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Between the Scalpel and the Lie: Comparing Theories of Physician Accountability for Misrepresentations of Experience and Competence

Heyward H. Bouknight, III

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Between the Scalpel and the Lie: Comparing Theories of Physician Accountability for Misrepresentations of Experience and Competence

Heyward H. Bouknight, III*

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I. Introduction

As science and technology catapult forward, American consumers have more and more options to take advantage of new medical advances.¹ The rising number of surgeries performed each year is partially because of a higher availability of elective surgeries as opposed to surgeries performed to save a patient's life.² Furthermore, studies show that doctors perform many elective, but still risky, surgeries for questionable or inappropriate reasons.³ Doctors also use magazine and television advertisements to lure patients into undergoing liposuction and other purely aesthetic surgeries.⁴ Because anyone with a medical license can perform cosmetic surgery, tragedies are not uncommon.⁵

Medical associations cannot adequately police all doctors; some responsibility lies with the patients to protect themselves.⁶ Dr. Lawrence Horowitz, former director of the U.S. Senate Subcommittee on Health, stated, "At its best, American medicine is the finest in the world. But you can't get the best by chance—you have to work at it. And often, the choices you make are more important in determining the outcome than the nature of the disease

1. See Joe Levine, *Hold That Scalpel! You Need Thorough Research and Expert Guidance Before You Decide Whether You Should Go Under the Knife*, MONEY, Feb. 1, 1989, at 105 (stating that more and more Americans are choosing surgery).

2. See *id.* (noting concern that doctors are pushing elective surgery upon unwary medical consumers).

3. See *id.* (citing studies by the *Journal of the American Medical Association* estimating that nearly half of all coronary artery bypasses, an open heart procedure, are inappropriate; studies by the American College of Obstetricians and Gynecologists that physicians are performing unnecessary hysterectomies; and a study by the American Academy of Ophthalmology that doctors are performing "investigational" eye operations too often).

4. See Gary Cohen, *When Liposuction Goes Wrong, the Result Can Be Deadly*, U.S. NEWS & WORLD REP., Feb. 21, 2000, at 56, 56 (noting the pervasiveness of aggressive and often misleading marketing).

5. See *id.* at 57 (stating that cosmetic surgery is invasive surgery and can be a dangerous procedure).

6. See *id.* at 58 (finding that state medical boards are unable to regulate doctors effectively without patient awareness).

itself."⁷ An informed medical consumer must ask questions to make informed decisions.⁸

After deciding to have surgery, a medical consumer must also make an informed decision in choosing a surgeon.⁹ All surgeons are not created equal.¹⁰ One of the most important inquiries that a potential patient can make involves the surgeon's credentials and experience level.¹¹ Realizing the importance of an informed patient, several state legislatures have created databases allowing consumers to obtain information about a potential doctor or surgeon with a single phone call.¹² The creation of such statutes demonstrates widespread public acknowledgement that informed patients make a difference in combating medical disasters.¹³

Despite the increased media coverage and the initiative in state legislatures to encourage informed decision-making by medical consumers, the legal system has thus far been unwilling to respect the importance of such behavior.¹⁴ Consider the plight of Cecil Deville, a thirty-year-old man who recently suffered a heart attack. After recovering from the heart attack, Mr. Deville meets with Dr. Evil to discuss his diagnosis. Dr. Evil informs Mr. Deville that

7. See Levine, *supra* note 1, at 105 (explaining the need for Americans to be informed medical consumers).

8. See Deborah M. Prum, *Finding a Doctor: Making the Smart Choice*, CURRENT HEALTH, Mar. 1, 2000, at 20, 20 (explaining that asking questions lessens the risk of a medical nightmare).

9. See Levine, *supra* note 1, at 105 (urging a medical consumer to select carefully both the type of surgery and the surgeon that performs the procedure).

10. See *id.* (noting that mortality rates for the same procedure performed at different U.S. hospitals can vary from less than one percent to as high as twenty percent).

11. See Cohen, *supra* note 4, at 58 (encouraging the patient to inquire as to the specialty in which the doctor is certified, how many procedures that the doctor has performed, and whether the doctor has ever been disciplined or lost any malpractice suits); Levine, *supra* note 1, at 105 (urging patients to inquire about their surgeon's credentials, success rate for the type of operation, and the number of such procedures that the surgeon has performed); Prum, *supra* note 8, at 20 (encouraging patients who are choosing a new doctor to inquire about the doctor's credentials and whether the physician is board-certified).

12. See Steven K. Berenson, *Is it Time for Lawyer Profiles?*, 70 FORDHAM L. REV. 645, 656-57 (2001) (noting that approximately two dozen states have provided for some form of publicly accessible physician profiles).

13. See *id.* at 657-58 (acknowledging public realization that consumers of health care can make worthwhile use of information relating to the background of a physician); see also Michelle M. Mello & Troyen A. Brennen, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1597 (2002) (explaining market theory that informed medical consumers will create greater medical safety).

14. See Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 223 (1985) (identifying the law's failure to respond to pressures for greater recognition of patient autonomy).

his life depends upon receiving bypass surgery. Mr. Deville has read several articles about the importance of being an informed medical consumer and asks Dr. Evil how many times he has performed such a procedure and what his success rate has been. Dr. Evil explains to Mr. Deville all of the possible complications of the surgery and claims that he has performed bypass surgery over 100 times in the last year with a success rate of ninety-seven percent. After performing research on the Internet, Mr. Deville finds Dr. Evil's experience and success rate to be an acceptable risk. Mr. Deville consents to the surgery.

Unfortunately, Mr. Deville's luck is not good, and he develops complications from a blood clot following the surgery. As a result, Mr. Deville is confined to a wheelchair for the remainder of his life. During depositions for his medical malpractice lawsuit, Mr. Deville learns that Dr. Evil has only performed bypass surgery twenty times in the previous year and that his success rate was only eighty-five percent. This Note considers the legal actions available to Mr. Deville in light of Dr. Evil's misrepresentation of his qualifications to perform the bypass surgery.

Three theories would allow the patient in this fact scenario a cause of action: the informed consent doctrine, the deceit-based tort of fraud, and some states' consumer protection statutes.¹⁵ State courts differ as to which theory is most appropriate. The New Jersey Supreme Court denied a plaintiff's fraud claim stating that a more appropriate basis for legal action would be the informed consent doctrine.¹⁶ But the Pennsylvania Supreme Court refused to allow an informed consent action against a physician misrepresenting his credentials, opting instead to endorse a fraud action.¹⁷ The Pennsylvania court found that using the informed consent action to include a doctor's experience would necessitate expanding the doctrine to include personal attributes of a physician and would only create a redundant cause of action.¹⁸ Finally, Texas courts allowed a deceived patient to bring a claim under the state's consumer

15. See *Howard v. Univ. of Med. & Dentistry of N.J.*, 800 A.2d 73, 85 (N.J. 2002) (finding that patient pursuing claim against doctor for misrepresenting credentials must use informed consent); *Duttry v. Patterson*, 771 A.2d 1255, 1259 (Pa. 2001) (holding that patient pursuing claim against doctor for misrepresenting credentials may not use informed consent but may have an action in fraud); *Rhodes v. Sorokolit*, 846 S.W.2d 618, 621 (Tex. App. 1993) (allowing fraud claim against doctor under the state consumer protection act).

16. See *Howard*, 800 A.2d at 85 (refusing a separate action for fraud when a plaintiff can pursue a physician's misrepresentations regarding experience as an informed consent claim).

17. See *Duttry*, 771 A.2d at 1259 (refusing to expand informed consent doctrine because other causes of action provide adequate remedies).

18. See *id.* at 1258-59 (identifying previous precedent refusing to expand limited doctrine of informed consent).

protection statute.¹⁹ But this avenue is only available in a few states.²⁰ Traditionally, state consumer protection statutes have exemptions for the "learned professions" including both lawyers and doctors.²¹ More recently, some state courts have allowed patients to sue doctors under the consumer protection statute so long as medical negligence is not the basis of the claim.²²

This Note addresses what cause of action a state court should allow in a situation similar to the hypothetical involving Mr. Deville and Dr. Evil. Part II of this Note begins with an examination of the history of a patient's ability to hold her doctor liable, with particular emphasis on the history of judicial paternalism toward doctors and the development of the informed consent doctrine.²³ Part III takes a more in-depth look at existing case law by examining the three potentially available actions.²⁴ Part IV analyzes this case law in light of public policy concerns focusing on the burdens of proof presented by an informed consent doctrine and the importance of trust in a doctor-patient relationship.²⁵ Finally, Part V concludes by recommending that state courts allow a fraud action for deceived patients.²⁶

II. Background

An analysis of the development of medical malpractice jurisprudence is crucial to understanding this issue. To this end, this Part first focuses on judicial paternalism in medical malpractice and the ensuing breakdown of the tradition of protecting physicians in recent years. Next, this Part traces the

19. See *Chapman v. Wilson*, 826 S.W.2d 214, 219–20 (Tex. App. 1992) (allowing patient's consumer protection claim against doctor for knowing misrepresentations).

20. See Michael Flynn, *Physician Business (Mal)practice*, 20 *HAMLIN L. REV.* 333, 340–43 (1996) [hereinafter *Malpractice*] (stating that only Washington and Texas extend liability through consumer protection acts to physicians); Michael Flynn, *Physician Deceptive and Unfair Business Practices*, 71 *FLA. BAR J.* 49, 50 (1997) [hereinafter *Unfair Business Practices*] (acknowledging that no case law exists but explaining that the Florida consumer protection statute only exempts medical negligence claims and does not specifically mention physicians).

21. See *Unfair Business Practices*, *supra* note 20, at 49 (explaining the learned professions exemption).

22. See *Malpractice*, *supra* note 20, at 342 (noting that some states allow claims against physicians separate from negligence).

23. See *infra* Part II (discussing background of patient-doctor lawsuits).

24. See *infra* Part III (discussing case law involving doctor's misrepresentations to patient).

25. See *infra* Part IV (analyzing case law in light of relevant public policy concerns).

26. See *infra* Part V (recommending that courts allow deceived patients to pursue a misrepresentation action).

historical evolution of the doctrine of informed consent. Finally, this Part considers the emerging role of outcome status in managing health care quality.

A. Medical Malpractice Paternalism

The dominance of allopathic medical treatment was not the result of market economics, but instead resulted from a political power struggle between competing medical factions.²⁷ Competing medical groups sought political recognition in the name of consumer protection, claiming that "the esoteric nature of [their] craft was understandable only to the initiated, that laymen could not distinguish between 'charlatans' and true professionals."²⁸ At the turn of the century, allopaths achieved, through legislative mandates, a monopoly right to practice medicine in nearly all states.²⁹ After gaining political recognition, allopaths reinvoked this rhetoric, this time to claim that medicine was too complex for laymen to regulate.³⁰ Furthermore, the judiciary deferred to the paternalistic American Medical Association's code of ethics as a means of governing the medical profession.³¹

The tradition of protecting doctors began to break down amid media disclosure in the 1980s that revealed much greater incidences of medical negligence than the general public had previously presumed.³² From 1976 to 1986, the number of malpractice claims per 100 physicians increased more than

27. See JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 30–31 (1984) ("[A]n exclusive mandate to practice medicine was waged through the political process rather than through individual citizens' acceptance of doctors' services."). The dictionary defines allopathic medicine as the system of medical practice that aims to combat disease by use of remedies producing effects different from those produced by the treated disease. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 57 (1993). In most states, allopathic medicine is the only allowed medical practice. One can contrast allopathy with homeopathy, which the dictionary defines as the system of medical practice that treats disease by administering minute doses of a remedy that would in healthy persons produce symptoms of the treated disease; homeopathy is still legal in a few states. *Id.* at 1083.

28. KATZ, *supra* note 27, at 31.

29. See *id.* at 39 (noting that the defeat of homeopathy created a medical monopoly by allopaths).

30. See *id.* at 45 (explaining that judicial paternalism arises from the political acquiescence to the historical rhetoric that medical knowledge is incomprehensible to the layman).

31. See Emmanuel O. Ihekweumere, *Doctor, Are You Experienced? The Relevance of Disclosure of Physician Experience to a Valid Informed Consent*, 18 J. CONTEMP. HEALTH L. & POL'Y 373, 377 (2002) (noting that the judiciary with few exceptions was more than willing to approve the AMA's physician paternalism).

32. See Berenson, *supra* note 12, at 659 (citing dramatic rise in medical malpractice claims in the 1980s).

ten percent per year.³³ Predictably, this increase in claims and greater media exposure created a heightened emphasis by the public on judicial remedies and patients' rights against doctors.³⁴ Unfortunately, recent reports demonstrate that this action has not fixed the problem; a 1999 report from the National Academy of Sciences' Institute of Medicine estimated that between 44,000 and 98,000 American hospital patients die each year due to medical errors.³⁵ The recent move away from judicial paternalism has been only partial and has not eliminated the enormous problem of medical error facing American patients today.

B. Development of Informed Consent

Despite courts' paternalism towards physicians, all states have established the doctrine of informed consent, providing at least limited rights to information prior to surgery.³⁶ Hippocrates, the creator of the Hippocratic oath still given to many doctors, expressly counseled physicians to perform their duties "calmly and adroitly, concealing most things from the patient while you are attending to him."³⁷ For twenty-four centuries, patients allowed physicians to heed Hippocrates' advice.³⁸ However, at least in theory, patients are no

33. See *id.* (noting a dramatic increase in medical malpractice claims).

34. See *id.* at 660 (stating that public perception led the judiciary to believe that "something must be done").

35. See *id.* (recognizing continuing problem with medical errors). This statistic only covers those who die in hospitals because of medical errors. Thus, the survey does not include medical errors involving minor surgeries occurring outside of hospitals. See Cohen, *supra* note 4, at 56 (stating that frequently cosmetic surgery takes place in a doctor's office, away from potentially lifesaving emergency equipment).

