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## THE DOCTRINE OF INFORMED CONSENT: PROTECTING THE PATIENT'S RIGHT TO MAKE INFORMED HEALTH CARE DECISIONS

Martin R. Studer\*

Negligence in medical diagnosis or treatment gives rise to a cause of action for medical malpractice. Unauthorized medical treatment gives rise to a cause of action for battery. The doctrine of informed consent adds a remedy for patients with injuries that result from undisclosed risks, even though they consented to treatment and are unable to show negligent diagnosis or treatment.

According to the doctrine of informed consent, a physician may be held liable for a patient's injuries, absent medical negligence, if those injuries arose from risks which the physician should have disclosed when securing the patient's consent to treatment. Additionally, some courts have held physicians liable for failing to disclose alternatives to the proposed treatment,<sup>1</sup> abnormal conditions in the patient's body,<sup>2</sup> and test results.<sup>3</sup>

The physician's duty of disclosure is the principal component of informed consent. There are two approaches to defining the scope of that duty. A majority of courts define it in terms of the prevailing standard of medical custom, identified through expert testimony.<sup>4</sup> A substantial minority define it in terms of the patient's need to know, using the reasonable person standard.<sup>5</sup> Accordingly, the law of informed consent varies widely from state to state.

To hold a physician liable for injury, a plaintiff must do more than show a breach of the duty to disclose. The plaintiff must also prove that the undisclosed risk ripened into injury, and that non-

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1. See generally *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

2. See, e.g., *Gates v. Jensen*, 92 Wash. 2d 246, 251, 595 P.2d 919, 923 (1979); *Jamison v. Lindsay*, 108 Cal. App. 3d 223, 232, 166 Cal. Rptr. 443, 447 (1980).

3. See, e.g., *Phillips v. Good Samaritan Hosp.*, 65 Ohio App. 2d 112, 115, 416 N.E.2d 646, 648 (1979). Some courts require even more. See, e.g., *Truman v. Thomas*, 27 Cal. 3d 285, 292, 611 P.2d 902, 907, 165 Cal. Rptr. 308, 312 (1980) (discussion of availability and value of tests); *Crosby v. Grandview Nursing Home*, 290 A.2d 375, 380 (Me. 1972) (post treatment care recommendations).

4. See generally *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, clarified, 187 Kan. 186, 354 P.2d 670 (1960).

5. See generally *Canterbury*, 464 F.2d 772.

disclosure was a cause of the injury. Some courts have analyzed causation from the plaintiff's point of view.<sup>6</sup> However, the most widely accepted test of causation requires the plaintiff to prove that a reasonable patient would not have consented to treatment if adequately informed of the risk that ripened into injury.<sup>7</sup>

This article traces the development of the doctrine of informed consent from judicial recognition of patients' rights to make their own health care decisions to the present status of the two standards of disclosure. The law of informed consent in Montana merits special attention.

### I. DEVELOPMENT OF THE DOCTRINE OF INFORMED CONSENT

One of the earliest reported cases involving medical treatment without the patient's consent is *Mohr v. Williams*.<sup>8</sup> In that 1905 Minnesota case a physician had obtained consent to operate on one ear, but after the patient had been anesthetized he re-examined her and decided instead to operate on the other ear. His decision was medically sound and the operation was successful, but the patient sued for an unauthorized touching.<sup>9</sup> The court stated: "If the operation was performed without plaintiff's consent, and the circumstances were not such as to justify its performance without, it was wrongful; and, if it was wrongful, it was unlawful."<sup>10</sup>

Following *Mohr*, other courts recognized a cause of action for battery when medical treatment had been provided without the patient's consent.<sup>11</sup> In a 1914 landmark case, *Schloendorff v. Society of New York Hospitals*,<sup>12</sup> Judge Cardozo, writing for the Court of Appeals of New York, established the jurisprudential principle that every patient has a right to determine his or her own course of medical treatment. The plaintiff had entered a hospital suffering from an unknown stomach disorder and consented to be examined under anesthetic, but while she was unconscious her physician discovered and removed a tumor. After the operation and allegedly because of it, gangrene developed in one of her arms requiring the

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6. See generally *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979) (subjective test of causation); *Leyson v. Steuermann*, \_\_\_ Haw. App. \_\_\_, 705 P.2d 37 (1985) (modified objective-subjective test).

