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THE DECLINE OF "INFORMED CONSENT"

MARcus L. PLANT*

Introduction

The cause of action identified by the expression "informed consent" normally involves a claim by a patient or his successor against a physician or hospital that defendant did not inform plaintiff sufficiently as to certain aspects of a contemplated medical or surgical procedure. The nondisclosures most frequently alleged relate to the dangers of the proposed procedure or to alternative remedies that might have been pursued.

The action has had an erratic history during the past two decades. Its popularity began to develop in 1957 following publication of a thoughtful article by the late Professor Allan H. McCoid of The University of Minnesota Law School and the issuance of the opinion of the California District Court of Appeals for the First District in Salgo v. Leland Stanford, Jr. University Board of Trustees. Both McCoid and the California Court recognized that under certain conditions a physician could be liable to a patient for failure to disclose sufficient information prior to undertaking treatment. The general idea was not new; it had been articulated by other courts much earlier. For example, in 1918 the Virginia Supreme Court of Appeals, in Hunter v. Burroughs, upheld a claim based on the allegation "that it is the duty of a physician in the exercise of ordinary care to warn a patient of the danger of possible bad consequences of using a remedy."

In the plaintiff-minded milieu that developed in the post World War II era, the concept experienced an enthusiastic revival. Many actions were brought and a steady stream of commentary flowed into the law reviews. Confusion developed as to the specific nature of the cause of action. Certain early opinions were ambiguous as to whether it was an action for

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1 McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment, 41 MINN. L. REV. 381, 424 (1957).
3 123 Va. 113, 133, 96 S.E. 360, 366 (1918).
4 See the numerous citations to appellate cases collected in D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE, ¶ 22.01-22.09 (1960) particularly the 1976 Cumulative Supplement. Howard Hassard, Legal Counsel for the California Medical Association, attributes the popularity of the informed consent action at least partially to the general development of "consumerism" in the United States. He indicates that after Cobbs v. Grant, 8 Cal.2d 229, 104 Cal. Rptr. 505, 502 P.2d 1 (1972), see text accompanying note 45 infra, "[o]ne thing is certain and that is that the plaintiff's lawyers will allege lack of informed consent as a routine matter in future malpractice suits." 119 WESTERN J. MED. 51-52 (1973).
an unpermitted medical procedure involving trespass or battery, or an action for negligence involving a violation of the physician's duty to use due care in treating the patient. The notion that the "new" action sounded in trespass or battery was appealing to those who saw it as a means of avoiding the necessity of expert testimony usually required in a medical negligence case, thereby expanding greatly the possibility of plaintiffs' success in medical accident litigation. In 1968 this writer presented an analysis which attempted to clear away the confusion by distinguishing between two basically different cases: (1) the relatively rare type of case in which the physician misrepresents or fails to disclose fully the nature and character of the surgery or treatment about to be undertaken, in which case trespass or battery principles are applicable, and (2) the much more common case in which the physician fails to disclose collateral hazards attendant upon the surgery or treatment, in which case negligence principles are pertinent, including the requirement of expert testimony to establish the physician's violation of duty. Ultimately almost all informed consent cases came to be treated as falling in the negligence area.

The latter approach was not satisfactory, however, to those whose basic philosophical orientation is that in all medical accident cases the injured person should be compensated. From that standpoint an informed consent action grounded in negligence is "something of a paper tiger" as one writer put it. Further efforts to expand the scope of the informed consent action were to be expected. The most potent of these efforts appeared in 1972 in the case of Canterbury v. Spence, discussed at greater length below. The doctrine enunciated in that decision permits the jury to decide the basic issues in virtually every informed consent case without benefit of expert testimony. It is the general thesis of this article that the Canterbury doctrine is unsound and unwise; that rejection of it, notably by the Supreme Court of Virginia, is well-advised; and that legislative reactions to the Canterbury approach, such as have emerged in some states, are likely to curtail the informed consent action to the point of virtual abolition.

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8 Plant, supra note 5.