36. See Iheukwumere, *supra* note 31, at 375–80 (explaining the origins of informed consent doctrine); see also KATZ, *supra* note 27, at 1–29 (documenting the history of silence between patient and doctor from Plato until the twentieth century). Katz concludes his chapter on the history of silence by stating, "Little appreciation of disclosure and consent can be discerned in this history, except negatively, in the emphasis on patients' incapacities to apprehend the mysteries of medicine . . ." *Id.* at 28.

37. Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 ARIZ. L. REV. 313, 313 (2002) (quoting Hippocrates, *Decorum*, in 2 HIPPOCRATES 279, 297 (W.H.S. Jones trans. 1962)). Other early philosophers agreed with Hippocrates. See Iheukwumere, *supra* note 31, at 376 (noting that other great thinkers echoed Hippocrates' views). For example, Plato believed that lying to a patient was justified so long as the lie was to advance "good and noble purposes." *Id.*

38. See Morris, *supra* note 37, at 314 (recognizing the patient's acquiescence to such a relationship).

longer powerless to question the decisions of their physicians because of the adoption of the informed consent doctrine in all fifty states.³⁹

Requiring patient consent developed initially as a battery action and only required that a doctor obtain consent for the particular procedure.⁴⁰ Patient autonomy in medical decision-making originated from a statement by Justice Cardozo while he served as a judge on the New York Court of Appeals.⁴¹ Cardozo declared: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."⁴² Battery was the first tort to represent patient autonomy because the early fact patterns involved patients who either specifically objected to an operation or patients who authorized a different operation from the one actually performed.⁴³ Despite the recognition of a patient's right to consent in the early twentieth century, judicial approaches to consent remained paternalistically protective of physicians.⁴⁴ For example, in 1955, a North Carolina court refused to hold liable a surgeon who failed to advise his patient of the inherent dangers of the impending surgery.⁴⁵ Despite severe injuries resulting from the surgery, the court found it understandable for a surgeon to withhold such information from the patient for the purpose of curtailing undue apprehension in the patient.⁴⁶ Clearly, this court refused to

39. *See id.* at 315 (explaining the transition of patients into autonomous beings capable of questioning physicians). *But see* KATZ, *supra* note 27, at 83 (stating that the idea of judicially enforced informed consent remains a fairy tale idea to which reality has yet to catch up).

40. *See* Morris, *supra* note 37, at 317–23 (tracing the battery origins of informed consent).

41. *See id.* at 317 (explaining the origin of the informed consent doctrine).

42. *See* Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (finding that the patient should have battery action), *overruled on other grounds by* Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957). *But see* KATZ, *supra* note 27, at 51–52 (noting that the strong language supporting patient autonomy was not representative of a new movement, but instead reacted to the defendant doctor's flagrant ambivalence to his patient's opposition to the surgery and the doctor's deception in performing the surgery). In reality, the case did not recognize patient self-determination but showed the unbelievable fact situation necessary for judicial action. *See id.* at 52 (recognizing the difficulty in raising a faulty consent action).

43. *See* 1 BARRY R. FURROW ET AL., HEALTH LAW 315 (practitioner treatise series 2d ed. 2000) (stating that the original battery theory required nothing more than disclosure by doctors of their proposed treatment).

44. *See* Iheukwumere, *supra* note 31, at 377 (recognizing judicial paternalism by courts).

45. *See* Hunt v. Bradshaw, 88 S.E.2d 762, 763 (N.C. 1955) (refusing liability for a surgeon despite the physician's claim that the surgery was "simple" and there "wasn't nothing to it").

46. *See id.* at 766 (classifying the surgeon's decision as a mistake but not worthy of liability).

recognize a patient's right to bodily integrity.⁴⁷ Although many courts granted patients limited autonomy, judicial paternalism frequently remained an overbearing burden on the patient.⁴⁸ Courts limited the tort of battery to protecting a patient's ability to refuse the act of surgery, but the tort did not obligate the physician to inform the patient of the risks and alternatives of the procedure.⁴⁹

During the last fifty years, the right of patients to consent has expanded into a right to specific information about the procedure. The California Court of Appeal coined the modern phrase "informed consent,"⁵⁰ which now represents a national doctrine of potential liability for all physicians.⁵¹ But courts also abandoned using the battery action in favor of using negligence to protect patients' rights to this information.⁵² Although informed consent imposes an obligation on the physician to disclose information about a proposed treatment to a patient to consider while deciding whether to permit the treatment, the use of negligence law focuses the court's decision not on the disclosure of the doctor, but on whether the patient's injury resulted from a breach of the doctor's disclosure duty.⁵³

After the California Court of Appeal coined the phrase, other state courts adopted the same terminology, but the doctrine's ambiguity resulted in a split

47. See KATZ, *supra* note 27, at 55 (stating that *Hunt* is representative of the futility of claiming a right of patient self-determination as recently as the 1950s); Iheukwumere, *supra* note 31, at 379 (identifying court's refusal to consider patient's rights). This case and others from the era illustrate not only that doctors did not talk to their patients about risks, but that neither physicians, nor judges, nor attorneys found this either surprising or odd. See *id.* (noting the accepted custom of silence between physician and patient).

48. See Iheukwumere, *supra* note 31, at 377-79 (documenting examples of courts refusing to find physicians liable).

49. See Morris, *supra* note 37, at 319 (explaining court's unwillingness to treat as battery a surgeon's failure to disclose risks, benefits, and alternatives of a procedure). The tort of battery protected against unauthorized behavior; the development of informed consent later created an affirmative duty upon physicians to inform patients about the risks and alternatives of a proposed procedure. See KATZ, *supra* note 27, at 59 (explaining the transition from battery torts against doctors to informed consent actions).

50. See *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 181 (Cal. Ct. App. 1957) (using term "informed consent" in the court's discussion of physicians' duty to disclose).

51. See KATZ, *supra* note 27, at 60-61 (noting that the California Court of Appeal introduced in a brief paragraph at the end of the opinion an ambiguous definition of a concept signifying physician discretion and full disclosure rights in the same concept).

52. See Morris, *supra* note 37, at 323 (preferring negligence to handle medical consent cases).

53. See *id.* at 324 (explaining that using negligence as the basis for informed consent is another means of judicial paternalism protecting physicians from liability); see also 1 FURROW ET AL., *supra* note 43, at 316 (explaining the reasons why allowing informed consent cases as a battery tort favors the patient).

regarding the correct standard of disclosure.⁵⁴ The Kansas Supreme Court chose a physician-based standard of disclosure in the next major case adopting the informed consent doctrine.⁵⁵ The court stated the standard by emphasizing that the duty to disclose "is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment."⁵⁶ Thus, in the same opinion acknowledging patients' right to information, the court also allowed physicians an easy escape from liability.⁵⁷ The physician-based standard requires the plaintiff to offer expert medical testimony to establish that a reasonable medical practitioner would make the disclosure and then to show that the defendant failed to comply with this standard.⁵⁸ Many early cases discussing informed consent adopted this "doctor knows best" test for the duty of disclosure.⁵⁹ Thus, while courts in most states grew to accept the informed consent doctrine, the courts continually favored a paternalistic physician-based standard.⁶⁰

Perhaps because of expanding recognition by courts of a physician conspiracy of silence, which made it very difficult for many patients to make out a prima facie case under the physician-based standard, courts in the early 1970s created a reasonable patient standard.⁶¹ Although not the first case to announce a patient standard, the celebrated case of *Canterbury v. Spence*⁶² is

54. See Iheukwumere, *supra* note 31, at 380–81 (explaining that the result of *Salgo's* ambiguity was a split between a reasonable physician standard and a reasonable patient standard to determine the scope of a doctor's duty to disclose information to the patient).

55. See *id.* (noting adoption of physician standard in Kansas).

56. *Natanson v. Kline*, 350 P.2d 1093, 1106 (Kan. 1960).

57. See KATZ, *supra* note 27, at 66–67 (finding that the opinion's ultimate effect was quite limited although the court's pronouncement of disclosure rights was radical). When the opinion's ambiguities were pointed out to Justice Schroeder, he authored another opinion unsuccessfully attempting to clarify this new right of self-determination. See *id.* at 67 (noting Justice Schroeder's inability to clarify the new doctrine).

58. See I FURROW ET AL., *supra* note 43, at 318 (explaining the need for expert testimony under physician standard).

59. See Iheukwumere, *supra* note 31, at 383 (recognizing other courts' adoption of the physician standard).

60. See *id.* at 385 (identifying courts' continued paternalism towards doctors).

61. See *id.* at 385–86 (noting that the physician standard required expert testimony that the reasonable physician would have disclosed the information and that plaintiffs were unable to find doctors willing to testify against other doctors). *But see* KATZ, *supra* note 27, at 56 (claiming that no "conspiracy of silence" prevented doctors from testifying; instead the silence is a direct result of the long established medical custom that "reasonable physicians" do not disclose the risks of procedures to patients).

62. *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972). In *Canterbury*, the U.S. Court

the leading case.⁶³ The *Canterbury* court rejected the physician standard, stating, "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."⁶⁴ In jurisdictions adopting the *Canterbury* reasonable patient standard, courts no longer required plaintiffs to produce expert testimony to establish what information the physician should have disclosed.⁶⁵ Instead, courts allowed juries to choose whether a "reasonable patient" would have desired the information in question.⁶⁶ Although commentators frequently cite *Canterbury* for the reasonable patient rule, Judge Robinson, the author of the opinion, succumbed to the same pressures as his forbearers and followed his bold statement of patients' rights with escape valves for the physicians to avoid this standard.⁶⁷ For example, the opinion states that "prevailing medical practice must be given its *just due*" when medical judgments enter the physician's disclosure decision.⁶⁸ Despite its shortcomings, commentators recognize *Canterbury*'s positive role in reinvigorating the policy of a patient's right to self-determination of medical treatment.⁶⁹

of Appeals for the D.C. Circuit debated the proper standard of care necessary for a doctor regarding disclosure of operating risks prior to surgery. *Id.* at 779. After visiting his doctor complaining of back pain, the nineteen-year-old plaintiff was subjected to an operation without being informed of the risk of paralysis. *Id.* at 777. Following the operation, the plaintiff became paralyzed from the waist down. *Id.* The court began its analysis by focusing upon a patient's right to bodily integrity. *Id.* at 780. After finding a duty of the physician to disclose relevant information, the court also considered the scope of this duty. *Id.* at 783–84. The court rejected the use of the commonly accepted physician standard because a patient's right to self-determination should not hinge upon a custom created by physicians themselves. *Id.* at 784. Instead, the court chose to define the scope of the physician's duty of disclosure according to the reasonable patient's need for information. *Id.* at 786.

63. See Ihekumwumere, *supra* note 31, at 386 & n.71 (calling *Canterbury* the "lightning rod" for the adoption of the reasonable patient standard and the most well-known informed consent case).

64. *Canterbury*, 464 F.2d at 784 (footnote omitted).

65. See Aaron D. Twerski & Neil B. Cohen, *Comparing Medical Providers: A First Look at the New Era of Medical Statistics*, 58 BROOK. L. REV. 5, 27 (1992) (discussing plaintiffs' proof burden in an informed consent case). *But see* 1 FURROW ET AL., *supra* note 43, at 319 (noting that expert testimony is still frequently needed to clarify treatments and the probabilities of risk as well as to testify that the physician should have been aware of such risk).

66. See Twerski & Cohen, *supra* note 65, at 27 (discussing reasonable patient standard).

67. See KATZ, *supra* note 27, at 74 (noting that the rule laid out is far from clear).

68. *Id.* at 74–75 (quoting *Canterbury v. Spence*, 464 F.2d 772, 785 (D.C. Cir. 1972)) (noting that the opinion allows doctors to use the medical professional standard as a defense for failing to disclose the risks of a procedure) (emphasis added by Katz).

69. See *id.* at 76 (noting that *Canterbury* reminded courts that the doctrine's purpose is to foster individual choice); Ihekumwumere, *supra* note 31, at 390 (noting that informed consent's

Thirty years after *Canterbury*, states' standards defining a physician's duty to disclose information still vary.⁷⁰ Nonetheless, courts are nearly unanimous in categorizing informed consent as a negligence action.⁷¹ The Supreme Court of Wisconsin identified five reasons why negligence became the preferred theory of liability.⁷² First, the doctor is acting for the patient's benefit, and the failure to disclose is not equal to an unauthorized procedure.⁷³ Second, failing to give information is not an affirmative, intentional act.⁷⁴ Third, failing to disclose is not a contact or touching.⁷⁵ Fourth, the doctor's malpractice insurance often does not cover intentional misconduct.⁷⁶ Finally, failure to disclose information does not warrant the possibility of punitive damages.⁷⁷

Despite the near unanimity among state courts, commentators find glaring weaknesses in placing the informed consent doctrine under the rubric of negligence.⁷⁸ Although some of the reasons supporting the negligence standard seem to reflect a misreading of tort law,⁷⁹ the overriding principle behind choosing the negligence theory was the ability of judges to insulate further physicians from liability.⁸⁰ Under the negligence theory of liability, if a patient successfully establishes a breach of the duty to inform, the patient still has

purpose is to allow patients access to information to make an informed decision).