7. See generally *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977).

8. 95 Minn. 261, 104 N.W. 12 (1905).

9. *Id.* at 264-65, 104 N.W. at 13.

10. *Id.* at 271, 104 N.W. at 16.

11. See generally *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906) (affirming a judgment for battery).

12. 211 N.Y. 125, 105 N.E. 92 (1914).

amputation of several fingers.<sup>13</sup> Writing for the court, Cardozo stated what has since become a cornerstone in the doctrine of informed consent: "Every human being of adult years and sound mind has a right to determine what shall be done with his [sic] own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."<sup>14</sup>

Gradually the focus shifted from whether the treatment was authorized to whether consent was "informed." In *Salgo v. Stanford University*,<sup>15</sup> a California district court of appeals held that uninformed consent to medical treatment is not true consent, and thus, a physician must disclose all information necessary for the patient to make informed health care decisions.<sup>16</sup> "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."<sup>17</sup>

However, the *Salgo* court also recognized that physicians must be allowed some discretion in deciding how much information to disclose, particularly when full disclosure would be likely to increase the risks by alarming an unduly apprehensive patient.<sup>18</sup> The *Salgo* court thus articulated two contrasting considerations at the heart of informed consent law; the patient's right to receive all of the information material to an informed health care decision, and the need for judicial deference to medical discretion in some circumstances.

The two contrasting considerations articulated by the *Salgo* court reveal a fundamental dichotomy in the law of informed consent, manifested in two distinct standards of disclosure. Most courts apply a physician oriented standard, giving the medical profession broad discretion in deciding what information to disclose and what to withhold.<sup>19</sup> A growing minority require disclosure of all information that a reasonable person in the patient's position would consider material to making an informed decision.<sup>20</sup>

During the 1960's a number of courts reconsidered the efficacy of the battery cause of action as a remedy for injuries attributed to

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13. *Id.* at 128, 105 N.E. at 93.

14. *Id.* at 129-30, 105 N.E. at 93.

15. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

16. *Id.* at 578, 317 P.2d at 181.

17. *Id.*

18. *Id.*

19. See *infra* text accompanying notes 26-37.

20. See *infra* text accompanying notes 38-61.

uninformed consent.<sup>21</sup> In 1972, the California Supreme Court abandoned the battery cause of action and placed the doctrine of informed consent squarely within negligence law.<sup>22</sup> In *Cobbs v. Grant*<sup>23</sup> it stated:

The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. However, when the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation, the action would be pleaded in negligence.<sup>24</sup>

Claims based upon a lack of informed consent are now generally pleaded in negligence, although plaintiffs still utilize a battery cause of action when there was no consent, either informed or uninformed.<sup>25</sup>

## II. STANDARDS OF DISCLOSURE

### A. *The Physician-Oriented Standard of Disclosure*<sup>26</sup>

In most states, a physician will be liable for injuries that result from treatment if those injuries ripen from risks the physician should have disclosed when securing the patient's consent to treatment, but did not.<sup>27</sup> Most courts measure the adequacy of disclosure by reference to medical custom. This so-called "reasonable physician standard" was first articulated in 1960 by the Kansas Supreme Court in *Natanson v. Kline*.<sup>28</sup>

21. See generally *Natanson*, 187 Kan. 186, 354 P.2d 670 (radiation therapy resulted in burn); *Tangora v. Matansky*, 231 Cal. App. 2d 468, 42 Cal. Rptr. 348 (1964) (intramuscular penicillin injection resulted in anaphylactic shock).