10 See Meisel, supra note 7.


The Canterbury Case

Defendant surgeon performed a laminectomy\(^1\) on plaintiff. The next day plaintiff fell out of his hospital bed and thereafter experienced symptoms of paralysis below the waist. Defendant immediately performed additional surgery at the site of the laminectomy. Plaintiff's control over his muscles improved somewhat after the second operation but nine years later at the time of trial he still suffered paralysis and functional disability. Suit was brought against the surgeon and the hospital alleging "several" causes of action. One was that defendant failed to inform plaintiff of the danger of paralysis before proceeding with the surgery.

Plaintiff introduced no expert evidence\(^4\) except that defendant was called as an adverse witness. He testified he had performed "in excess of two thousand" laminectomies and that paralysis might be expected in "somewhere in the nature of one percent" which he termed "a very slight possibility."\(^5\) At the close of plaintiff's case defendant's motion for directed verdict was granted.\(^0\) The Court of Appeals reversed and remanded for a new trial on the ground, inter alia, that defendant's failure to reveal the risk of paralysis "made out a prima facie case of violation of the physician's duty to disclose . . . ."\(^17\) It is evident from the opinion that this ground for reversal was the most prominent element in the decision for it occupied seven of ten subdivisions of an elaborate discussion of twenty and one-half printed pages with 149 footnotes.

Although any attempt to summarize the court's views involves a risk of doing an injustice to the judges, it is necessary to provide a synopsis of the principal thesis of the opinion. The court agrees that a physician's departure from an established professional practice to inform may give rise to liability to the patient, just as would any other departure from prevailing medical practice that caused injury. It refuses, however, to accept what it conceives to be the rule that such a departure is the only basis of liability or that "the patient's cause of action is dependent upon the existence and non-performance of a relevant professional tradition." Several bases are presented for objection to this supposed rule. First, the very existence of a "custom" may be doubtful because of the "myriad of variables" among patients.\(^18\) Second, to bind the obligation to medical usage is to "arrogate" the decision of proper practice to the physician whereas the standard should be set by law.\(^18\) Last and most crucial, the question of disclosure "is oftimes a non-medical judgment" within the scope of ordinary care rather than within the standard of care applicable to the medical profes-

\(^1\) A surgical procedure in which the posterior arch of a vertebra is removed.
\(^4\) 464 F.2d at 778.
\(^5\) Id.
\(^0\) Id.
\(^17\) Id.
\(^18\) Id. at 784.
\(^19\) Id.
sion," and "does not bring his [the physician's] medical knowledge and skills peculiarly into play." The court's conclusion is that "the standard measuring performance of that duty by physicians, as by others, is conduct which is reasonable under the circumstances." Reasonable care requires disclosure of all risks that are "material" to the patient's decision and what disclosures fall within the scope of the obligation is to be left to the jury.

A risk is "material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk in deciding whether to forego the proposed therapy," taking into account the incidence of injury and the degree of potential harm. It follows that "whenever non-disclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of the facts."

Two exceptions to the principle are acknowledged. One is the conventional emergency situation in which the patient is unconscious or otherwise incapacitated and serious danger from failure to treat greatly outweighs the hazards of treatment. The other is when risk disclosure poses such threat of psychological detriment to the patient as to be contra-indicated from a medical point of view. The last mentioned exception, however, must be "carefully circumscribed," and does not include "the paternalistic notion" that the physician may remain silent simply because divulgence might prompt the patient to forego therapy that is really needed. The physician in any event must make disclosure to close relatives.

The concluding remarks of the court reveal its basic philosophy and purpose.

It is evident that many of the issues typically involved in nondisclosure cases do not reside peculiarly within the medical domain. Lay witness testimony can competently establish a physician's failure to disclose particular risk information, the patient's lack of knowledge of the risk, and the adverse consequences following the treatment. Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment or the reasonably, expectable effect of risk disclosure on the decision. These conspicuous examples of permissible uses of nonexpert testimony illustrate the relative freedom of broad areas of the legal problem of risk nondisclosure from the demands for expert testimony that shackle plaintiffs' other types of medical malpractice litigation.
It seems clear that the court is seeking to eliminate the requirement of expert testimony on the issue of reasonable care in informed consent cases, and to give the jury free rein on that question.