70. See Iheukwumere, *supra* note 31, at 391 (noting that the physician standard remains the majority view); see also 1 FURROW ET AL., *supra* note 43, at 318–19 (noting that the patient standard is the modern trend and is approaching a majority position).

71. See Morris, *supra* note 37, at 319 (discussing courts' reluctance to characterize informed consent as a battery).

72. See *Trogun v. Fruchtmann*, 207 N.W.2d 297, 312–13 (Wis. 1973) (explaining reasons for adopting a negligence standard of liability).

73. See *id.* (same).

74. See *id.* (same).

75. See *id.* (same).

76. See *id.* (same).

77. See *id.* (same).

78. See, e.g., Morris, *supra* note 37, at 319–21 (refuting each of the Wisconsin Supreme Court's reasons for choosing the negligence action); see also Alan Meisel, *A "Dignitary Tort" as a Bridge Between the Idea of Informed Consent and the Law of Informed Consent*, 16 LAW, MED., & HEALTH CARE 210, 212 (1988) (suggesting that by merely invoking the principles of battery law to acknowledge the patient's dignitary interest in adequate disclosure, courts could accomplish the policy goals of informed consent jurisprudence).

79. See KATZ, *supra* note 27, at 68 (noting that the preference for negligence may be a result of judges simply misunderstanding the law of battery); Morris, *supra* note 37, at 321–22 (noting that currently existing intentional, dignitary torts would allow informed consent to be a battery).

80. See KATZ, *supra* note 27, at 69 (explaining that the choice of negligence law made the possibility of patients proving a legally cognizable injury significantly less likely).

another difficult proof problem in establishing causation.⁸¹ First, the patient must establish injury causation by proving that the procedure chosen by the physician resulted in the plaintiff's injuries.⁸² Next, the patient must also establish decision causation by proving that the patient would have chosen a different course of action had he known the withheld information.⁸³ This higher burden of proof imposed on the patient is likely one reason courts have refused to use a battery theory.⁸⁴ Despite the flaws in its reasoning, the informed consent doctrine today appears to be deeply rooted in negligence law.⁸⁵

Although the informed consent doctrine still fails to provide a true right of patient self-determination, the doctrine is a work in progress and has created an awareness of patients' rights to information.⁸⁶ The judicial development of informed consent has become one of the forces altering the attitudes of a new generation of doctors toward their patients.⁸⁷ Because informed consent reflects one of society's highest values, individual autonomy, courts will continue to struggle with the conflicting needs to protect physicians from overbearing liability and the need to protect patients' right to choose appropriate medical treatment.⁸⁸ Outside of the courtroom, the doctrine also has positive effects, as medical schools are now training doctors in the importance of communication with patients and no longer are teaching the virtues of silence.⁸⁹

81. See Twerski & Cohen, *supra* note 65, at 27 (explaining causation proof problems).

82. See *id.* (same).

83. See *id.* at 28 (same).

84. See Morris, *supra* note 37, at 320 (stating that the reasons given for adopting a negligence theory are unpersuasive and that negligence liability has decreased plaintiffs' opportunity for recovery).

85. See *id.* at 323 (explaining reasons courts have fitted physicians' disclosure duty into the tort of negligence).

86. See KATZ, *supra* note 27, at 83–84 (stating that the doctrine has promoted an atmosphere in which patient freedom has the potential to survive and grow).

87. See 1 FURROW ET AL., *supra* note 43, at 315 (documenting the effect of the informed consent doctrine).

88. See KATZ, *supra* note 27, at 49 (noting judges' inability to fashion an informed consent doctrine that provides patients liberty of choice yet also retains physician protection against needless liability); FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE, at xv (3d ed. 2002) (noting that patient autonomy is likely to be a subject of renewed interest in the future because "[f]ederal patient rights standards and state legislation are driving this interest along with the watershed of information available on the Internet").

89. See Barry R. Furrow, *The Changing Role of the Law in Promoting Quality in Health Care: From Sanctioning Outlaws to Managing Outcomes*, 26 HOUS. L. REV. 147, 182 (1989) (explaining positive effects of informed consent despite its many shortcomings).

C. Health Care Quality and Outcome Management

Despite the goal of medical malpractice claims and the informed consent doctrine to eliminate the "bad apples" in the medical field and to create a better health care system, medical error remains an alarmingly high cause of death and injury.⁹⁰ The failure of medical malpractice litigation to deter costly medical errors has led some commentators to urge the use of competitive market forces to control the rising incidence of medical error.⁹¹ Market advocates believe that informed consumers will shop for health care services based on quality and thereby drive poorly performing doctors out of business.⁹² For consumers to influence the medical market, however, they must have access to quality assessment information.⁹³

Avedis Donabedian's pioneering work on health care quality assessment has instigated a new theory of protecting against medical error—outcome analysis.⁹⁴ Donabedian defines "outcomes" as "change[s] in a patient's current and future health status that can be attributed to antecedent health care."⁹⁵ Meaningful study of outcomes is not always easy because although some outcomes, like death, are clear-cut, many others, such as patient attitudes and satisfaction levels, are more difficult to measure.⁹⁶ Nonetheless, some states are beginning to amass databases of physician profiles containing disciplinary actions, experience levels, and awards and honors held by individual physicians.⁹⁷ One commentator has concluded that "greater sophistication in the statistical modeling is only a matter of time."⁹⁸ As more information becomes

90. See Sandra G. Boodman, *No End to Errors*, WASH. POST, Dec. 3, 2002, at F1 (stating that medical error kills more Americans than breast cancer, traffic accidents, or AIDS).

91. See Mello & Brennan, *supra* note 13, at 1595 (stating that professional dominance has minimized the ability of educated consumers to control the market).

92. See *id.* at 1597 (explaining the market theory).

93. See *id.* (same).

94. See Furrow, *supra* note 89, at 155 (1989) (stating that the outcome assessment in theory is the best evaluation method because it directly relates to the goal of medicine—making the patient better).

95. 1 AVEDIS DONABEDIAN, *THE DEFINITION OF QUALITY AND APPROACHES TO ITS ASSESSMENT* 82–83 (1980).

96. See Furrow, *supra* note 89, at 155–56 (explaining the difficulties of acquiring outcomes data).

97. See Berenson, *supra* note 12, at 656–57 (discussing state physician profile legislation).

98. Twerski & Cohen, *supra* note 65, at 7.

accessible to medical consumers, economists hope market forces will eliminate many of the medical errors that current reliance on ex post facto malpractice claims have been unable to prevent.⁹⁹ Because consumers will never have perfect information, examination of all outcomes is not possible, but states are recognizing the value of making outcomes information accessible to medical consumers.¹⁰⁰

Although the allure of a market based health care system has caused other nations to emulate its principles in reforming their own health care systems, medical consumers have yet to affect significantly the health care market by flocking to better performing health plans, hospitals, or physicians.¹⁰¹ Barriers to achieving a market health care system include lack of awareness of the available information, difficulty in interpreting the available information, and the inability of many medical consumers to choose their physicians because of insurance restrictions or travel distance.¹⁰² Even assuming that quality statistical information on outcomes becomes available, the largest obstacle to a self-regulating health care marketplace remains determining how to make consumers believe that the quality of physicians does vary and how to ensure consumers that they have a choice in selecting a physician.¹⁰³

Unfortunately, the legal system does not currently protect patients who are attempting to make informed medical decisions based on even the simplest health care quality indicator—a physician's experience level. Despite Dr. Evil's deliberate deception in answering Mr. Deville's inquiry about Dr. Evil's experience level, state courts have not provided a clear cause of action to hold Dr. Evil liable for his misrepresentations.¹⁰⁴

99. See Frances H. Miller, *Medical Discipline in the Twenty-First Century: Are Purchasers the Answer?*, 60 LAW & CONTEMP. PROBS. 31, 34 (1997) (listing the potential benefits of increased information resources).

100. See *id.* (same).

101. See E.C. Schneider & T. Lieberman, *Publicly Disclosed Information About the Quality of Health Care: Response of the U.S. Public*, 10 QUALITY IN HEALTH CARE 96, 96 (June 2001) (explaining the irony that consumers do not appear to actually use the available information despite nations emulating the system).

102. See *id.* at 98–99 (listing the barriers to achieving a functioning health care market).

103. See *id.* (discussing the necessary consumer mindset to create an economically regulated health care market).

104. See *supra* Part I (considering hypothetical situation between Dr. Evil and Mr. Deville).

III. Exploring the Approaches of the State Courts¹⁰⁵

Most state courts have yet to address Mr. Deville's situation directly, and the minority of courts that have done so have taken remarkably divergent positions. Perhaps because the emphasis on patients acting as informed consumers has only recently developed, state courts have only decided a few cases similar to Mr. Deville's situation. Nonetheless, patients like Mr. Deville must be able to rely on the legal system to protect their right to such inquiries.

A. Informed Consent

The first state court to address a doctor's deceitful responses to patient inquiries upheld a patient's informed consent action against the doctor.¹⁰⁶ In *Johnson v. Kokemoor*,¹⁰⁷ the Wisconsin Supreme Court ruled on whether evidence that a physician had misrepresented his experience to his patient was admissible in an informed consent action.¹⁰⁸ The plaintiff's family physician referred her to the defendant, a neurosurgeon, for treatment of her frequent headaches.¹⁰⁹ The defendant diagnosed an enlarging aneurysm on Johnson's brain and recommended surgery.¹¹⁰ During surgery the defendant successfully clipped the aneurysm, but the surgery rendered Johnson an incomplete quadriplegic following the operation.¹¹¹ Prior to surgery, Johnson specifically asked the defendant about his experience in performing this type of operation; Kokemoor replied that he had performed the surgery "dozens" of times and "lots of times."¹¹² During discovery, the plaintiff learned that Kokemoor had in fact very limited experience with aneurysm surgery and had never operated on

105. When considering the following case law, one must remember that although the previous Part examined the history of informed consent, the current status of the doctrine's evolution varies from state to state.

106. See *Johnson v. Kokemoor*, 545 N.W.2d 495, 509 (Wis. 1996) (finding that evidence that a doctor misled the patient about his experience in performing surgery is admissible in an informed consent action).

107. *Johnson v. Kokemoor*, 545 N.W.2d 495 (Wis. 1996).

108. *Id.* at 498.

109. *Id.*

110. *Id.*

111. *Id.* at 499. Johnson remains unable to walk or to control her bowel and bladder movements; in addition, her vision, speech, and upper body coordination remain partially impaired. *Id.*

112. *Id.*

an aneurysm such as the plaintiff's.¹¹³ In addition, the plaintiff also introduced evidence that Kokemoor misrepresented the morbidity and mortality rate associated with this type of procedure.¹¹⁴

The Wisconsin Supreme Court began its analysis of the issue by tracing the history of the state's informed consent doctrine back to *Canterbury* and the reasonable patient standard.¹¹⁵ The court quoted *Canterbury* in defining a material risk as occurring when "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."¹¹⁶ In rejecting the defendant's proposed bright line rule that it is error as a matter of law in an informed consent case to admit evidence regarding the physician's experience, the court stressed that determining what information is reasonable for each patient involves examining the facts and circumstances of each case.¹¹⁷ The facts and circumstances of Johnson's surgery included evidence that Johnson made direct inquiry of the defendant's experience and that basilar bifurcation aneurysms are more difficult than any other type of aneurysm surgery and are among the most difficult procedures in all of neurosurgery.¹¹⁸ In its conclusion, the court cited to the plaintiff's brief, which admitted "[i]t is a rare exception when the vast body of medical literature and expert opinion agree that the difference in experience of the surgeon performing the operation will impact the risk of morbidity/mortality as was the case here."¹¹⁹ Thus, the court found that Johnson's direct inquiries of Kokemoor's experience together with the unusual complexity of this procedure caused evidence regarding his experience to be material under the facts and circumstances of this case.¹²⁰

The *Kokemoor* decision was the first case to discuss the relevance of a physician's experience to the informed consent doctrine, and the case spurred both criticism and praise.¹²¹ After *Kokemoor*, many plaintiffs and

113. *Id.*

114. *Id.*

115. *Id.* at 501.

116. *Id.* (quoting *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972)).

117. *Id.* at 504.

118. *Id.* at 505.

119. *Id.* at 510.

120. *Id.* at 505. In the original trial, the jury concluded that the defendant failed to inform the plaintiff adequately of the risks associated with her surgery and that a reasonable patient, if fully informed of the risks of the surgery, would have withheld consent from the defendant; thus, upholding the admission of such evidence affirmed the jury verdict in favor of Johnson. *Id.* at 497.