22. *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

23. *Id.*

24. *Id.* at 240-41, 502 P.2d at 8, 104 Cal. Rptr. at 512.

25. See, e.g., *Pizzalotto v. Wilson*, 437 So. 2d 859, 865 (La. 1983) (hospital consent form was too ambiguous to preclude hysterectomy in patient's battery action).

26. The patient-oriented standard of disclosure varies from state to state. Most variations are overshadowed by the relative similarity of the standards, and except for those noted herein, are beyond the scope of this discussion.

27. Georgia may be the only exception. See, e.g., *McMullan v. Vaughan*, 138 Ga. App. 718, 721, 227 S.E.2d 440, 442 (1976) (informed consent is not a viable principle of law in Georgia).

28. 186 Kan. 393, 350 P.2d 1093 (1960).

In *Natanson*, the plaintiff had consented to radiation therapy after a mastectomy, and was injured by the radiation. She initiated a typical medical malpractice suit, but also alleged that her physician had wrongfully failed to disclose the risks of radiation therapy.<sup>29</sup> The *Natanson* court ruled that her consent was legally inadequate because her physician failed to make an adequate disclosure.

[The physician] was obligated to make a reasonable disclosure to the [patient] of the nature and probable consequences of the suggested or recommended . . . treatment, and he was also obligated to make a reasonable disclosure of the dangers within his knowledge which were incident to, or possible, in the treatment he proposed to administer.<sup>30</sup>

*Natanson* signalled a new theory of recovery for injured patients who could not show negligent diagnosis or treatment. It proved to be a popular theme, as courts in thirteen other states adopted the physician-oriented standard of disclosure.<sup>31</sup> The legislatures in thirteen additional states enacted statutes defining the same duty of disclosure.<sup>32</sup> Courts in these states focus on whether the physician's judgment squared with professional custom. The inquiry mirrors that of typical medical negligence cases in which medical custom provides the applicable standard of care.<sup>33</sup> For example, the *Natanson* court allowed that: "How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment."<sup>34</sup> Naturally, courts which enforce a physician-oriented standard of disclo-

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29. *Id.* at 406, 350 P.2d at 1103.

30. *Id.* at 410, 350 P.2d at 1106.

31. See generally *Roberts v. Wood*, 206 F. Supp. 579 (S.D. Ala. 1962); *Bloskas v. Murray*, 618 P.2d 719 (Colo. Ct. App. 1980); *Coleman v. Garrison*, 327 A.2d 757 (Del. Super. Ct. 1974), *aff'd*, 349 A.2d 8 (1975); *Green v. Hussey*, 127 Ill. App. 2d 174, 262 N.E.2d 156 (1970); *Kranda v. Houser-Norborg Medical Corp.*, \_\_\_ Ind. \_\_\_, 419 N.E.2d 1024 (1981); *Marchlewicz v. Stanton*, 50 Mich. App. 344, 213 N.W.2d 317 (1973); *Ross v. Hodges*, 234 So. 2d 905 (Miss. 1970); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); *Collins v. Itoh*, 160 Mont. 461, 503 P.2d 36 (1972); *Folger v. Corbett*, 118 N.H. 737, 394 A.2d 63 (1978); *Calabrese v. Trenton State College*, 162 N.J. Super. 145, 392 A.2d 600 (1978); *Bly v. Rhoads*, 216 Va. 645, 222 S.E.2d 783 (1976); *Govin v. Hunter*, 374 P.2d 421 (Wyo. 1962).