**Some Weaknesses of Canterbury**

It is the writer's view that the decision in *Canterbury* was in error as to the manner in which it was reached, the legal principles and authority on which it was based, and the policy it implemented.

A basic postulate of the adversary system of judicial lawmaking is that a court confronted with an issue carrying significant societal implications should decide those issues only after considering thorough arguments, written and oral, by opposing counsel. It is not uncommon for courts to request briefs *amicus curiae* if the need exists. It is in this respect that the judges deciding *Canterbury* may have made a basic methodological error. True, the extended opinion had a long period of gestation and evinces considerable study. But the study appears to have been done by the court *sua sponte*. Without intending any undue criticism, plaintiff's brief on appeal contained only five pages of argument and cited only 20 cases, several of which did not have any bearing on informed consent. Defendant's brief was slightly more extensive, being 22 pages long and citing 28 judicial authorities and one academic authority. Neither brief contained anything like a thorough analysis of the informed consent problem. Nor does the record disclose that any briefs *amicus curiae* were requested or filed. Even though it be respectfully conceded that the learned members of the court reached their conclusions only after reflective thought, such judicial cerebration is simply not an adequate substitute for well prepared disputation by skillful counsel representing opponents with substantial interests in the outcome.

The foregoing deficiency in the court's procedure may account for some of the substantive infirmities of the opinion. An initial flaw lies in the court's willingness to accept without analysis the generalization that evidence of a medical "custom" binds the jury if defendant has complied with it. This is a "straw man." It is true that, in the past, some courts have occasionally used terms such as "custom," or "customary practice," or "standard practice" in stating the nature of the duty owed by physicians to patients. But it is error to suppose that an alleged custom or standard

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29. K. Llewellyn, *The Common Law Tradition—Deciding Appeals*, 29-31 (1960). "... the regime of argument renders the deciding also a process oriented partly from without by analysis, by arrangement of data, and by persuasion: oriented however, not by judicially-minded helpful consultants but by adversaries to each of whom the tribunal serves either as an obstacle or as a tool, or, more commonly, as both at once," (emphasis added).


31. The case was argued in December, 1969 and the decision was not announced until May, 1972, approximately 30 months later.

32. See, e.g., DiFilippo v. Preston, 53 Del. 539, 173 A.2d 333 (1961) in which the Delaware
practice cannot be shown by competent evidence to be bad medical practice. For example, in Naccarato v. Grob the issue was whether defendants, two Detroit area pediatricians, breached their duty to the infant plaintiff by failing to test him for phenylkentonuria (PKU), a rare but potentially devastating childhood disease. Three Detroit pediatricians testified that it was the practice in that area to test for PKU only when certain symptoms were observed but not to test every infant for the disease. Their testimony was to the effect that defendants did not vary from the usual "standard of care" of pediatricians in the Detroit area. Despite this evidence, testimony of two experts from other parts of the country was admitted to show that this "custom" was improper medical practice, and that every infant should be tested as a routine procedure. It was held that a jury question was presented as to whether defendants had failed to meet their legal duty as physicians.

Whether a "custom" does or does not exist, the ultimate issue always is whether defendant's conduct constituted proper medical practice in the specific circumstances of the case before the court. Indeed, a customary practice may be so obviously wrong as to be held negligent as a matter of law. An impressive illustration may be found in Helling v. Carey in which the Washington Supreme Court ruled that defendant was negligent even though he had followed a practice accepted as proper by the entire body of ophthalmologists in the country.

It is submitted that the court in Canterbury was in error insofar as it rested its opinion on the notion that medical custom always binds the factfinder and thus "arrogates" the decision in medical negligence cases to the medical profession.

