aneurysm surgery a total of nine times.\textsuperscript{51} In support of Johnson's contention that Kokemoor's lack of experience would have affected her treatment decision, a medical expert testified that "experience and skill with the [surgeon] is more important when performing basilar tip aneurysm surgery than with any other neurosurgical procedure."\textsuperscript{52}

With very similar factual situations underlying the decisions in \textit{Duttry} and \textit{Johnson}, the two courts reached very different conclusions. The conflicting results are due in large part to each court's interpretation of what constitutes the "material information" upon which a patient's informed consent is contingent. The \textit{Duttry} court, drawing from previous Pennsylvania case law in which the nature of material information was discussed,\textsuperscript{53} concluded that the only information necessary for a physician to impart to a patient in order to conform with the requirements of informed consent is the "nature of the operation to be performed, the seriousness of it, the organs of the body involved, the disease or incapacity sought to be cured, and the possible results."\textsuperscript{54} Though the Pennsylvania Supreme Court found that evidence of a physician's experience-related information is irrelevant to a patient's ability to provide informed consent,\textsuperscript{55} the Wisconsin Supreme Court disagreed. In \textit{Johnson}, the Court concluded "a reasonable person in [Johnson's] position would have considered such [experience-related] information material in making an intelligent and informed decision about the surgery."\textsuperscript{56}

Regardless of whether a court employs the objective or subjective model of the "reasonable patient" standard,\textsuperscript{57} a healthy judge or jury may find it difficult to contemplate what information will prove essential to a patient's informed consent decision. Although courts generally agree that the theoretical medical risks and benefits associated with an operation must be presented to a patient,\textsuperscript{58} courts and legal commentators have not been able to reach a consensus with respect to a physician's personal characteristics.\textsuperscript{59} The Pennsylvania Supreme Court ruled that an

\begin{thebibliography}{99}
\bibitem{51} Id.
\bibitem{52} Id.
\bibitem{53} See \textit{supra} note 29 and accompanying text.
\bibitem{54} \textit{Duttry}, 771 A.2d at 1258.
\bibitem{55} Id. at 1259.
\bibitem{56} \textit{Johnson}, 545 N.W.2d at 505.
\bibitem{57} See \textit{supra} notes 18-22 and accompanying text.
\bibitem{58} See Shugrue, \textit{supra} note 12.
\bibitem{59} See Twerski, \textit{supra} note 4. In Pennsylvania, the trend has been to view "material
inclusion of such information would be "highly problematic" because a determination of the information that is material to the "reasonable person" is based upon an objective, rather than a subjection analysis, and this objective analysis "does not shift . . . on how inquisitive or passive the particular patient is." The court's argument here however is founded on the superior court's decision in Kaskie v. Wright, which involved a physician's nondisclosure of his alcoholism. The degree to which physician-experience data can predict future surgical outcomes is not based upon the extraneous personal qualities of the physician; this data is based on physician training and the volume of surgery previously performed. As such, the supreme court's attempt to analogize Kaskie to Duttry seems overbroad and generalized.

Although the Duttry decision implies that the "possible results" of a surgical procedure, a factor that the Pennsylvania Supreme Court does require physicians to address with patients, are not affected by the relative skill of the operating physician, the Wisconsin Supreme Court embraced a more expansive view of what the reasonable patient considers material when evaluating a procedure's risk and potential outcome. With regard to Kokemoor's overstatement of his surgical experience to Johnson, as well as Kokemoor's failure to inform her of the "availability of other [medical] centers and physicians better able to perform [her] procedure," the court held that provision of such information would have "facilitated Johnson's awareness of 'all of the viable alternatives' available to her and thereby aided her exercise of informed consent." Specifically addressing the nature of information that is material to a patient's informed consent to

---

60. Duttry, 771 A.2d at 1259.
61. Id.
62. Id.
63. Id. at 1258.
65. Id.
66. See supra note 84.
67. Duttry, 771 A.2d at 1258.
68. Johnson, 545 N.W.2d at 498.
69. Id.
surgery, the court stated:

A reasonable disclosure of significant risks . . . requires an assessment of and communication regarding the gravity of the patient's condition, the probabilities of success, and any alternative treatment or procedures of such are reasonably appropriate so that the patient has the information reasonably necessary to form the basis of an intelligent and informed consent to the proposed treatment or procedure.70

This more inclusive conception of the information that may affect a reasonable patient's treatment decision was tempered with the admonition that the court's decision does not impose a blanket requirement of physicians to always provide patients with "comparative risk evidence in statistical terms to obtain informed consent."71 The court's holding, as well as its reference to the application of the doctrine of informed consent as "fact-driven and context specific,"72 does, however, reflect the important consideration, on a case-by-case basis, whether such information would have been critical to a patient's decision to provide consent.73