121. See Iheukwumere, *supra* note 31, at 402, 406 (calling the case an "audacious and

commentators have used the precedent in an attempt to make physician experience part of the mandatory disclosure required in all informed consent cases.¹²² However, a careful reading of *Kokemoor* does not support this position. *Kokemoor* only allows a jury to find a doctor's experience material under the particular facts and circumstances of this case—the patient directly inquired about his doctor's experience and experts agreed that because of the complexity of the surgery, physician experience impacted the likelihood of success.¹²³ On its facts, *Kokemoor* does not stand for the proposition that a doctor whose patient fails to inquire about his physician's experience level must disclose such information.¹²⁴ Furthermore, the decision does not even clearly establish that a patient who makes a direct inquiry of his physician's experience in a less complicated procedure would have a valid informed consent action.¹²⁵

The most recent case to consider a doctor's deceitful response to a query about his credentials also found the physician's misrepresentations to be actionable under informed consent.¹²⁶ In *Howard v. University of Medicine & Dentistry of New Jersey*,¹²⁷ the New Jersey Supreme Court considered the causes of action available when a patient contends that his physician misrepresented his credentials and experience at the time that the doctor obtained the patient's consent to surgery.¹²⁸ The plaintiff, Howard, had a history of cervical spine disease, and after he was involved in two automobile accidents, his treating physician referred him to the defendant to consider surgical options.¹²⁹ Howard had two pre-operative consultations with the defendant before consenting to surgery.¹³⁰ The plaintiff contended that during

well-reasoned ruling," but also noting that other commentators reacted to the case "with alarm, and attacked its foundation as unsound").

122. See *id.* at 407–13 (listing cases after *Kokemoor* deciding whether experience is material to informed consent).

123. See *supra* notes 109–18 and accompanying text (identifying facts of the case).

124. See *id.* (same).

125. See *id.* (same). The unique finding of *Kokemoor* is that physician-specific information can, under the right facts and circumstances, be material in an informed consent case. See *Johnson v. Kokemoor*, 545 N.W.2d 495, 504 (Wis. 1996) (rejecting defendant's proposed bright line rule that it is error as a matter of law to admit evidence in an informed consent case regarding a physician's experience).

126. See *Howard v. Univ. of Med. & Dentistry of N.J.*, 300 A.2d 73, 85 (N.J. 2002) (rejecting the plaintiff's fraud claim by stating that the action should be informed consent).

127. *Howard*, 300 A.2d at 73.

128. See *id.* at 75 (setting forth the issue in the case).

129. *Id.* at 75–76.

130. *Id.* at 76.

the consultation his wife asked Dr. Heary, the defendant, whether he was board certified and how many similar operations he had performed.¹³¹ The defendant responded that he was board certified and had performed approximately sixty corpectomies in each of the previous eleven years.¹³² The surgery was unsuccessful, and Howard filed a malpractice action.¹³³ During discovery, Howard learned that Heary was not board certified and that he had only performed "a couple dozen" corpectomies during his career.¹³⁴ Based on the new information, Howard unsuccessfully moved to amend his complaint to include a fraud action.¹³⁵

In examining the issue, the court looked to other state courts that had addressed this issue.¹³⁶ The court noted that Wisconsin allowed a claim based on lack of informed consent and that although several state courts hinted that a fraud-based claim would be appropriate, none had held to that effect.¹³⁷ The New Jersey Supreme Court concluded, "The thoughtful decision of the Appellate Division notwithstanding, we are not convinced that our common law should be extended to allow a novel fraud or deceit-based cause of action"¹³⁸ Interestingly, New Jersey precedent seemed to support Howard's fraud cause of action by naming an exception to the rule that any consent by a patient prevents a battery theory; the exception provided, "If consent was obtained by the use of fraud or misrepresentation, an action for battery may be appropriate."¹³⁹ The *Howard* court quickly distinguished this precedent stating that such an exception applies only when the misrepresentation "induced plaintiff to proceed with *unnecessary surgery*."¹⁴⁰ Because the physician's misrepresentation in this case may have misled Howard about material information needed to grant an informed consent, the court found, "Stripped to its essentials, plaintiff's claim is founded on lack of informed consent."¹⁴¹ Other jurisdictions have also used the fact that a misrepresentation related directly to the informed consent inquiry to distinguish

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.* at 76–77.

135. *Id.* at 77.

136. *Id.* at 81–82.

137. *Id.* at 82.

138. *Id.* at 82.

139. *Tonelli v. Khanna*, 569 A.2d 282, 286 (N.J. Super. Ct. App. Div. 1990).

140. *Howard v. Univ. of Med. & Dentistry of N.J.*, 300 A.2d 73, 83 (N.J. 2002) (emphasis added).

141. *Id.* at 84.

precedent supporting a potential battery action.¹⁴² Furthermore, the *Howard* court stressed its reluctance to allow such a claim when the damages from the fraud arise exclusively from the doctor-patient relationship involving the corpectomy procedure.¹⁴³ The court stated its unwillingness to allow a patient in Howard's position to pursue punitive damages or to circumvent the proof requirements of both causation and damages imposed by the traditional informed consent action.¹⁴⁴

After rejecting Howard's fraud claim, the court continued its analysis by examining the validity of an informed consent action under these facts.¹⁴⁵ The court traced New Jersey's history of informed consent establishing that New Jersey, like Wisconsin, uses the reasonable patient standard to determine what information a doctor must disclose.¹⁴⁶ Unlike the *Kokemoor* court, the New Jersey Supreme Court explicitly stated that informed consent does not normally include the duty to inform the patient of experience or credentials.¹⁴⁷ However, when the plaintiff specifically asks such questions, the court concluded a jury could reasonably find that the physician's misrepresentation of his experience was a material risk for the patient.¹⁴⁸ Directly after admitting the possibility of proving a valid informed consent action, the court continued by pointing out the "difficulty inherent in meeting the materiality standard required in order for physician experience to have a role in an informed consent case."¹⁴⁹ The court explained that a possibility of materiality exists if the defendant's true level of experience could enhance substantially the risk of paralysis from undergoing a

142. See *Paulos v. Johnson*, 597 N.W.2d 316, 320 (Minn. Ct. App. 1999) (stating that "because Johnson made the misrepresentations as precursors to Paulos's surgery, the claims present a pure informed consent issue"); see also *infra* notes 325–28 and accompanying text (discussing the "gravamen" of the claim theory).

143. See *Howard*, 300 A.2d at 84 (stating tort of fraud is actionable "only when the alleged fraud occurs separately from and subsequent to the malpractice . . . and then only where the fraud claim gives rise to damages separate and distinct from those flowing from the malpractice" (quoting *Spinosa v. Weinstein*, 571 N.Y.S.2d 747, 753 (N.Y. App. Div. 1991))).

144. *Id.*

145. *Id.* at 82–86.

146. *Id.* at 79.

147. See *id.* at 83 (noting that no court has ever found, nor does the court in this case hold, that a doctor has a duty to detail his experience as part of the required informed consent disclosure). *Kokemoor*'s failure to limit its holding explicitly to patients who specifically ask their physician about credentials and experience resulted in many commentators urging courts to interpret the case as creating a new disclosure duty. See *supra* notes 121–22 and accompanying text (explaining that some commentators have urged that courts use *Kokemoor* as a springboard to requiring mandatory disclosure of experience).

148. *Howard v. Univ. of Med. & Dentistry of N.J.*, 300 A.2d 73, 83 (N.J. 2002). Unlike *Kokemoor*, this court did not emphasize the complexity of the surgical procedure provided.

149. *Id.* at 84.

corpectomy; a jury could then find that a reasonably prudent patient would not have consented to the procedure had the physician not misrepresented his experience.¹⁵⁰ In addition, the two-pronged causation inquiry necessary for a successful claim will "impose a significant gatekeeper function."¹⁵¹ Although the New Jersey Supreme Court ultimately reached the same result as *Kokemoor*, the result for the plaintiff was very different. In *Kokemoor* the court accepted the plaintiff's proffered cause of action—informed consent; however, in *Howard* the court rejected the plaintiff's proffered cause of action, fraud, in favor of what the court viewed as the more difficult to prove cause of action, informed consent.¹⁵² Therefore, the court stated that Howard's only valid cause of action would be under informed consent and then explained that he was unlikely to prove such a case.¹⁵³

Disappointed patient advocates reacted negatively to the court's rejection of a separate fraud cause of action, calling the ruling disturbing.¹⁵⁴ Bruce Nagel, attorney for Howard, commented on the ruling claiming that "[i]t created a shield It insulates doctors when they lie to patients."¹⁵⁵ Noting the apparent inequitable treatment of medical consumers, Nagel stated, "You can win damages for fraud from a salesman who lied about the capabilities of a refrigerator or a car, but you can't sue a doctor for fraud when you hire him because he lies about his credentials and you become a quadriplegic."¹⁵⁶ In contrast, Matthew Schorr, the attorney representing the defendant doctor, explained the ruling as "mean[ing] physicians can continue defending claims on merits rather than frivolous claims going forward. This decision refocuses the

150. *Id.*

151. *See id.* at 85 (stating that the misrepresented experience of the defendant must substantially increase a plaintiff's risk of paralysis from undergoing the procedure and that this substantially increased risk must cause a reasonably prudent person not to consent to undergo the procedure).

152. *See id.* (rejecting a fraud claim in favor of the informed consent action so long as it is consistent with the court's stringent requirements). Furthermore, unlike *Howard*, the decision in *Kokemoor* did not specifically reject a separate fraud cause of action. *See Johnson v. Kokemoor*, 545 N.W.2d 495, 497 (Wis. 1996) (identifying issue of the case as whether a doctor's failure to accurately disclose information was material to an informed consent case).

153. *Howard*, 300 A.2d at 82.

154. *See* Tanya Albert, *Dispute over Credentials Not a Case of Fraud*, AMNEWS, July 22, 2002 (reporting reactions to the New Jersey Supreme Court decision), <http://www.ama-assn.org/amednews/2002/toc0722.htm> (last visited Sept. 13, 2003) (on file with the Washington and Lee Law Review).

155. *Id.*

156. Henry Gottlieb, *No Cause of Action in Fraud When Doctors Lie About Their Credentials in New Jersey*, THE LEGAL INTELLIGENCER, June 27, 2002, at 4.

attention on medicine, where it should be."¹⁵⁷ The postcase comments are striking when compared to the *Kokemoor* outcome because what the Wisconsin Supreme Court viewed as a victory for the plaintiff, lawyers in the *Howard* case viewed as a devastating defeat to the plaintiff.¹⁵⁸

B. Fraud

Although an informed consent action may be available for Mr. Deville in some jurisdictions, he may also have the opportunity to plead a fraud action against Dr. Evil. The fraud cause of action allows a better opportunity for recovery because a fraud action would focus on physicians' lies, not on their medical abilities.¹⁵⁹ The Restatement (Second) of Torts states that consent does not protect against liability for invasion or harm when a person is induced to consent by another's misrepresentations.¹⁶⁰ The physician-patient relationship is a fiduciary one; therefore, the court must judge a doctor's representations to his patient by the high standard applicable to fiduciaries.¹⁶¹ A doctor's liability for misrepresentation or failure to state the facts adequately can legally void the patient's formally expressed consent to a procedure, allowing the procedure to be actionable as an assault and battery.¹⁶² Because fraud vitiates the patient's consent, the claim resembles the early consent cases in which a doctor performed a procedure without any consent.¹⁶³ This action fundamentally differs from the typical negligence informed consent action that focuses upon the information disclosed. To prove a claim of fraudulently obtained consent, the patient must establish that the physician made a material misrepresentation of fact, knowing it to be false.¹⁶⁴ Because fraud vitiates the patient's consent, a

157. Albert, *supra* note 154.

158. *See id.* (explaining that the plaintiff's attorney found the informed consent action "virtually impossible to prove" under the court's ruling).

159. *See* Gottlieb, *supra* note 156, at 4, 7 (explaining fraud claim as focusing on the damages caused by the deceit).

160. *See* RESTATEMENT (SECOND) OF TORTS § 892B(2) (1979) (explaining the rule for consent under misrepresentation); 6A C.J.S. *Assault & Battery* § 16 (2002) (same).

161. *See* 1 DAVID W. LOUISELL & HAROLD WILLIAMS, *MEDICAL MALPRACTICE* § 8.10[2] (2002) (explaining basis for fraud recovery against a physician).

162. *See id.* (explaining fraud as a theory of recovery against physicians).

163. *See supra* notes 40–48 and accompanying text (discussing early cases that allowed patients a battery action when the doctor operated without consent).

164. *See* ROZOVSKY, *supra* note 88, at 1:14 (explaining the proof requirements of a fraud action against a physician).

court can charge a doctor with battery after finding the doctor guilty of fraudulently receiving the patient's consent.¹⁶⁵

Although the New Jersey Supreme Court disallowed a patient's fraud claim, the Wisconsin Supreme Court did not specifically address whether a patient could bring an action in fraud.¹⁶⁶ However, in its analysis of informed consent, the court acknowledged the overlap between actions in misrepresentation and informed consent, stating that the "allegations made and evidence introduced by the plaintiff might have fit comfortably under either theory."¹⁶⁷ Thus, *Kokemoor's* acceptance of an informed consent action under limited facts and circumstances did not preclude a fraud action.¹⁶⁸

Prior to the unanimous decision of the New Jersey Supreme Court, the Appellate Division of the New Jersey Superior Court believed that Howard could bring a valid cause of action in fraud under New Jersey law.¹⁶⁹ The intermediate appellate court compared Howard's consent to cases involving "ghost surgery," or when a patient consents to one doctor performing surgery but in reality another doctor performs the operation.¹⁷⁰ In a prior New Jersey case involving ghost surgery, the New Jersey Supreme Court allowed a battery cause of action observing, "Even more private than the decision who may touch one's body is the decision who may cut it open and invade it with hands and instruments Few decisions bespeak greater trust and confidence than the decision of a patient to proceed with surgery."¹⁷¹ In ghost surgery, a battery action is appropriate because the patient never gave consent for the particular surgeon to operate.¹⁷² Similarly, the court found that Dr. Heary did not have Howard's permission to operate because Howard only consented to a doctor of significantly greater experience.¹⁷³ In essence, the appellate court found that Dr. Heary, in lying about his qualifications and experience, misled Howard about the true identity of the physician who would perform the surgery.¹⁷⁴ Therefore, unlike the New Jersey Supreme Court, the Appellate Division did not force Howard to establish the difficult causation standard required by

165. See *Howard v. Univ. of Med. & Dentistry of N.J.*, 768 A.2d 195, 198 (N.J. Super. Ct. App. Div. 2001) (using fraud to vitiate patient's consent and create a battery action).