Perhaps the most glaring weakness of Canterbury relates to its concept that the decision as to risk disclosure is a non-medical one and can be appraised by a jury without the aid of, or in opposition to, expert evidence. In the first place the "authority" cited in support of this proposition is extremely questionable. The idea seems to have had its origin in a 1962 student note in the "Recent Cases" section of the Harvard Law Review. In that discussion the student writer nonchalantly asserts: "Such a decision (i.e. to disclose or not) does not call for expertise significantly different from that usually attributed to court and jury, and the judgment appears to be one properly


The case resembled Naccarato in some respects. The practice or "custom" was that a patient under 40 years of age was not tested for glaucoma unless certain symptoms were observed. In view of the severity of the hazard and the simplicity of the test, the court held the practice to be negligent as a matter of law and reversed judgment for defendant.

Note, 75 Harv. L. Rev. 1445 (1962).
left within the traditional decisional process.” No judicial or other authority is cited; it is simply the writer’s *ipse dixit.*

In 1967 the notion was repeated in the student comment in the *California Law Review.* There the writer makes the following statements:

> it is submitted, however, that in the absence of established custom, a jury can set a standard just as well as an interested expert witness. A jury, unlike an expert witness, feels no reluctance to criticize a fellow physician. Specialized knowledge is not required to determine which risks are relevant in deciding whether or not to submit to an operation. Since neither the jury nor the court is motivated by professional self interest, they are more likely than an interested expert witness to reach a reasonable conclusion about the duty to disclose.

The closest approach to an authoritative endorsement of these views appears in an article by Waltz and Scheuneman. The thesis is treated more elaborately but no judicial authority is cited. The weight of the sentiment is raised from student writing to faculty writing.

It may seem graceless for a faculty person to express skepticism for “academic“ authority. In this instance, however, it must be noted that not only was there no medical or judicial opinion supporting the viewpoint expressed by these writers but their approach had been rejected and an exactly opposite point of view taken by the Missouri Supreme Court as early as 1965 in a leading case in the field. That court wrote:

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

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38 *Id.* at 1447.
40 The “interest” the writer ascribes to a medical expert is the general antagonism said to be felt by all doctors to medical malpractice lawsuits.
41 *Informed Consent,* supra note 36, at 1405.
42 Waltz & Scheuneman, *supra* note 5.
43 Aiken v. Clary, 396 S.W.2d 668 (Mo. Sup. Ct. 1965).
disclosure of all risk which had any reasonable likelihood of occurring, but in others the facts and circumstances would dictate a guarded or limited disclosure. In some cases the judgment would be less difficult than in others, but *in any event, it would be a medical judgment.*

Neither in the *Canterbury* opinion nor in the writings upon which it relies so heavily is there an answer to the Missouri Supreme Court, other than unsupported contrary statements. Perhaps the position of the Missouri court was overlooked. The same failure is generally true of those courts that have followed *Canterbury,* except in Wisconsin, where a majority of the Supreme Court implemented *Canterbury*'s doctrine in *Scaria v. St. Paul Fire and Marine Ins. Co.* Justice Hansen, in a vigorous dissent, wrote:

> Children play at the game of being doctor but judges and juries ought not . . . . [T]he added hairshirt of the average man tests, here placed [by *Canterbury and Scaria*] on the backs of the medical profession, is placed, in malpractice lawsuits, on no other professional group.

One of the most impressive statements on the subject was issued by the

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44 *Id.* at 674-75 (part of emphasis added).


46 A number of courts have adhered to their position requiring expert medical testimony but it is not clear from the opinions that the *Canterbury* doctrine was expressly urged upon them. Karp v. Cooley, 493 F.2d 408 (5th Cir. 1974) (applying Texas law); Riedisser v. Nelson, 111 Ariz. 542, 534 P.2d 1052 (1975); Coleman v. Garrison, 327 A.2d 757 (Del. Sup. 1974); Charley v. Cameron, 215 Kan. 750, 526 P.2d 1205 (1974); Murchiewicz v. Stanton, 50 Mich. App. 344, 213 N.W.2d 317 (1973); Jacobs v. Theimer, 519 S.W.2d 846 (Tex. 1975).