The Johnson decision relied, in part, on the application of Wisconsin's informed consent statute.74 The Duttry decision did not

70. Id. at 502 (citation omitted).
71. Id. at 507.
72. Id. at 508.
73. See Johnson, at 507. The court refused to implement "a bright line rule excluding evidence of comparative risk relating to the provider." Id. at 506. "[W]e hold that evidence of morbidity and mortality outcomes of different physicians was admissible under the circumstances of this case." Id. at 507. Exemplifying the importance of such as consideration, the court stated that "while there may be a general risk of ten percent that a particular surgical procedure will result in paralysis or death, that risk may climb to forty percent when the particular procedure is performed by a relatively inexperienced surgeon." Id. In the court's opinion, "the second statistic would be material to the patient's exercise of an intelligent and informed consent regarding treatment options." Id.
74. Wis. Stat. Ann. § 448.30 (West 1993-94). Wisconsin's informed consent statute reads as follows:

Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments. The physician's duty to inform the patient under this section does not require disclosure of:

(1) Information beyond what a reasonably well-qualified physician in a similar medical classification would know.

(2) Detailed technical information that in all probability a patient would not understand.

(3) Risks apparent or known to the patient.

(4) Extremely remote possibilities that might falsely or detrimentally alarm the
rely on Pennsylvania’s statute. The only notable difference between the two statutes, however, appears to be Pennsylvania’s requirement that the patient must prove “that receiving [material] information would have been a SUBSTANTIAL FACTOR in the patient’s [treatment] decision.” It is possible, however, that the Pennsylvania statute’s failure to delineate a patient’s appreciation of his physician level of surgical experience as a “substantial factor” would not affect the court’s consideration of whether such information is material to a patient’s informed consent decision. The Louisiana Supreme Court’s decision in Hondroulis v. Schumacher specifically considered whether a physician’s duty to disclose material risks to a patient is limited solely to the risks specified in the statute. Answering this question in the negative, the court held that “[although] the statute establishes a rebuttable presumption of consent to encounter risks described in the [patient’s signed consent] form, [] providers must disclose known material risks that may foreseeably result in any of the consequences listed in the statute . . . .” Again, the key to whether certain information must be provided to the patient hinges on the court’s understanding of the term “material risk.”

IV. INCLUSION OF PHYSICIAN’S EXPERIENCE RELATED INFORMATION IN THE INFORMED CONSENT ANALYSIS

The Superior Court of Pennsylvania, in Duttry, looked beyond the traditional framework of “material information.” Echoing the sentiment of Johnson, superior court Judge Del Sole determined that the doctrine of informed consent should require physicians to

---

(5) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.

(6) Information in cases where the patient is incapable of consenting.


75. See infra note 23.

76. Id. (emphasis added).

77. 546 So.2d 466 (La. 1989).

78. Hondroulis, 546 So.2d at 468.

79. Id. at 475.

80. In determining that a patient’s informed consent may extend to information not specifically delineated in an informed consent statute, courts have based their analyses on different legal grounds. Hondroulis, 546 So.2d 466 (La. 1989) (focusing on Louisiana’s constitutional right of privacy); Smith v. Weaver, 407 N.W.2d 174 (Neb. 1987) (reconsidering the central meaning of the law); Natson v. Kline, 350 P.2d 1093 (Kan. 1960) (holding patient’s right to receive information not listed in the statute should be determined through the patient’s own self-exploration prior to surgery).
be truthful about their experience in performing the surgery discussed with patients.81 The Superior Court of Pennsylvania decision in Duttry did, however, draw a distinction between situations in which a physician provides false information in response to a patient's affirmative request for a physician's experience in performing a type of surgery and instances where a physician simply fails to detail his experience to the patient without being questioned about it.82 This distinction hinged on the superior court's prior decision in Kaskie v. Wright.83 Although the superior court, in Duttry, was not prepared to mandate that physicians should volunteer personal information to patients, it concluded differently when a patient such as Duttry affirmatively questioned a physician about his prior experience:

We too conclude that individuals who question their surgeons prior to surgery about their competence, experience and expertise are seeking information that is highly relevant to them in making an informed decision about their surgeon. A particular surgeon's skill, which many times is borne by virtue of experience, is important to those making a choice of their personal surgeon. Certainly one who questions a physician about these matters deems the answers important and is entitled to truthful and accurate information. A surgeon who, when answering a patient's inquiries, misinforms the patient about this information and misleads the patient into believing that the hands of an experienced surgeon will be performing the operation, does not have the true consent of that patient.84

As put forth in the superior court's decision in Duttry, the patient's understanding of what information is material to his informed consent to a surgical procedure appears to be plainly obvious when that patient makes affirmative inquiries for