166. See *supra* notes 123–25 and accompanying text (clarifying the finding of *Kokemoor*).

167. *Johnson v. Kokemoor*, 545 N.W.2d 495, 504 n.29 (Wis. 1996).

168. See *id.* (discussing viability of fraud claim).

169. *Howard*, 768 A.2d at 198.

170. *Id.* at 197.

171. *Id.* (quoting *Perna v. Pirozzi*, 457 A.2d 431, 437 (N.J. 1983)).

172. *Id.* at 198.

173. *Id.*

174. *Id.*

informed consent because it found that Howard had a valid fraud cause of action.¹⁷⁵

In *Duttry v. Patterson*,¹⁷⁶ the Pennsylvania Supreme Court expressly rejected the plaintiff's informed consent claim, stating that the proper action would be one of fraud.¹⁷⁷ Because the patient did not bring a fraud action against the doctor, the sole issue before the court was whether the lower court erred as a matter of law in determining that a doctor's misrepresentations regarding his qualifications and experience were relevant to an informed consent claim.¹⁷⁸ The plaintiff's family physician had recently diagnosed her with esophageal cancer and recommended that she consult with Dr. Patterson, the defendant, regarding whether she needed surgery.¹⁷⁹ During this consultation, Duttry questioned Dr. Patterson regarding his experience in performing the recommended surgery.¹⁸⁰ Dr. Patterson told Duttry that he performed this type of procedure approximately once every month.¹⁸¹ Relying upon this information, Duttry consented to the surgery.¹⁸² Dr. Patterson performed the procedure on June 5, 1989, and three days later a leak developed that ruptured necessitating emergency surgery, which eventually led to Duttry developing further complications including permanent damage to her lungs.¹⁸³

After bringing suit for medical malpractice, the plaintiff discovered that Patterson had in fact only performed the procedure nine times in the preceding five years.¹⁸⁴ At trial, Duttry sought to introduce this evidence, but the trial court found the evidence inadmissible because it was not relevant to the informed consent claim.¹⁸⁵ The intermediate appellate court reversed acknowledging that a physician's experience is not normally relevant, but finding that this information is material to an informed consent claim when the particular patient raises specific questions regarding that experience.¹⁸⁶

175. *See id.* (explaining that Howard, once he established fraud, would have a battery action and would not need to establish the difficult causation issues associated with informed consent).

176. *Duttry v. Patterson*, 771 A.2d 1255 (Pa. 2001).

177. *See id.* at 1259 (refusing to expand the doctrine of informed consent into a catch-all doctrine).

178. *Id.* at 1257.

179. *Id.* at 1256.

180. *Id.*

181. *Id.* at 1256-57.

182. *Id.* at 1257.

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.*

The Pennsylvania Supreme Court began its analysis with a discussion of the informed consent doctrine, noting that the doctrine requires physicians to provide patients with material information necessary to determine whether to proceed with the procedure.¹⁸⁷ The court explained that the "material information" the physician must disclose requires that the physician "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."¹⁸⁸ Furthermore, the court noted that information particular to the surgeon, rather than information concerning the procedure itself, was generally not relevant to an informed consent claim.¹⁸⁹

In refusing to distinguish such precedent on the basis of Dr. Patterson's intentional misrepresentations in response to his patient's specific questions, the court noted that the doctrine of informed consent is a limited one focusing only on imparting information relative to the surgery itself.¹⁹⁰ The Pennsylvania Supreme Court found the fact that the patient inquired about his physician's experience irrelevant because the doctrine is based on an objective standard that only requires disclosure of what a *reasonable person* would want to know; therefore, the court concluded that mandatory disclosure under informed consent "does not shift depending on how inquisitive or passive the particular patient is."¹⁹¹ In rejecting Duttry's informed consent action, the court noted that a physician who misleads a patient is not immune from all lawsuits, by noting that "we are merely stating that the doctrine of informed consent is not the legal panacea for all damages arising out of any type of malfeasance by a physician."¹⁹² In cases in which the physician provides inaccurate information regarding his qualifications and experience in performing a procedure, the patient should pursue a cause of action for misrepresentation.¹⁹³

The decision by the Pennsylvania Supreme Court was largely in accord with the amicus brief submitted by the Pennsylvania Medical Society (PAMS), a nonprofit corporation formed by members of the medical profession to participate in matters of concern to physicians and their patients.¹⁹⁴ The brief

187. *Id.* at 1258.

188. *Id.* (quoting *Gouse v. Cassel*, 615 A.2d 331, 334 (Pa. 1992) (emphasis added)).

189. *Id.* at 1259.

190. *Id.*

191. *Id.*

192. *Id.*

193. *Id.*

194. See Brief for Amicus Curiae Pennsylvania Medical Society at 1–2, *Duttry v. Patterson*, 771 A.2d 1255 (Pa. 2001) (No. 69 MD 2000) [hereinafter *Amicus Brief*] (explaining the purpose of the brief).

acknowledged that physicians should allow a patient to question them about issues of concern and that physicians should provide accurate information in response; however, the brief opposed expanding informed consent to cover these issues.¹⁹⁵ In opposition to allowing an informed consent claim, PAMS emphasized that informed consent, since its inception in Pennsylvania jurisprudence, has always focused on the surgical procedure at issue, not on the surgeon's personal characteristics.¹⁹⁶ The brief argued that holding physicians liable under the doctrine in response to direct questions about their credentials or personal problems necessarily replaces the objective patient standard with the widely rejected subjective patient standard.¹⁹⁷ In explaining the policy concerns of such a limitless obligation, PAMS stated, "Once informed consent is unmoored from its focus on the benefits and complications of surgery, physicians can have no certainty that they are complying."¹⁹⁸ But by remaining focused on the procedure itself, not only can courts more easily administer the standard, but surgeons are able to ensure the simple and accurate conveyance of information about the procedure in a standard manner.¹⁹⁹ Because the specific issue of whether a fraud action should exist for Duttry was not before the court, the brief does not state a position; however, PAMS does recognize that other actions against the physician would be proper.²⁰⁰

The Pennsylvania Supreme Court's rejection of an informed consent action in favor of allowing a fraud suit outraged at least one commentator.²⁰¹ Brad Rostolsky stated that a doctor cannot obtain a patient's true consent when the doctor misrepresents information in response to patient inquiries.²⁰² Courts designed the doctrine of informed consent to ensure that doctors disclose all information material to the reasonable patient.²⁰³ Because scientific studies consistently show that better surgical outcomes result from physicians who

195. *Id.* at 11 (stating PAMS's position on the issue).

196. *Id.* at 12–16 (tracing history of informed consent in Pennsylvania jurisprudence).

197. *Id.* at 10 (noting that such a holding would impose a limitless obligation on the doctor to disclose all information any patient may deem material).

198. *Id.*

199. *Id.* at 17–18 (noting that such a ruling would create a "moving platform" of physicians' standards of disclosure).

200. *Id.* at 19–20 (noting that a misrepresentation action would be more proper).

201. See Brad M. Rostolsky, Comment, *Practice Makes Perfect: Experience-Related Information Should Fall Within the Purview of Pennsylvania's Doctrine of Informed Consent*, 40 DUQ. L. REV. 543, 559 (2002) (stating that the fraud doctrine is inadequate to protect patients from physicians' deceit).

202. *Id.* at 556–57 (noting that it is clear that informed consent is not met by providing false information).

203. *Id.* at 544–47 (explaining the informed consent doctrine).

possess greater experience, Rostolsky finds unappealing the court's refusal to accept that a physician's experience would concern a reasonable patient.²⁰⁴ Rostolsky found the court's intimations about a fraud action unsatisfactory because fraud actions, unlike informed consent, have not been "tailored through years of judicial interpretation to address the intricacies of doctor-patient interaction."²⁰⁵ Thus, at least one commentator finds the rejection of an informed consent action in favor of allowing fraud actions unsatisfactory.

The *Duttry* case is particularly interesting today because of new tort reform legislation enacted after the case by the Pennsylvania legislature. The legislation explicitly provides a statutory informed consent action for patients whose physician knowingly misrepresents his or her professional credentials, training, or experience.²⁰⁶ Therefore, the state legislature apparently has also rejected the court's reliance on common law fraud to protect adequately patients whose doctors misrepresent their credentials or experience.²⁰⁷

In addition to the *Duttry* case, a few other courts have briefly addressed the issue of whether a physician is liable for fraud by misrepresenting his credentials in dealing with other issues. The United States District Court for the District of Maryland refused to allow a plaintiff to bring an informed consent action under the Federal Tort Claims Act (FTCA) when the claim centered on allegations that a Navy physician misrepresented his experience.²⁰⁸ The FTCA does not waive sovereign immunity for claims involving misrepresentations.²⁰⁹ The court found that "misrepresentations peculiar to the person of the surgeon or physician are just that—misrepresentations—and cannot be brought under the FTCA by recasting them in the guise of a negligence action based on lack of informed consent."²¹⁰ Thus, the federal court decided that the patient's informed consent claim was nothing more than artful pleading to avoid sovereign immunity.²¹¹ Additionally,

204. *Id.* at 557 (stating that the scientific and medical communities have recognized experience-related information as valuable information).

205. *Id.* at 558.

206. See 40 PA. CONS. STAT. ANN. § 1303.504(d)(2) (West 2002) (providing an informed consent action for future plaintiffs similar to *Duttry*).

207. No party has used the statute, and it remains to be seen whether its existence will preclude a patient from seeking recovery under a common law fraud claim.

208. See *Wachter v. United States*, 689 F. Supp. 1420, 1421 (D. Md. 1988) (refusing to allow the claim under the FTCA).

209. See *id.* (stating that FTCA excludes misrepresentation claims from waiver of sovereign immunity).

210. *Id.*

211. Ironically, most plaintiffs face the reverse problem—courts finding that fraud claims are artful pleadings designed to avoid the stricter proof requirements of informed consent. See *infra* notes 325–28 and accompanying text (explaining the "gravamen" of the claim theory).

in North Carolina, a man brought an action against his physician for misrepresenting his prior medical experience as it related to performing the surgical procedure.²¹² Unfortunately, the court failed to reach a final ruling because the defendant was able to prove that the statute of limitations barred the claim.²¹³ Therefore, despite the consideration of a fraud claim by several courts, no court has expressly allowed a fraud action against a doctor misrepresenting his credentials.

C. Consumer Protection Statutes

In addition to pursuing recovery under a common law fraud claim, some states may allow Mr. Deville to pursue a claim under the state's consumer protection statute covering unfair and deceptive trade practices. Traditionally, these consumer protection statutes exempted the "learned professions," including physicians, lawyers, and priests.²¹⁴ However, in 1979, the United States Supreme Court held that no blanket exemption existed to protect these professions under the Federal Trade Commission Act (FTC Act).²¹⁵ Because states modeled their consumer protection statutes after the FTC Act, some states have attempted to clarify their own statutes in the wake of the Supreme Court ruling.²¹⁶ A few states responded by specifically excluding the learned professions from coverage by statute.²¹⁷ In other states, the courts continued to exempt the learned professions because self-regulating boards already governed such professions.²¹⁸ However, most states have allowed courts to decide on a case-by-case basis whether learned professionals are engaging in trade or commerce subject to state consumer protection statutes.²¹⁹

The Washington Supreme Court was the first state court to allow a patient to pursue a deceptive trade practices claim against her physician.²²⁰ Although

212. See *Foard v. Jarman*, 378 S.E.2d 571, 576 (N.C. Ct. App. 1989) (explaining plaintiff's claim), *vacated on other grounds by* 387 S.E.2d 162 (N.C. 1990).

213. See *id.* (dismissing the case due to statute of limitations).

214. See *Malpractice*, *supra* note 20, at 338 (explaining history of state unfair and deceptive trade practice statutes).

215. See *Goldfarb v. Va. State Bar*, 421 U.S. 773, 787-88 (1975) (finding no blanket exemption for lawyers).

216. See *Malpractice*, *supra* note 20, at 339 (explaining state reaction to *Goldfarb*).

217. See *id.* (noting that North Carolina, Ohio, and Maryland statutorily excluded the learned professions).

218. See *id.* (explaining another approach that states have taken following *Goldfarb*).

219. See *id.* (explaining majority approach).

220. See *id.* at 341 (discussing the extension of consumer statutes to cover physicians).

several other courts have since allowed such claims, these courts have all struggled with drawing a line between claims relating to entrepreneurial aspects of the medical practice, which a consumer protection statute allows, and claims arising out of a doctor's negligence, which plaintiffs must bring under a medical malpractice claim.²²¹ All states agree that claims grounded in a doctor's negligence are properly brought as medical malpractice actions and not deceptive trade practices claims.²²² Therefore, whether such states would allow Mr. Deville's claim depends on whether the court finds a misrepresentation of a doctor's experience in response to a patient's direct question to be an entrepreneurial aspect of the practice of medicine.