68 Wis.2d 1, 227 N.W.2d 647 (1975).

47 *Id.* at 24-25, 227 N.W.2d at 659-60.
Virginia Supreme Court in Bly v. Rhoads when it was urged to adopt the "modern trend" represented by Canterbury. In declining to take that course, the court wrote:

The matters involved in the disclosure syndrome, more often than not, are complicated and highly technical. To leave the establishment of such matters to lay witnesses, in our opinion, would pose dangers and disadvantages which far outweigh the benefits and advantages a "modern trend" rule would bestow upon patient plaintiffs. In effect, the relaxed "modern trend" rule permits lay witnesses to express, when all is said and done, what amounts to medical opinion. Undoubtedly, such a rule would cause further proliferation of medical malpractice actions in a situation already approaching a national crisis. This is a result which, if at all possible consonant with sound judicial policy, should be avoided.

In addition to authoritative and theoretical weaknesses, the Canterbury doctrine has mischievous practical implications. Its most unsettling result is that it compounds enormously the uncertainty that has always bedeviled this area of law. This vagueness can appear at several levels. For example, how will a lawyer who is consulted by a physician advise his client as to what to disclose in a specific case? Suppose he tells the physician that he must make all disclosures that "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance . . . in deciding whether or not to forego the proposed therapy." Can it be thought that this will be meaningful to any person unaccustomed to thinking in broad legal concepts? When the lawyer adds that the physician's effort to comply with this obscure standard is subject to later review by a jury of laymen who are free to disregard any expert evidence he may produce, the physician's distress will be understandable.

As an illustration, take the facts in Cobbs v. Grant, one of Canterbury's followers, at least in part. Plaintiff, having undergone surgery for a duodenal ulcer, had to endure three successive subsequent agonies

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49 Id.
50 The unhappiness of the medical profession with the informed consent doctrine because of its uncertainty has been expressed often. Richard P. Bergen, Esq., of the American Medical Association Legal Department has written: "A physician seeking specific guidance on what information he should give a patient to obtain 'informed consent' for a particular medical or surgical procedure is confronted by legal confusion." 229 A. M. A. J. 325 (July 15, 1974).
51 See also Kaplan, Greenwald & Rogers, all M.D.'s, of Veterans Administration Hospital, Miami, Florida, 296 New Eng. J. Med. (May 12, 1977).
53 8 Cal. 2d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).
spleen removal, gastric ulcer, and premature suture absorption). It would be interesting to have the members of the California Supreme Court who signed that opinion, or the judges in Canterbury, write out the advice they would have given to the surgeon prior to the original procedure describing his duty to disclose the hazards that later materialized, and to guide him in such a way that a subsequent jury could not find against him.

It is one thing to formulate a verbally attractive rule of law in the quiet of an academic cloister or a judicial chamber; it is another thing for a practicing lawyer to make that rule of law function; and it is still quite another thing for a physician, not versed in the subtleties of the law and its ways, to live and work under it with any reasonable degree of security. It has been written by a widely respected legal philosopher that the "inner morality" of the Anglo-American legal system is that the rules of law promulgated by judges and legislatures to meet specific problems should be workable and administrable.53

Consider another area of uncertainty spawned by Canterbury—variation in jury verdicts. Assume two unrelated cases involving the same set of medical facts in which each surgeon fails to disclose the same hazard. The patient in each case is injured by that hazard. Assume further that the cases are tried to different juries, and that the same expert evidence is adduced in each case to the effect that each surgeon followed proper medical practice. One jury finds its defendant-surgeon liable; the other jury finds its defendant-surgeon not liable. A law oriented person is familiar with inconsistent jury verdicts and can live in relative intellectual comfort with them. But it is difficult to explain this to a physician, particularly when she or he must guide professional conduct in light of the jury's ultimate control. It is doubtful that any amount of theoretical argument can persuade a non-lawyer of the fairness or soundness of a rule of law that can bring such results.

A similar situation could develop with a time variable. For example, in 1977, a jury decides that a physician should not be held liable for failure to disclose hazard A in preparing for procedure B. In 1978, in the same county, another jury, having heard the identical expert evidence, holds that another physician should be held liable for failing to disclose hazard A in preparation for procedure B.