81. Duttry, 741 A.2d at 201.
82. Id. "We conclude that a reasonable person would consider [experience-related information] significant and an individual surgeon who provides false information when so questioned would be subject to a claim of lack of informed consent." Id. (emphasis added).
83. 589 A.2d 213 (Pa. Super. Ct. 1991). In Kaskie, the superior court held that a physician did not have to voluntarily reveal his level of experience with respect to the number of times a specific procedure had been performed. Kaskie, 589 A.2d at 217. The Pennsylvania Supreme Court, in Duttry, acknowledged that the patient in Kaskie did not ask the physician about his prior surgical experience of qualifications. Duttry, 771 A.2d at 1258 (emphasis added).
84. Duttry, 741 A.2d at 201-02.
information from the physician. Implicit to appreciating the conflicting decision of the Pennsylvania Supreme Court is that the language traditionally used to describe a patient's right to provide informed consent prior to surgery remains amorphous. The language typically employed to describe the patient's right to informed consent, as well as that which describes the information material to this decision, is not easily quantifiable. Representative language includes: "a true understanding of the nature of the operation to be performed," and "risks . . . that a reasonable person would consider significant," Although informed consent is rooted in Justice Cardozo's statement that the patient must maintain control over what is done to his body, the courts have limited the patient's ability to make informed decisions about his real-life ailment to considerations of theoretical risk and benefit. Is it truly possible for the reasonable patient to "understand the nature of the undertaking" without an appreciation of the skill possessed by the physician, especially if this information has been shown to affect surgical outcomes?

Scientific studies have consistently shown that better surgical outcomes result from physicians who possess greater experience in performing the surgery. The value of such experience-related information has not escaped the notice of the scientific and medical community. As the empirical data suggests, it is not unreasonable to assume that a patient may be concerned with his physician's experience. This is true because the patient's outcome may be directly related to the surgical experience of the operating

85. Id. at 202.
88. Gray, 223 A.2d 663.
89. Twerski, supra note 4, at 13 n.30. Here, the authors list eight studies in which patient outcomes are shown to be directly related to the volume of surgeries performed. See also Julie Ann Sosa, MD et al., The Importance of Surgeon Experience for Clinical and Economic Outcomes From Thyroidectomy, 228 Annals of Surgery 320 (September 1998); James A. O'Neill Jr, MD et al., A Longitudinal Analysis of the Pediatric Workforce, 232 Annals of Surgery Number 3 (September 2000); Douglas Sharrott, Note, Provider-Specific Quality-of-Care Data: A Proposal for Limited Mandatory Disclosure, 58 BROOK L. REv. 85 (1992).
90. Twerski, supra note 4, at 13.
91. Sharrott, supra note 70, at 89. "Proponents of public disclosure contend that the public has a right to know this information since such information will encourage patients to make more informed decisions about which hospital and physicians to select for treatment." Id.
surgeon. Justice Cappy's very language in the \textit{Duttry} decision, which states that information qualifies as material to the patient when it "impart[s] information relative only to the surgery itself," would seem to support the inclusion of physician-performance information if this information is actually shown to reflect surgical outcomes. It then appears axiomatic that experience-related information, especially when that information is requested by the patient, should fall within the Pennsylvania Supreme Court's understanding of what a patient must be told regarding the "nature of the operation to be performed." \cite{92}

Although the supreme court did state that its holding in \textit{Duttry} "should not . . . be read to stand for the proposition that a physician who misleads a patient is immune from suit," the court's insistence that an action in negligence or misrepresentation will sufficiently protect a patient's interests may not reflect an appreciation of the interest protected by the doctrine of informed consent. Justice Cardozo's original invocation of patients' rights requires that a physician be prevented from providing surgical care without prior approval from the patient. Unless, prior to the performance of surgery, physicians are saddled with a duty to address the extent of their surgical experience with the patient, the patient is stripped of his ability to address reasonable concerns relating to competence. \cite{95} This is particularly true when a patient specifically questions the physician about his past surgical experience. A cause of action for misrepresentation may provide some harmed patients with a viable recourse against an inexperienced physician, but it is only the doctrine of informed consent that has been specifically tailored through years of judicial interpretation to address the intricacies of doctor-patient interaction. \cite{96}