The Texas Court of Appeals allowed a patient to bring suit under the state consumer protection statute when her doctor made false and misleading statements.²²³ The court concluded that knowing misrepresentations are not within the plain meaning of negligence and that a plaintiff can bring such claims under the state's consumer protection act.²²⁴ In a previous case, the same court allowed a consumer protection claim against a dentist for exaggerating his expertise in wisdom tooth extraction.²²⁵

In contrast, the New York Court of Appeals has taken a narrower view of entrepreneurial activity. The New York court allowed plaintiffs' claim against the operators of an *in vitro* fertilization program for misrepresenting success rates and health risks associated with the procedure.²²⁶ In dictum, the court emphasized the importance of the plaintiffs' proof that the defendants had disseminated such false information to the public through promotional materials, advertisements, and slide presentations at seminars.²²⁷ The court distinguished these plaintiffs from a victim of deception in a single transaction

221. See *id.* at 341–46 (listing state courts that have included physicians within consumer protection statutes).

222. See *id.* at 345 (noting that the decisions by state courts that do not exempt physicians from consumer protection liability will only allow claims related to the entrepreneurial aspects of the practice of medicine).

223. See *Rhodes v. Sorokolit*, 846 S.W.2d 618, 621 (Tex. App. 1993) (allowing a claim based upon a doctor's knowing misrepresentations to his patient).

224. See *id.* (same).

225. See *Chapman v. Wilson*, 826 S.W.2d 214, 219–20 (Tex. App. 1992) (allowing a patient's consumer protection claim against doctor for knowing misrepresentations).

226. See *Karlin v. IVF Am., Inc.*, 712 N.E.2d 662, 666 (N.Y. 1999) (refusing to allow a blanket exemption for providers of medical services and finding plaintiffs' claim of lack of informed consent separate and distinct from the consumer protection issue).

227. See *id.* at 667 (explaining the reason that plaintiffs' claim constituted entrepreneurial activity governed by the statute). But see *Taylor v. Medenica*, 479 S.E.2d 35, 44 (S.C. 1996) (defining entrepreneurial activity as an action capable of repetition by the defendant in the future that thus meets the public interest requirement).

in which the only parties truly affected by an alleged misrepresentation would be the plaintiff and defendant.²²⁸ Therefore, even states that do not exempt physicians from their consumer protection statutes may limit liability to a narrow definition of entrepreneurial activity.

At least two states, Ohio and Pennsylvania, have refused to apply consumer protection statutes to physicians. However, one commentator finds these cases distinguishable from court decisions in other states.²²⁹ In Pennsylvania, the court refused to allow a patient to sue her physician for an unsuccessful surgery for weight loss based on the doctor's statements of probable results.²³⁰ Flynn argues that the plaintiff in the Pennsylvania case failed to properly emphasize the entrepreneurial aspects of the practice of medicine and the business aspects of a physician's statements to his patient.²³¹ Although consumer protection statutes offer plaintiffs another possible cause of action, state application of such statutes to physicians remains uncertain.²³²

IV. Policy and Analysis

Mr. Deville's questioning of Dr. Evil prior to his operation is precisely the behavior many commentators and market economists believe can curb the alarming rate of medical error in the American health care system.²³³ Part III examined the various approaches state courts have taken in response to patients similar to Mr. Deville. This Part analyzes the advantages and disadvantages of adopting a fraud cause of action instead of relying solely on the informed consent doctrine.

Informed consent and fraudulent misrepresentation protect against two different kinds of wrongful acts.²³⁴ Commentators praise *Kokemoor* and its

228. See *Karlin*, 712 N.E.2d at 667 (distinguishing this case from Pennsylvania cases that refused to allow a consumer protection claim).

229. See *Malpractice*, *supra* note 20, at 343-45 (discussing cases refusing to include physicians in consumer protection statutes).

230. See *id.* at 344-45 (explaining facts of Pennsylvania case).

231. See *id.* (stating that plaintiff failed to argue the entrepreneurial aspects of the practice of medicine).

232. See *Unfair Business Practices*, *supra* note 20, at 50 (noting that although the application of Florida's Unfair Trade Practice statute to physicians is uncertain, consumer statutes like Florida's are underutilized when it comes to pursuing the business practices of doctors).

233. See *supra* notes 6-13, 90-98 and accompanying text (explaining the need for patients to become informed medical consumers).

234. See ROZOVSKY, *supra* note 88, § 1.3.3, at 1:16 ("There is a difference between a case premised on lack of informed consent and one that is based on misrepresentation or deceit.").

progeny for allowing informed consent to cover the experience and qualifications of surgeons and hope such cases will lead to a new revolution in informed consent.²³⁵ Instead of focusing solely upon informed consent, this Note attempts to look at the possibility of using another cause of action under existing tort law that would apply to the specific fact pattern in *Kokemoor* and its progeny. First, this Part analyzes the benefits of using a fraud action under the mechanics of current tort law. Second, this Part demonstrates through public policy arguments that a fraud action is a more acceptable solution than creating a broader informed consent action.

A. *The Principles of Fraud and Informed Consent*

Fraudulent misrepresentation is a stand-alone tort that recognizes an action for harms resulting from misinformation even without a showing of physical injury.²³⁶ Courts list between four and nine elements of the common law tort, but they agree in substance that the plaintiff must prove (1) an intentional misrepresentation (2) of fact or opinion (as distinct from a promise) (3) that is material and (4) intended to induce and (5) that does induce reasonable reliance by the plaintiff, (6) proximately causing pecuniary harm to the plaintiff.²³⁷ Fraudulent misrepresentations relied upon by a plaintiff can also negate consent.²³⁸ By voiding the patient's formally expressed consent to a procedure, fraud allows the patient to bring an action for battery based on an unconsented touching.²³⁹ A fraud action properly focuses the court's decision on whether the physician actually had legal consent to perform the procedure. Courts should judge the act of obtaining consent to a surgical procedure based on the actual interaction between the physician and the patient.²⁴⁰ Therefore, because proof of fraud voids consent, a fraud action prevents a person from obligating

235. See, e.g., Aaron D. Twerski & Neil B. Cohen, *The Second Revolution in Informed Consent: Comparing Physicians to Each Other*, 94 NW. U. L. REV. 1, 1 (1999) (stating that a revolution in informed consent is brewing).

236. See DAN B. DOBBS, *THE LAW OF TORTS* § 469 (2000) (explaining the definition of fraudulent misrepresentation).

237. See *id.* § 470 (listing the elements of fraudulent misrepresentation).

238. See *id.* § 100 (stating that misrepresentation nullifies consent).

239. See 1 LOUISELL & WILLIAMS, *supra* note 161, § 8.10[2] (identifying possible basis of liability upon a finding of physician fraud).

240. For example, if a physician made all required disclosures to a drunken patient and then had him sign that he consented to a nonurgent procedure, the consent suit could be brought as a battery because there was no legal consent. See DOBBS, *supra* note 236, § 98 (stating that consent is invalid from an intoxicated person).

herself based on false information and provides a legal remedy to a patient that has a different surgeon than the surgeon she intended to perform the procedure.²⁴¹

In contrast, the typical informed consent action focuses on whether the information disclosed to the patient was satisfactory. A negligence standard applies to determine whether the physician disclosed all material information about the nature of a proposed procedure.²⁴² Informed consent recognizes patients' need to weigh the procedure's risks, benefits, and alternatives.²⁴³ Most jurisdictions, either by statute or case law, have attempted to define the necessary disclosures.²⁴⁴ Although states vary as to whether they define the scope of the duty using either a physician or prudent patient standard, both standards rely on a finding that the information is "reasonably" necessary to a patient's decision to undergo the procedure.²⁴⁵ Although courts have supported a patient's right to information about the procedure, courts have been much less likely to enforce a patient's right to information about the surgeon.²⁴⁶ Typical informed consent litigation occurs as a result of doctors' nondisclosure of information that state law deems necessary as a minimum level of information every patient should know before agreeing to a procedure.²⁴⁷ Courts have not adopted a pure subjective standard because of fears that a patient would always claim that the undisclosed information was so important to her that she would have declined treatment.²⁴⁸ Therefore, the informed consent doctrine's purpose is to provide standard information to all patients in an attempt to increase patient autonomy.²⁴⁹

241. FOWLER V. HARPER ET AL., THE LAW OF TORTS § 3.10 (3d ed. 1996) (stating that no person is bound by consent if the consent is obtained by a misrepresentation).

242. See DOBBS, *supra* note 236, § 250 (explaining principles of informed consent).

243. See Amicus Brief, *supra* note 194, at 14 (identifying traditional focus of informed consent).

244. See 3 LOUISELL & WILLIAMS, *supra* note 161, § 22.05 (explaining how states determine the scope of physicians' duty of disclosure).

245. See *supra* notes 40–70 and accompanying text (explaining how the scope of disclosure has developed and is currently defined under both the physician and the reasonable patient standards).

246. See Twerski & Cohen, *supra* note 65, at 29 (explaining that courts generally do not find provider-specific information material in informed consent cases).

247. See Shultz, *supra* note 14, at 226–27 (explaining purpose of informed consent litigation).

248. See 1 FURROW ET AL., *supra* note 43, at 319 (identifying reasons why courts have refused to adopt a subjective standard of disclosure).

249. See *id.* at 347–48 (identifying the effects informed consent has created in the medical profession).

Because of the doctrine's negligence standard, informed consent does not offer adequate protection to a deceived patient whose doctor deliberately provided false answers to patient inquiries.²⁵⁰ Informed consent is not a flexible doctrine. Indeed, Grant Morris criticized the doctrine's inflexibility stating, "The real concerns of a flesh-and-blood patient are of no concern to the courts if a hypothetical being would not consider them material."²⁵¹ Because Mr. Deville's situation is analogous to the patient who endures a surgical procedure without any consent, a fraud cause of action, which would allow Mr. Deville to bring a battery action, is the most appropriate cause of action. Judge Cardozo's powerful words apply directly to Mr. Deville's situation, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages."²⁵² Dr. Evil's misrepresentation voided the consent provided by Mr. Deville and a battery action is appropriate. State courts have recognized liability for battery when the surgeon who performs the procedure is not the surgeon that the patient authorized.²⁵³ When a surgeon performs a procedure after misrepresenting his experience, the situation is analogous to "ghost surgery."²⁵⁴ One commentator noted that these decisions reserve battery "for cases of deliberate, material deviation from the patient's consent."²⁵⁵ Mr. Deville's situation is fundamentally different from the typical informed consent action where a surgeon fails to disclose the required information.²⁵⁶ In addition, a comparison between the causation requirements and the specific injury redressed by informed consent and fraud actions further reveals the inadequacy of an informed consent action under Mr. Deville's circumstances.

250. See Morris, *supra* note 37, at 368–71 (acknowledging the limits of current informed consent law).

251. *Id.* at 368.

252. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914), *overruled on other grounds* by Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957).

253. See, e.g., Perna v. Pirozzi, 457 A.2d 431, 438 (N.J. 1983) (finding a battery action for "ghost surgery"); Pugsley v. Privette, 263 S.E.2d 69, 74 (Va. 1980) (same).

254. See *supra* notes 169–75 and accompanying text (discussing the rationale behind the New Jersey Superior Court's decision to affirm a fraud claim).

255. Thomas Lundmark, *Surgery by an Unauthorized Surgeon as a Battery*, 10 J.L. & HEALTH 287, 293 (1995–1996).

256. See *id.* at 292 (stating that "the quantum level of the case is distinguishable from the next class of cases in which the surgeon fails to reveal all of the risks of the surgery").

1. Causation

In an informed consent action, even assuming a patient can establish that a doctor withheld information regarding a material risk, two difficult causation questions remain as barriers to the patient's recovery.²⁵⁷ A plaintiff first must establish injury causation, which requires that the plaintiff prove to the jury that the plaintiff's decision to undergo the procedure resulted in harm that would not have otherwise occurred if the plaintiff had made a different choice.²⁵⁸ Proving injury causation requires conjecture about both what alternate procedure the doctor may have performed and the risks of such an alternate procedure.²⁵⁹ Injury causation exists because courts cannot base negligence damages on deprivation of patient autonomy alone; only physical injuries resulting from an increase in the risk of harm are compensable.²⁶⁰

Arguably, requiring a patient to prove her injury would not have occurred if she had chosen a surgeon with more experience is an unfair burden on the patient. Although studies demonstrate a correlation between doctor experience and success of an operation, such a statistical study may not convince a jury that more likely than not the injury would not have happened had the patient used a different physician.²⁶¹ Because of the patient's right to bodily integrity, a patient should be able to choose the risks she takes without regard to whether her choices are more likely than not to prevent an injury. Unlike an informed consent claim, establishing a fraud claim vitiates the plaintiff's consent and allows a battery action for unconsented touching.²⁶² Under a battery theory, the patient may recover all damages resulting from the unconsented touching without a showing of injury causation.²⁶³

In addition to proving injury causation, a patient must also establish decision causation to recover successfully in an informed consent action.²⁶⁴ Decision causation requires proving to the jury that a

257. See Twerski & Cohen, *supra* note 235, at 9 (noting that establishing that a doctor withheld material risk is not the most difficult part of an informed consent action).

258. See *id.* (defining injury causation).

259. See *id.* at 9–10 (identifying the uncertainty in establishing injury causation).

260. See *id.* at 10–11 (explaining the need for injury causation).

261. See *id.* (same).

262. See 1 LOUISELL & WILLIAMS, *supra* note 161, § 8.10[2] (identifying the possible basis of liability upon a finding of physician fraud).