As one reflects on these aspects of the problem, there come to mind the words of Judge Cardozo:

The hazards of a business [profession] conducted on these terms are so extreme as to enkindle doubt whether a flaw may not exist in the implication of a duty that exposes to these consequences.54

53 "The demands of the inner morality of law . . . are, as we loosely say, affirmative in nature: . . . make the law . . . coherent and clear." L. FULLER, THE MORALITY OF LAW, (1964) at 42; see also, Aigler, Legislation in Vague and General Terms, 21 MICH. L. REV. 831 (1923).

54 Ultramares Corp. v. Touche, 255 N.Y. 170, 174 N.E. 441, 444 (1931).
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Legislative Intervention

If a segment of any profession conducts its activities in a manner unacceptable to society, the legislature is likely to intervene. The medical profession has occasionally undergone this experience. For example, in 1965 Michigan's legislature enacted a statute that requires that every newborn child be tested for phenylketonuria (PKU). It is likely that the legislation was prompted by the revelation as a result of certain litigation that Detroit pediatricians did not test for PKU until specific symptoms manifested themselves, whereas in other areas of the country the test was given routinely to all newborn children.

Similarly, if the courts embark on decisional paths that expose the medical profession to uncertain or fortuitous liability, or to an unacceptable degree of liability, one possible social reaction is legislative intervention. An example of this sequence seems to have occurred in Alaska in 1967, when that legislature eliminated the doctrine of res ipsa loquitur in medical malpractice cases after a Supreme Court decision had demonstrated an alarming use of the principle. A comparable course of events occurred in Michigan. In 1971 the Supreme Court issued an opinion that seemed to expand greatly the liability of a physician for breach of contract to cure without any showing of negligence. The legislature promptly amended the statute of frauds to require that any such alleged promise to cure be in a writing signed by the promisor.

While one can never be entirely certain what stirs legislatures to action, it is true that recent legislative intervention seems to be proceeding rapidly in the area of informed consent. In the period between April, 1975 and December, 1976, twenty-one state legislatures enacted some kind of statute on the subject. Undoubtedly the so-called "crisis" in medical malpractice in 1975 provided a legislative climate that rendered these enactments more likely. An interested observer might infer from the nature of the new statutes, however, that dissatisfaction with the Canterbury doctrine had a major influence.

Not all of these statutes have been available to the writer for the preparation of this article. Even as to those available, it would prolong the discussion unduly to offer an analysis of all. The following, therefore, is a summary of several selected enactments exemplifying different approaches.

58 1974 Mich. Pub. Acts 343, amending, Mich. Comp. Laws Ann. § 566.10. This reaction against an unwise court decision (or dictum) was probably as extreme and unfortunate as some of those discussed below relating to informed consent. The statute seems now to open a broad path for unscrupulous charlatans.
59 1 Malpractice Claims, National Assoc. of Insurance Commissioners 136 (May 1977).
In New York the statute is designated expressly as a "limitation" of the medical malpractice action based on informed consent. The opening section defines lack of informed consent as failure "to disclose . . . the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed. . . ." (Emphasis supplied). The action is allowed only in cases involving non-emergency treatment or a diagnostic procedure requiring invasion or disruption of the integrity of the body. Several defenses are expressly spelled out, including common knowledge of the risk, patient's expressed willingness to go forward regardless of the risk, impossibility of procuring consent, and medical inadvisability of disclosure. It is plain that the legislative purpose is to circumscribe the cause of action, abolish the Canterbury doctrine, prescribe a medically determined standard in each case and, as a necessary corollary, reinstate the requirement of expert testimony as to whether defendant violated the standard.

Another approach followed by several states, is exemplified by the Iowa statute. It provides for "a presumption that informed consent was given" if the consent is written, signed, and sets forth in general terms (a) the nature and purpose of the procedure or procedures, (b) the known risk, if any, of six specific hazards—death, brain damage, quadriplegia, paraplegia, loss or loss of function of any organ or limb, and disfiguring scars—with the probability of each such risk if reasonably determinable, and (c) acknowledges disclosure of the above information and states that all questions about the procedure have been answered satisfactorily. Obviously, the Iowa legislature is seeking to bring more certainty to the physician's obligation of risk disclosure. Although the statutory "presumption" is not likely to be construed as a conclusive one, the burden of overcoming the presumption will be on the patient.