32. These include: ALASKA STAT. § 09.55.556(a) (1983); ARIZ. REV. STAT. ANN. § 12-563(1) (1982); ARK. STAT. ANN. § 34-2614(b)(1) (1985); FLA. STAT. ANN. § 768.46(3)(a)(1) (1986); GA. CODE ANN. § 31-9-6 (1985); HAW. REV. STAT. § 671-3 (1984) (also empowers medical board to establish standards of disclosure); IDAHO CODE § 39-4304 (1985); KY. REV. STAT. § 304.40-320(1) (1981); NEB. REV. STAT. § 44-2816 (1981 reissue); NEV. REV. STAT. § 449.710(6) (1985); N.C. GEN. STAT. § 90-21.13(a)(1) (1985); TENN. CODE ANN. § 29-26-118 (1980); TEX. HEALTH & SAFETY CODE ANN., APT. 4590i, § 6.05 (1986).

33. W. PROSSER & W. KEETON, *THE LAW OF TORTS* § 32 at 186-87 (5th ed. 1984).

34. *Natanson*, 186 Kan. at 409, 350 P.2d at 1106.

sure rely on expert medical testimony to establish the scope of legally adequate disclosure. "The precise scope of the physician's duty of disclosure is determined on the basis of expert testimony demonstrating the extent of information given by reasonably careful physicians practicing the same specialty in the same or similar community."<sup>36</sup>

The physician-oriented standard of disclosure assumes that the physician knows best. As one commentator has observed, widespread judicial reliance on the physician-oriented standard of disclosure "reveals the enormous deference paid by courts to the medical community's definition of its responsibilities, and the relatively low value they have placed upon the autonomy of the patient."<sup>36</sup>

Judicial deference to medical custom permits physicians to control the test courts use to resolve informed consent cases. Because physicians decide the content and scope of legally adequate disclosure, plaintiffs have a difficult time making a case. In states where courts apply the physician-oriented standard of disclosure, plaintiffs must prove through the testimony of one physician that another did not meet professional standards. That can be an onerous burden.<sup>37</sup>

It is one thing to require each physician to meet professional standards in diagnosing and treating illness but it is something quite different to permit medical custom to excuse liability when injury results from a risk an informed patient would not have accepted. Recognizing this distinction, many courts have rejected the physician oriented standard of disclosure in an effort to find one more compatible with patients' rights to make their own health care decisions.

### B. *The Patient-Oriented Standard of Disclosure*<sup>38</sup>

An increasing number of courts and legislatures have recog-

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35. *Bloskas v. Murray*, 646 P.2d 907, 914 (Colo. 1982). Prevailing custom is not always dispositive even in jurisdictions which recognize the physician-oriented standard of disclosure. For example, the Minnesota Supreme Court has ruled that "even if . . . disclosure conforms to accepted medical practice, a physician nevertheless should be liable if he fails to inform the patient of a significant risk of treatment or of an alternative treatment." *Cornfeldt v. Tongen*, 262 N.W.2d 684, 702 (Minn. 1977).

36. Riskin, *Informed Consent: Looking for the Action*, 1975 U. ILL. L.F. 580, 586.

37. See, e.g., *Salgo*, 154 Cal. App. 2d at 568, 317 P.2d at 175. The physician oriented standard of disclosure is often criticized because of the burden it places on plaintiffs to overcome a conspiracy of silence among members of the medical professions. See, e.g., Comment, *Informed Consent: A New Standard for Texas*, 8 ST. MARY'S L.J. 499, 509 (1976).

38. The patient oriented standard of disclosure varies from state to state. Except for those noted herein, such variations are beyond the scope of this article.

nized that the physician-oriented standard of disclosure is inconsistent with patients' rights to make their own health care decisions. Courts and legislatures in sixteen states and the District of Columbia have rejected that standard, and require physicians to disclose all of the information that a reasonably prudent patient would consider material to the decision whether to accept treatment.<sup>39</sup>

The District of Columbia Circuit Court was the first to articulate a patient-oriented standard of disclosure in a 1972 case, *Canterbury v. Spence*.<sup>40</sup> There the plaintiff sought damages for personal injuries allegedly caused by a negligent laminectomy. He also claimed his physician had not disclosed the risk of serious disability inherent in the operation.<sup>41</sup>