263. See *id.* (explaining the advantages of using a battery theory for patients).

264. See Twerski & Cohen, *supra* note 235, at 9 (identifying second causation problem).

"reasonable patient" supplied with the omitted information would not allow the physician to perform the recommended procedure.²⁶⁵ This objective decision causation rule is unique to medical informed consent cases; in a normal negligence case, establishing the defendant's breach and its causal role in injuring the plaintiff would be enough.²⁶⁶ After describing decision causation, Dan Dobbs commented, "the rule does not reflect the [normal negligence] causation requirement but imposes some additional and most unusual obstacle."²⁶⁷ Another commentator has observed that the causation principles of informed consent have mutated "what began as a concern for individual autonomy almost necessarily comes to be subjected to standardizing and oversimplifying criteria that are alien to individuality."²⁶⁸ Nonetheless, arguments that this "reasonable patient" requirement undercuts the goal of patient autonomy have failed to eliminate the requirement.²⁶⁹

Under a fraud claim, the patient must prove only that she in fact relied upon the misrepresentation.²⁷⁰ Dobbs explains that to prove reliance the patient must prove that she chose the procedure because of, or partly because of, the representation.²⁷¹ Thus, under a fraud cause of action, the patient's subjective reliance is sufficient. Therefore, unlike an informed consent action, fraud protects patients who take the initiative to gather information above and beyond the information a "reasonable" patient would deem necessary.

265. *See id.* (explaining decision causation). But if the recommended procedure was so risky in comparison to its potential benefits that most reasonable patients would refuse such an operation, the doctor's act of recommending the procedure would almost certainly constitute a straightforward medical malpractice action for negligent treatment rather than one for lack of informed consent. *Id.* Thus, to bring a "true" informed consent case, the patient presupposes that the doctor acted reasonably in choosing the recommended treatment. *Id.* But, this assumption makes establishing decision causation difficult because "reasonable patients generally follow the nonnegligent recommendations of their reasonable doctors." *Id.*

266. *See* DOBBS, *supra* note 236, § 250 (stating that the required decision causation for informed consent is unique to such cases).

267. *Id.*

268. Shultz, *supra* note 14, at 250.

269. *See* Twerski & Cohen, *supra* note 235, at 8–9 (acknowledging courts' refusal to accept patient autonomy arguments).

270. *See* DOBBS, *supra* note 236, § 474 (identifying requirement of reliance).

271. *See id.* (defining the reliance requirement).

2. *Compensable Injury*

Informed consent forces physicians to disclose routine information about a pending procedure, but the doctrine does not fully protect individual autonomy.²⁷² Under informed consent, the only injury that constitutes a compensable harm is an adverse medical outcome; informed consent provides no cause of action for a plaintiff whose surgery is successful.²⁷³ Because of the generally low level of treatment risks, the vast majority of potential plaintiffs in such a cause of action still cannot litigate because they lack the required injury.²⁷⁴ Requiring an adverse medical outcome fails to protect the patient's right to personal autonomy over his own body. Medical uncertainty necessitates many choices of patient treatment options, and values outside of medicine shape these decisions.²⁷⁵ Shultz finds that the reasoning behind requiring an adverse medical outcome "reflects a pervasive fear that plaintiffs making such claims will recover when they have not 'really' been injured, or that doctors will be held liable when they have not 'really' done anything wrong."²⁷⁶ Although such a policy argument may be applicable to a typical informed consent case, no person can claim that a doctor has not done anything "really" wrong by intentionally deceiving his patient with misinformation. A deceived patient suffers an injury to his personal autonomy rights at the time the surgery occurs because a surgeon other than the one the patient intended to hire is operating on his body. Informed consent fails to protect against such harms.

In contrast, under a fraud action, proof of a physician's fraudulent misrepresentation allows a patient to bring an action in battery for an unconsented touching regardless of physical injury.²⁷⁷ The battery action better protects patient autonomy because battery actions do not provide physicians a defense based upon the medical outcome.²⁷⁸ The physician is liable for physical harms resulting from the battery, but he is also liable for his

272. See Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 925-26 (1994) (noting the doctrine's inconsistency with a commitment to individual autonomy).

273. See *id.* at 925 (identifying the source of compensation in an informed consent suit).

274. See *id.* at 936 (explaining that potential plaintiffs often cannot successfully litigate informed consent cases).

275. See Shultz, *supra* note 14, at 276 (explaining the need to protect patient autonomy as a separate injury because the "conflicts of value and judgment that are inherent in all human decision are both consequential and problematic").

276. *Id.* at 232.

277. See DOBBS, *supra* note 236, § 28 (identifying damages available for simple battery).

278. See Shultz, *supra* note 14, at 224 (stating that professional competence is not a defense to a battery action).

impermissible touching that is not physically harmful.²⁷⁹ Because battery is a dignitary tort, the traditional rule allows the plaintiff to recover substantial damages even without proving physical injury or mental distress; nonetheless, in cases involving medical procedures, a jury should also consider the ultimate benefit to the patient in determining the appropriate award.²⁸⁰

In addition, under a battery theory, the jury will also have the discretion to award punitive damages.²⁸¹ The New Jersey Supreme Court cited the possibility of punitive damages as one of its reasons for denying the plaintiff a fraud cause of action.²⁸² The possibility of awarding punitive damages is not a reason to deny a fraud claim. Punitive damages are only available to the jury when the defendant "has committed quite serious misconduct with a bad intent or bad state of mind such as malice."²⁸³ Punitive damage awards act as a social sanction against physicians.²⁸⁴ The remedy vents community outrage, deters the specific doctor from committing similar wrongs in the future, and deters others in the medical community from engaging in similar misconduct.²⁸⁵ A physician's fraudulent misrepresentation of his experience in response to a patient's direct inquiry is behavior that juries should deter. Punitive damages may be the most effective method of ensuring doctors are not misleading their patients.²⁸⁶ Dr. Evil is likely to be confident that Mr. Deville will never discover his true level of experience. Furthermore, Dr. Evil currently knows that even if Mr. Deville were to discover the truth, so long as he successfully performs the operation, no liability will attach as a result of his misrepresentations. The possibility of punitive damages may be the only

279. See Lundmark, *supra* note 255, at 288 (explaining that the fact that battery has occurred is sufficient for damages).

280. See DOBBS, *supra* note 236, § 42 (identifying types of damages for dignitary harm without physical harm).

281. See *id.* (stating that punitive damages are permitted when the defendant's conduct and state of mind are especially odious).

282. See *Howard v. Univ. of Med. & Dentistry of N.J.*, 800 A.2d 73, 82 (N.J. 2002) (identifying policy reasons why the court refused to recognize a fraud action).

283. DOBBS, *supra* note 236, § 381.

284. See Michael Rustad & Thomas Koenig, *Reconceptualizing Punitive Damages in Medical Malpractice: Targeting Amoral Corporations, Not "Moral Monsters"*, 47 RUTGERS L. REV. 975, 1043 (1995) (stating that punitive damages are designed to warn the medical community that certain actions will not be tolerated).

285. See *id.* at 1044 (stating purpose of punitive damages).

286. See *id.* at 1006, 1018 (stating that contrary to popular opinion, punitive damages may actually be too few to protect the public because punitive damage litigation has resulted in improved practice parameters and has removed incompetent physicians from the medical community).

sufficient deterrent to prevent Dr. Evil from taking this calculated risk.²⁸⁷ The jury never has an obligation to impose punitive damages; they merely have the option in the appropriate situation.²⁸⁸ Therefore, courts should not view the availability of punitive damages as a reason to reject a fraud action.

Furthermore, a battery action allows courts to consider the particular factual issues surrounding the doctor's misrepresentation at the valuation stage rather than as part of the causation analysis. At least one commentator has argued that difficult problems of uncertainty, prediction, and credibility regarding what would have happened had the physician provided the patient a choice are more appropriately analyzed as questions of valuation.²⁸⁹ Evaluating such questions within the framework of injury valuation rightfully does not question the factual existence of harm to the patient.²⁹⁰ Informed consent ultimately rejected such protection for patients because, "[g]iven the absolute nature of battery, the narrowness of its defenses, and the breadth of its remedies, doctors could end up paying significant damages after providing faultless medical treatment, simply because some minor informational aspect of the consent process was questioned."²⁹¹ Nonetheless, jurisdictions retain the battery action against physicians in situations in which a physician has performed a medical procedure without any consent because such grossly inappropriate behavior as operating without consent does not warrant protection.²⁹²

Although the negligence standard of informed consent adequately protects the prototypical case, the prototypical case is not representative of all cases implicating an autonomy interest.²⁹³ Doctors who misrepresent their experience, credentials, and qualifications are not at risk of unacceptably harsh results. Because fraudulent misrepresentations void consent, a battery action is

287. The author does not mean to imply that there are numerous doctors today making such devious calculations, but the possibility of even a few such doctors in each state makes adopting a fraud cause of action a worthwhile project.

288. See Rustad & Koenig, *supra* note 284, at 1027 (stating that empirical analysis demonstrates that punitive damages are not assessed for inadvertent mistakes and that most awards arose from serious disregards of patient safety by malicious or unfit doctors).

289. See Shultz, *supra* note 14, at 251 (stating that valuation is a more appropriate time to handle these difficult questions than as part of the causation element).

290. See *id.* (same).

291. *Id.* at 225.

292. See *id.* at 225–26 (explaining the current use of battery doctrine).

293. See *id.* at 229 (recommending that a new tort be used to protect patient autonomy due to informed consent's frequent failures to adequately protect the nonprototypical autonomy interest).

appropriate for deceived patients.²⁹⁴ Nothing needs to be objectively reasonable about the patient's inquiry to deserve a truthful answer. The mere fact that the patient believed the information important enough to warrant a specific inquiry prior to the procedure is sufficient to require a truthful response. A fraud action only applies to the physician that actively and intentionally misrepresents the answer to a patient inquiry.

B. Public Policy Favors Fraud Cause of Action

Because the fraud doctrine offers a more reliable action for a patient similar to Mr. Deville, public policy favors adopting this approach. This Subpart focuses on the role of trust in the physician-patient relationship, the cost effectiveness of using a fraud action, and the treatment of other professionals who fraudulently misrepresent their credentials and experience.

1. The Important Role of Trust

Tort law should enforce physicians' duty to maintain a trusting relationship with their patients. Trust between physician and patient is essential for therapeutic purposes.²⁹⁵ Because of trust, a patient is willing to share confidential and sensitive information, to place confidence in the physician's medical judgments, and to comply with the physician's recommended treatment.²⁹⁶ Studies indicate that a correlation exists between the amount of trust patients invest in their physician and positive outcomes in the treatment of patients.²⁹⁷ Most commentators explain this correlation in reference to the placebo effect.²⁹⁸ The placebo phenomenon occurs because of patients' honest

294. Anyone concerned with possible runaway verdicts must remember that the proof burden on the patient remains difficult. The deceived patient remains responsible for proving to a jury that the physician misrepresented a response to the patient's inquiries. The purpose of this Note is to ensure that a patient who can establish such a misrepresentation has a valid legal action.

295. See Morris, *supra* note 37, at 344 (acknowledging the importance of trust in the doctor-patient relationship).

296. See *id.* (identifying the reasons trust is so vital to the doctor-patient relationship).

297. See Schuck, *supra* note 272, at 943 (explaining the importance of trust in physician-patient relationship).

298. See Frances H. Miller, *Trusting Doctors: Tricky Business When it Comes to Clinical Research*, 81 B.U. L. Rev. 423, 426-27 (2001) (explaining why analysts believe trusting your physician is correlated with positive outcomes). Studies indicate approximately one-third of patients respond positively to placebo therapy, including placebo surgery. *Id.* at 427.

belief that that their doctors are capable of healing them.²⁹⁹ In addition, patients with a greater level of trust in their physicians are less likely to bring malpractice actions.³⁰⁰ One commentator stated, "Trust is the core, defining characteristic of the doctor-patient relationship—the 'glue' that holds the relationship together and makes it possible."³⁰¹ The recent rise of managed care organizations has created loyalty conflicts between the patient's best interests and the doctor's need to control costs.³⁰² Because recent trends are already impacting the trust relationship between physician and patient, tort law must be especially careful to preserve physicians' responsibility to maintain truthful relationships with their patients. Grant Morris commented, "A patient's trust cannot be purchased with concealment, subterfuge, or bald-faced lies. It can only be developed through honest communication."³⁰³ Therefore, the legal system should allow patients a cause of action when a physician fails to communicate honestly in response to a patient's direct inquiries.

The legal system can best encourage honest communication and trust between physicians and patients by providing the patient with legal redress when she proves that her doctor deceived her. The informed consent action frequently fails to do this. However, allowing a patient to bring a battery action because the doctor's fraud negated consent will serve as an effective deterrent.³⁰⁴

2. Cost-Effectiveness

In the wake of *Kokemoor*, several commentators have urged the legal system to revolutionize the current informed consent doctrine to include physicians' experience and other provider-specific comparative statistical data.³⁰⁵ Support for a stricter version of informed consent comes from people

299. See *id.* (identifying why commentators believe the placebo effect is linked to patients trusting their physicians).

300. See Schuck, *supra* note 272, at 943 (explaining role of trust in limiting malpractice actions).

301. Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 470 (2002).

302. See Morris, *supra* note 37, at 347–48 (explaining the impact of managed care on the doctor-patient relationship).

303. *Id.* at 360.