Florida has pursued this approach even further enacting a statute which creates a conclusive presumption of validity if the written consent meets the statutory requirements, unless there is "a fraudulent misrepresentation of a material fact in obtaining the signature." The statutory requirements are that (a) the physician's conduct in obtaining the consent was "in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community"; and (b) from the information so provided by the physician a reasonable individual "would have a general understanding of the procedure and medically acceptable alternative procedures or treatments and substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among other physi-

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2 The Canterbury opinion had been referred to approvingly in Fogal v. Gennesee Hospital, 41 App. Div.2d 468, 344 N.Y.S.2d, 552, 559 (1973).
4 Florida Medical Consent Law, FLA. STAT. ANN. § 768.46 (West Supp. 1976).
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... in the same or similar community who performed similar treatments or procedures"; or (c) “The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he been advised by the physician... in accordance with the provisions” mentioned above. (Emphasis supplied).

The underscored terms seem to establish the so-called “locality” standard both as to specialists and general practitioners. Expert testimony will surely be needed to establish a departure from the standard. Apart from fraud, compliance with the statutory requirements insulates the physician from an informed consent suit because the presumption is conclusive. It is therefore unlikely that there will be many informed consent cases in Florida in the future.

An even more elaborate statute has been enacted in Ohio. That statute provides that a written consent that fulfills the statutory requirements shall be presumed to be valid and effective in the absence of proof “by a preponderance of the evidence” that the one procuring the consent was not acting in good faith, or that the consent was induced by fraudulent misrepresentation, or that the signer was not able to communicate effectively in English or the language in which consent is written. Furthermore the statute directs that, “Except as herein provided, no evidence shall be admissible to impeach, modify, or limit the authorization for performance of the procedure or procedures set forth in such written consent.” As in Iowa the Ohio statute enumerates six hazards to be disclosed—death, brain damage, quadriplegia, paraplegia, loss of function of any organ or limb, or disfiguring scars—together with “the probability of each such risk if reasonably determinable.” The consent must acknowledge that such disclosure of information has been made and that all questions have been answered satisfactorily. In addition, the statute sets out a consent form which is required to be in ten-point type with certain bold-face or large-print statements. The form breaks down the risks into nine categories including loss of organs, loss of an arm or leg, and loss of function of an arm or leg. Furthermore, the consent signature must be witnessed. Finally, a somewhat puzzling provision requires that “[A]ny use of the consent form stated [in the statute] has no effect on the common law rights and liabilities, including the right of a physician to obtain the oral or implied consent of a patient to a medical procedure that may exist as between physicians and patients at the time this section is enacted.” Similar statutes codifying the locality doctrine have also been enacted in Idaho.

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67 Id. Just what is meant by this provision of the statute is not at all clear. It is probably intended to mean that even though the statute is not complied with, and the presumption set forth therein is not created, a physician might still defend on the ground that he procured oral or other consent which is valid and effective. If it means that the cause of action for informed consent shall continue to exist as it did before the statute was enacted, the enactment of the statute would be a pointless act and the legislature has obliterated what it intended to do. The latter construction certainly should not be reached.
68 Medical Malpractice Cases Act, H.B. No. 478, § 2, 1976 Idaho Sess. Laws 951. The
Nebraska and Tennessee.

Pennsylvania is the only state known to the writer in which the new statutory language on informed consent seems to follow the doctrine of Canterbury. The Pennsylvania statute requires the physician to inform the patient "of the nature of the proposed procedure or treatment and of those risks and alternatives to treatment or diagnosis that a reasonable patient would consider material to the decision whether or not to undergo treatment or diagnosis," except in cases of emergency and therapeutic inadvisability.

Conclusion

In 1954 Melvin M. Belli published his "Modern Trials." The following year it was reviewed by the late William L. Prosser. Included in his appraisal was the following thought:

This book frightens me. It doth harrow up my soul, make by two eyes, like stars, start from their spheres, and cause my knotted and combined locks to part, and each particular hair to stand on end like quills upon the fretful porcupine.