The *Canterbury* court observed that the physician's duty to

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39. *Cobbs*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977); *Harnish v. Childrens Hosp. Medical Center*, 387 Mass. 152, 439 N.E.2d 240 (1982); *Plutshack v. University of Minn. Hosp.*, 316 N.W.2d 1 (Minn. 1982); *Henning v. Parsons*, 95 N.M. 454, 623 P.2d 574 (1980); *Congrove v. Holmes*, 37 Ohio Misc. 95, 308 N.E.2d 765 (1973); *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979); *Cooper v. Roberts*, 220 Pa. Super. 260, 286 A.2d 647 (1971); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972); *Cunningham v. Yankton Clinic*, 262 N.W.2d 508 (S.D. 1978); *Nixdorf v. Hicken*, 612 P.2d 348 (Utah 1978); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 227 N.W.2d 647 (1975).

IOWA CODE § 147.137 (1985); LA. REV. STAT. ANN. § 40:1299.40 (1985); OR. REV. STAT. § 677.097 (1985); WASH. REV. CODE § 7.70.050 (1986). However, only one of these statutes clearly embodies the minority standard. Washington's Revised Code provides:

(1) The following shall be necessary elements of proof that injury resulted from health care in a civil negligence case or arbitration involving the issue of the alleged breach of the duty to secure an informed consent by a patient or his representatives against a health care provider:

(a) that the health care provider failed to inform the patient of a material fact or facts relating to the treatment;

(b) that the patient consented to the treatment without being aware of or fully informed of such material fact or facts;

(c) that a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;

(d) that the treatment in question proximately caused injury to the patient.

(2) Under the provisions of this section a fact is defined as or considered to be a material fact, if a reasonably prudent person in the position of the patient or his representative would attach significance to it deciding whether or not to submit to the purposed treatment.

WASH. REV. CODE § 7.70.050(1), (2) (1986).

In Iowa, Louisiana, and Oregon, judicial interpretation of the relevant statutes has established a patient oriented standard of disclosure, although the statutory language itself is ambiguous. See *Cowman v. Hornaday*, 329 N.W.2d 422 (Iowa 1983); *Percle v. St. Paul Fire & Marine Ins. Co.*, 349 So. 2d 1289 (La. 1977); *Holland v. Sisters of St. Joseph of Peace*, 270 Or. 129, 522 P.2d 208, opinion withdrawn on other grounds, 270 Or. 139, 526 P.2d 577 (1974).

40. 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

41. *Id.* at 778.

disclose arose from three almost axiomatic considerations. First, every human being has a right to determine his or her own course of medical treatment. Second, real consent requires the informed exercise of choice, which in turn requires an opportunity to evaluate the options available and the risks associated with each. Third, the average patient has little understanding of medicine, and can only turn to a physician for advice.<sup>42</sup> Accordingly, the *Canterbury* court held that respect for the plaintiff's right of self-determination demands a standard set by law, rather than one which physicians set for themselves:

[T]he test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked . . . [A] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.<sup>43</sup>

The *Canterbury* court added that "[t]he duty to divulge may extend to any risk [the physician] actually knows, but he obviously cannot divulge any of which he may be unaware."<sup>44</sup>

Legally adequate disclosure under the patient-oriented standard includes more information than under the physician-oriented standard. The leading cases suggest it includes a discussion of the nature of the proposed treatment, whether it is necessary or merely elective, the risks, and the available alternatives and their risks and benefits.<sup>45</sup> However, the precise scope of disclosure usually evades definition. While some courts have required full disclosure,<sup>46</sup> most settle for "reasonable disclosure" as the California Supreme Court did in *Cobbs* when it adopted the minority standard of disclosure in that state.<sup>47</sup>

In *Cobbs* the plaintiff had alleged medical negligence and a lack of informed consent. After trial the jury returned a general verdict for the plaintiff, failing to distinguish which of the two theories of liability it relied upon.<sup>48</sup> On appeal, the California Supreme Court held that there was insufficient evidence of negligence

42. *Id.* at 780.