304. See *supra* Part IV.A. (explaining why a fraud action is better suited to deter doctors from misrepresenting their experience in response to a patient inquiry).

305. See, e.g., Iheukwumere, *supra* note 31, at 419 (concluding that *Kokemoor's* recognition of experience as a material risk is a necessary evolution of informed consent); Twerski & Cohen, *supra* note 235, at 42 (concluding that informed consent should require providers to share provider-specific risk information).

who believe market competition can create a safer and more efficient health care system; but critics point out the increased costs of requiring more disclosure.³⁰⁶ Although current studies document that more patients want to know more information about their health care, many patients fail to seek such information because of habit, ignorance, intimidation, lack of economic incentive, and the practice of referrals to designated specialists.³⁰⁷ Because the informed consent doctrine operates under the negligence standard, the doctrine creates standards that every physician should disclose before performing a procedure.³⁰⁸ Any increase in the demands on a physician under informed consent is naturally accompanied by an increase in costs to the health care system.³⁰⁹ Most of this increase in costs results from the additional time required for physicians to communicate with patients.³¹⁰ Peter Schuck recognizes, "Genuinely probing conversation, which advocates of the law in the books demand, is dearer [in price] still."³¹¹ Schuck also recognizes the costs of expanding the doctrine to extend beyond mere information costs and include largely unquantifiable costs of emotional distress, which the disclosed information might induce because of the inability of many patients to understand, or their desire to remain ignorant.³¹² Proponents of informed consent argue that disclosure of more information improves the treatment decision by assuring that the patient receives crucial information.³¹³ Schuck asserts that such claims of better informed and more knowledgeable patients are more an anomaly than the norm.³¹⁴ Hence, in an era of escalating health costs, Schuck argues that expanding informed consent is simply not cost effective.³¹⁵

306. See Schuck, *supra* note 272, at 939 (suggesting that toughening informed consent law would greatly increase costs with little corresponding benefits).

307. See *id.* at 931 (explaining the reasons many patients do not want more information).

308. See *supra* notes 242–49 and accompanying text (explaining the scope of informed consent).

309. See Schuck, *supra* note 272, at 942 (stating that any increase in the disclosure requirements of informed consent will be accompanied by an increase in costs to the health care system).

310. See *id.* at 942 (discussing the high costs of increasing the requirements of informed consent).

311. *Id.*

312. See *id.* at 942–43 (naming other costs associated with increasing disclosure requirements).

313. See *id.* at 932 (acknowledging that informed consent is useful to the patient's decision-making process).

314. See *id.* at 933–34 (stating that studies indicate that physicians discourage active dialogue, opting to deliver the required information as quickly as possible, and that patients rarely initiate a dialogue by asking questions).

315. See *id.* at 959 (finding that informed consent's effectiveness at achieving goals of

Schuck concludes that the incredible costs associated with expanding the doctrine do not justify its limited benefits to a consumer class that currently is not ready to use effectively such information.³¹⁶

In contrast, banning physicians from misrepresenting their experience to inquiring patients is structurally different from increasing the legal standard regarding what information physicians must routinely provide noninquiring patients. Informed consent has effectively created a baseline of disclosure that every physician must follow before performing a procedure.³¹⁷ Increasing this baseline to include provider-specific information will not be cost-effective because many patients are not capable of using such information; however, when patients specifically inquire about experience, the courts should provide legal redress if a physician deceitfully misrepresents this information.

The fraud cause of action offers an individualized cause of action to plaintiffs provided that they can prove reliance upon a misrepresented fact.³¹⁸ A fraud cause of action does not entail the same costs to the health care system as reforming the informed consent doctrine. Indeed, recognizing a fraud cause of action raises the information costs only for those patients who are capable and willing to use such information to make informed decisions. Furthermore, the emotional costs are minimized because patients who specifically inquire about information do not wish to remain ignorant of possible consequences and are likely to be capable of understanding the information. In addition, by protecting patients' rights to seek further information, a fraud cause of action could also yield a reduction in health care costs by limiting overtreatment and by allowing market forces to control the quality of health care provided.³¹⁹ As awareness of the startling proliferation of medical errors in the health care marketplace increases, the media and state legislatures have urged medical consumers to protect themselves by becoming better informed.³²⁰ Patients who take the initiative to seek this information need protection from the legal system to ensure the information they receive is accurate.

patient autonomy limited).

316. *See id.* (same).

317. *See supra* notes 242–49 and accompanying text (explaining the scope of informed consent).

318. *See supra* notes 236–37 and accompanying text (explaining the patient's proof requirements in a fraud action).

319. *See Shultz, supra* note 14, at 295–96 (noting that modern commentators believe informed medical consumers will result in a decrease in overall health care costs).

320. *See supra* notes 6–8 and accompanying text (explaining the need for medical consumers to protect themselves by seeking more information about their physicians before agreeing to a procedure).

3. *Physicians Should Not Enjoy More Protection than Other Professionals*

Other professionals face liability for misrepresenting experience. In Florida, a court found a consulting company liable for fraud when the company misrepresented its credentials and its past experience with public offerings.³²¹ Another Florida court found a seller of cement pumping equipment liable for fraud because it represented to the buyer that "it had extensive experience making similar or identical operations" when in fact the company did not have such experience.³²² Similarly, the Supreme Court of Alabama allowed the buyer of a swimming pool to sue for fraud when the seller misrepresented the experience of the company in installing pools.³²³ Most interestingly, the New Jersey Supreme Court, the same court that denied Howard's claim of fraud against his physician, upheld a fraud action against a residential real estate company for misrepresenting the credentials and experience of the builder constructing homes in a new development.³²⁴ State cases routinely allow fraud actions against professions ranging from swimming pool companies to consulting firms.

Courts have generally been wary of allowing patients to bring fraud actions against doctors arguing that plaintiffs should not be able to avoid proving the elements of medical malpractice.³²⁵ Courts sometimes find that medical malpractice is the "gravamen" of a fraud claim brought by patients against physicians.³²⁶ New York's Appellate Division recently disallowed a patient's fraud claim that alleged her doctor made fraudulent promises regarding the results of her foot surgery.³²⁷ Because the injuries asserted in her

321. See *Innovative Med. Servs., Inc. v. Reitz*, 793 So. 2d 125, 127 (Fla. Dist. Ct. App. 2001) (concluding that allegations of such misrepresentations state a valid cause of action for fraud).

322. See *E. Cement v. Halliburton Co.*, 600 So. 2d 469, 471 (Fla. Dist. Ct. App. 1992) (overruling the trial court's finding that such claims were mere puffing and allowing a fraud action).

323. See *Spartan Pools v. Royal*, 386 So. 2d 421, 423 (Ala. 1980) (affirming a jury verdict against the swimming pool company).

324. See *Gennari v. Weichert Co. Realtors*, 691 A.2d 350, 366 (N.J. 1997) (finding a valid cause of action for fraudulent misrepresentation).

325. See, e.g., *Christenson v. Gleason*, 2000 WL 133815 at *4 (D. Kan. Jan. 12, 2000) (stating that the Kansas Supreme Court has rejected claims by plaintiffs seeking to "creatively classify" malpractice actions as fraud).

326. See *id.* (stating that a fraud claim will only avoid the "gravamen" test when the physician's misconduct is beyond a breach of the legal duty which every doctor has the obligation to uphold).

327. See *Spinosa v. Weinstein*, 571 N.Y.S.2d 747, 753 (N.Y. App. Div. 1991) (rejecting

fraud claim were the same as those of her malpractice claim, the court found the fraud claim not to be separate and distinct from medical malpractice and dismissed the action.³²⁸ Despite courts' reluctance to allow claims outside the typical medical malpractice arena, commentators recognize the limitations of informed consent and urge courts to expand the possibilities of patient lawsuits. One treatise concludes its synopsis of informed consent by stating that the "[i]nformed consent doctrine as applied in tort cases can only take us so far in promoting physician-patient communication."³²⁹ Joan Krause further commented, "Traditional informed consent law is simply too fragile, too slender a reed on which to rest the burden of protecting patient informational rights in an era of health care cost containment."³³⁰ Commentators believe state tort law must play a greater role in preserving patients' rights.³³¹

Courts should not protect a person's right to choose a swimming pool company based on the company's experience installing swimming pools more than they protect a patient's right to choose his doctor based upon the doctor's experience in performing similar surgical procedures. A patient's right to control who touches his body demands that tort law provide adequate protection against a surgeon who misrepresents information about his experience or credentials to a potential patient.³³² Because a person could bring a fraud action against other professionals misrepresenting their credentials, courts should also allow patients to bring an action for fraud against their physicians.

In addition to recognizing a common law fraud action, state courts should also consider applying unfair and deceptive trade practice laws to physicians. Although only a few states have considered doing so, the majority of those that have were willing to construe ambiguous statutes to cover the entrepreneurial

the plaintiff's fraud claim).

328. See *id.* (dismissing the plaintiff's fraud claim). Ironically, the New York State Department of Health's website urges patients to report physician fraud. NEW YORK STATE DEPARTMENT OF HEALTH, FRAUD IN MEDICINE, at <http://www.health.state.ny.us/nysdoh/opmc/fraud.htm> (last visited Jan. 28, 2004) (on file with the Washington and Lee Law Review). An example of fraud specifically included in the website is "false and intentionally misleading statements to patients" and "lying about credentials or qualifications." *Id.* Thus, despite the court's disallowance of a separate fraud claim, the New York State Department of Health recognizes the potential problems of physician fraud. *Id.*

329. 1 FURROW ET AL., *supra* note 43, § 6-19.

330. Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 386 (1999).

331. See Morris, *supra* note 37, at 369-70 (stating that state tort law may be the only mechanism available to protect patients' informational rights).

332. See *supra* notes 250-56 and accompanying text (discussing the failure of informed consent to protect patients' right to receive truthful information from their physicians).

aspects of the practice of medicine.³³³ The standard of proof for deception under these statutes generally only requires that the plaintiff demonstrate that the business practice has a tendency or capacity to deceive; the plaintiff need not show negligence or intent.³³⁴ The standard of proof for unfairness only requires that the plaintiff establish that the business practice offends public policy or is illegitimate and substantially injures consumers.³³⁵ Flynn believes that these proof requirements "permit consumers to effectively and successfully confront unscrupulous business practices with relative ease."³³⁶ Permitting the application of consumer protection statutes not only would eliminate much of the judicial paternalism afforded to physicians, but also would help deter physicians from the temptation to compete for patients in an unscrupulous manner.³³⁷

V. Conclusion

Despite the movement away from judicial paternalism in medical malpractice jurisprudence, medical error kills more Americans than breast cancer, traffic accidents, or AIDS.³³⁸ Informed medical consumers can make a difference in combating medical error. The legal system has thus far been unwilling to respect the importance of informed decision-making by medical consumers. Unless courts begin to recognize a fraud action, patients such as Mr. Deville will frequently be without legal recourse.

Recognizing an informed consent action does not adequately protect a patient's right to have his physician respond truthfully to questions. Because the informed consent doctrine is a negligence-based action, courts focus their inquiry on an objective standard: Whether the physician has disclosed information sufficient for the ordinary, reasonable patient to make an informed decision concerning treatment. Because the focus of an informed consent inquiry is whether the physician provided adequate disclosure, the doctrine does not offer any recourse to a patient who actively seeks information beyond what a reasonable patient would find necessary to his decision.

333. See *Malpractice*, *supra* note 20, at 345–46 (summarizing the existing case law that has dealt with the application of consumer protection statutes to physicians).

334. See *id.* at 347 (explaining the proof requirements under unfair and deceptive trade practice statutes).

335. See *id.* (same).

336. *Id.*

337. See *id.* (concluding that applying state unfair and deceptive trade practice statutes to physicians would deter physicians from unscrupulous behavior).

338. See *Boodman*, *supra* note 90, at F1 (discussing the alarming rate of medical error).

In contrast, a fraud action protects medical consumers who actively seek information beyond what a reasonable patient would seek and promotes the recent trend of encouraging informed medical consumers to actively question their physicians.³³⁹ A fraud action focuses the court's inquiry on whether the patient legally consented to have his physician perform the procedure. Such an action protects a patient's right to actively seek information before agreeing to undergo a surgical procedure. Courts currently recognize a battery action when the surgeon who performs the procedure is not the same surgeon the patient authorized. Similarly, when a doctor misrepresents his level of experience prior to obtaining patient consent, the patient unwittingly will be forced to undergo surgery by a physician that the patient actively sought to avoid in the first place. Courts must recognize a fraud action in this situation because proof of fraud allows the patient to recover for battery if the patient has not provided legal consent to the physician.

In conclusion, this Note advocates the position of the intermediate appellate court of New Jersey.³⁴⁰ A patient who specifically inquires about his doctor's experience should have a legally enforceable expectation that the physician will respond truthfully pursuant to the doctor's duty to his patient.³⁴¹ A fraud cause of action does not focus on the information a physician must disclose to his patient; rather, the action exists because the patient never provided legal consent in the first place.³⁴² Recognizing a fraud action will provide informed medical consumers similar to Mr. Deville with legal recourse against physician deceit.

339. See *supra* notes 6–13 (discussing the need for informed medical consumers).

340. See *supra* notes 169–75 and accompanying text (discussing the opinion of the New Jersey Appellate Division).

341. See *supra* note 161 and accompanying text (identifying doctor-patient fiduciary relationship).

342. See *supra* notes 238–41 (explaining fraud's focus on legal consent).