Dean Prosser’s distress was understandable. He envisioned that full exploitation of the techniques described by Belli would intensify criticism of the jury trial system in tort cases in the United States and furnish additional ammunition to those who advocated its curtailment or abolition. For Prosser realized, as any thoughtful observer must, that if the adjudicative process is abused and distorted (whether by a specialized segment of the Bar or by a permissive judiciary or both) then to the extent that its results are unacceptable to those who are to be governed by it, the statute contains a sweeping provision that in any malpractice case plaintiff “must, as an essential part of his or her case in chief, affirmatively prove by direct expert testimony and by a preponderance of all the competent evidence, that such defendant then and there negligently failed to meet the applicable standard of health care practice of the community in which such care allegedly was or should have been provided. . . .” Another subsection describes restrictive requirements for an expert. The statute seems not only to cover informed consent cases but would also apparently eliminate res ipso loquitur.

The Nebraska Hospital-Medical Liability Act, Leg. Bill No. 434, § 16, 1976 Neb. Laws 151. It provides that informed consent means “consent to a procedure based on information which would ordinarily be provided to the patient under like circumstances by health care providers engaged in a similar practice in the locality or in similar localities.”

The doctrine is made applicable to specialists. The statute requires the plaintiff to prove “that the defendant did not supply appropriate information to the patient in obtaining his informed consent (to the procedure out of which plaintiff’s claim allegedly arose) in accordance with the recognized standard of acceptable professional practice in the profession and in the specialty, if any, that the defendant practices in the community in which he practices and in similar communities.”


M. BELL, MODERN TRIALS (1954).

PROSSER, BOOK REVIEW, 43 CALIF. L. REV. 556 (1955).

Id.; cf. W. SHAKESPEARE, HAMLET, Act I, Scene V.
system will be corrected and may be over-corrected. Long ago that occurred with the abolition of the cause of action for breach of contract to marry—the so-called “anti-heart balm” statutes. More recently it has occurred in a number of states with the adoption of no-fault compensation systems for automobile accidents. Furthermore, there are currently some signs that this kind of “reform” is likely to be initiated in the area of products liability, with a view to curtailing or eliminating the numerous causes of action that have developed in that area.

The foregoing sampling of recent statutes relating to informed consent reveals a comparable trend. The cause of action based on lack of informed consent is being drastically limited and, in some states such as Florida and Ohio it has been virtually abolished. To some observers, including the writer, this turn of affairs is a matter for regret. Apart from the Canterbury aberration, the action is generally sound in theory, relatively effective in practice, and not unduly burdensome on the medical profession. In states subscribing to the Canterbury doctrine, however, the situation is less than tolerable and the emergence of statutory “reform” is thus not surprising, especially when the class affected is as well organized, articulate, and politically potent as are most state medical societies. The unfortunate result is that in those states with “reform” legislation relief will now be available only in the most egregious cases. In jurisdictions which have not joined the statutory trend it is likely that pressure will develop to do so, particularly if their appellate courts begin to enlarge the cause of action in the Canterbury manner. Ironically, these restrictions on the cause of action for the lack of informed consent do not flow from the theoretical attacks on the tort system by its critics, but from abuses of the system by its friends.


77 In 1976 a Federal Interagency Task Force, chaired by the Undersecretary of Commerce, was created to study all aspects of the products liability problem. In Michigan, bills have been introduced in the 1977 Legislature (HB 4937, HB 5687) that would, among other things, place schedule limits on awards for pain and suffering; eliminate allowance of punitive damages under guise of compensatory damages; require the trial to be held in two stages (liability and damages); require plaintiff’s attorney to file an affidavit that the case was not solicited; limit manufacturer’s duty to warn; abolish the collateral source rule; set a specific statute of limitations; and expressly provide for certain defenses such as alteration, conformity to government standards, “state of the art”, etc.; and control terms of insurance company settlements. The bills are now in the Committee on Economic Development. The State Bar of Michigan has had a special task force at work on products liability for some time.