\begin{flushright}
\textit{\textsuperscript{92.} Duttry, 771 A.2d at 1259.}
\textit{\textsuperscript{93.} Id. at 1258.}
\textit{\textsuperscript{94.} Id. at 1259.}
\textit{\textsuperscript{95.} The requirement of informed consent addresses the physician's actions prior to surgery. Misrepresentation would better serve the needs of patients if physicians falsely report their experience-data to the National Practitioner Data Bank; patients, however, do not currently have access to the such information. Jean Hellwege, \textit{Law of Informed Consent Poised for Revolution}, Experts Say, 36 TRAL 128, 129 (July 2000).}
\textit{\textsuperscript{96.} Additionally, the duty imposed upon physicians by the doctrine of informed consent, as opposed legal pitfalls of misrepresentation, are often addressed during physician training and by physician organizations in literature to physicians. \textit{E.g.,} SHAWNA C. WILEY, MD, FACS, STATEMENT OF THE AMERICAN COLLEGE OF SURGEONS TO THE GENERAL AND PLASTIC SURGERY DEVICES PANEL OF THE MEDICAL DEVICES AUTHORITY COMMITTEE FEDERAL AND DRUG ADMINISTRATION (March 3, 2000). (addressing the elements of informed consent required prior to breast}
\end{flushright}
Furthermore, the Superior Court of Pennsylvania, in *Taylor v. Albert Einstein Medical Center*,\(^7\) held that "Pennsylvania law permits a patient to specifically limit his or consent to an invasive procedure to a particular surgeon."\(^8\) If a patient enjoys the right to provide his consent only to a particular surgeon, is it proper for a court to limit this right of selection when a physician misrepresents his experience to the patient in order to obtain the patient's informed consent? As the Wisconsin Supreme Court stated in *Johnson*, "[t]he question of whether certain information is material to a patient's decision and therefore requires disclosure is rooted in the facts and circumstances of the particular case in which it arises."\(^9\) The supreme court's decision in *Duttry* prematurely presumes that the facts and circumstances surrounding all medical decisions will not involve the patient having a genuine interest in his physician's professional experience.

**CONCLUSION**

A patient's decision to undergo surgery, let alone his decision to choose a particular surgeon, will often be made only following careful consideration of many treatment options. As such, the doctrine of informed consent must begin to protect patients' opportunity cost.\(^10\) When the patient's treatment decision relies on an misplaced appreciation of his surgeon's experience, thereby implicating the actual, as opposed to the theoretical, success rate augmentation surgery); PATRICK B. CURAN, RESIDENTS ASSISTING IN SURGERY: USE CAUTION (OUM PODIATRIST PROGRAM NEWS) (addressing whether surgeons should inform patients about the assistance of residents during surgery).


98. *Taylor*, 723 A.2d at 1034. In explaining its holding, the superior court stated: "Since Appellant has alleged facts which, if true, established that consent was not given to BAILES AND/OR QUIGLEY to perform the surgery in the manner in which it occurred, he has thereby alleged sufficient facts to establish a cause of action for battery against them." *Id.* at 1035 (emphasis added).

99. *Johnson*, 545 N.W.2d at 504-05. As is also true in Pennsylvania, the application of the doctrine of informed consent in Wisconsin is based upon the "reasonable patient" standard. *Id.* at 504.

100. Opportunity cost is defined as "[t]he value of the best alternative which is foregone in order to get . . . more of the commodity under consideration." SHERMAN FOLLAND ET AL., THE ECONOMICS OF HEALTH AND HEALTH CARE 603 (2d ed. 1997). In the case of a patient's decision to undergo surgery, only one physician or group of physicians can perform the operation. If the patient elects to have a particular physician operate, then the patient forgoes the opportunity to have that operation performed by any other physician. When the experience and skills of the chosen physician are questionable, the patient's recovery may be affected.
of the treatment, the patient suffers in three respects: (1) The surgery performed on the patient may not actually provide the level of results expressed by the surgeon; (2) The patient forgoes the potentially greater benefit associated with a more experienced surgeon having performed the surgery; and (3) The patient forgoes the ability to choose an altogether different treatment option, the success rate of which may have been greater than that of electing surgery with an inexperienced surgeon. Patients, in order to fully appreciate a given procedure's opportunity cost, must be told about the potential success of a given treatment option as performed by a particular physician.

The Pennsylvania Supreme Court's interpretation of what information is material to a reasonable patient's informed consent decision fails to consider the effects of scientific advancement in the area of surgical outcomes and physician-experience data. When the significance of such information extends beyond the perception of the medical and scientific communities, the average health care consumer may become savvier in his decision to approach a particular surgeon or hospital. At that time, the patient's appreciation of the relationship between his surgeon's experience and the potential success of a surgical procedure will certainly be a factor that the reasonable patient will consider before electing surgery. Though the degree to which the lay community presently appreciates the connection between a physician's training, practical experience, and success rate is not certain, the culturally embedded maxim that "Practice Makes Perfect" suggests that a patient may reasonably expect that a physician's proficiency will be related to the extent of his professional experience. Until physicians are bound to address patients' concerns about how their level of experience will affect surgical outcomes, any patient cannot give true informed consent.

Brad M. Rostolsky