43. *Id.* at 786-87.

44. *Id.* at 787, n.84.

45. See generally *Canterbury*, 464 F.2d 772; *Sard v. Hardy*, 281 Md. 432, 379 A.2d 1014 (1977).

46. See, e.g., *Berkey v. Anderson*, 1 Cal. App. 3d 790, 804, 82 Cal. Rptr. 67, 77 (1969).

47. *Cobbs*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514. See also *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 11, 227 N.W.2d 647, 653 (1975).

48. *Cobbs*, 8 Cal. 3d at 235, 502 P.2d at 5, 104 Cal. Rptr. at 509.

treatment, and since it was unable to ascertain which theory the jury relied on, it reversed the judgment and remanded the case.<sup>49</sup> It also instructed the trial court on the physician's duty to secure informed consent.

[T]he patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. . . . However . . . when a given procedure inherently involves a known risk of death or serious bodily harm, a medical doctor has a duty to disclose to his patient the potential of death or serious harm, and to explain in lay terms the complications that might possibly occur.<sup>50</sup>

Since *Cobbs*, the California Supreme Court has expanded the duty. In *Truman v. Thomas*,<sup>51</sup> it held that when a patient declined a pap smear, her physician had a duty to advise her of the risks involved in foregoing it.<sup>52</sup> Thus, at least in California, the physician's duty to disclose is no longer limited to situations in which the physician performs treatment, but also arises when the patient wants to forego recommended tests.

The minority rule of disclosure is subject to a number of exceptions. For example, a physician may give emergency medical treatment without a patient's consent if the patient suffers an injury requiring immediate treatment and is incapacitated and unable to give an informed consent.<sup>53</sup> Additionally, physicians may withhold information when candid disclosure would adversely affect a patient's condition.<sup>54</sup> "The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs."<sup>55</sup>

Courts will also excuse inadequate disclosure when the risk is either known to the patient or is so obvious that knowledge can be presumed—for example, the risk of infection from surgery.<sup>56</sup> Furthermore, physicians are usually not required to discuss risks inherent in common procedures when it is widely known that such

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49. *Id.* at 238, 502 P.2d at 507, 104 Cal. Rptr. at 510-11.

50. *Id.* at 244, 502 P.2d 511, 104 Cal. Rptr. at 515.

51. 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (patient declined pap smear).

52. *Id.* at 292, 611 P.2d at 907, 165 Cal. Rptr. at 312.

53. *Cobbs*, 8 Cal. 3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514; see also F. Rozovsky, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* (1984).

54. *Sard v. Hardy*, 281 Md. 423, 444-45, 379 A.2d 1014, 1022 (1977).

55. *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

56. *Sard*, 281 Md. at 445, 379 A.2d at 1022.

risks rarely materialize, or when the physician does not know of the risk and could not have been aware of it in the exercise of ordinary care.<sup>57</sup>

The patient-oriented standard of disclosure articulated in *Canterbury* has become the prevalent minority view. Emphasis on patients' rights on self-determination shifts the focus away from medical custom to what a reasonably prudent patient would consider material to his or her health care decisions. Since the scope of the duty under the patient-oriented standard is measured by the patient's need to know instead of medical custom, expert witnesses play a lesser role. As a Washington court in *Brown v. Dahl*<sup>58</sup> stated:

"Specifically, expert testimony is . . . necessary to prove the existence of a risk, its likelihood of occurrence, and the type of harm in question" . . . . Once materiality [to the patient's decision] is established, however, "expert testimony is of secondary importance and it is for the jury to place themselves in the position of a patient and decide whether, under the circumstances, the patient should have been told."<sup>59</sup>

Although expert testimony may still be necessary to establish the existence of risks, it is not necessary for establishing the standard of disclosure. Moreover, as disclosure is not a matter of medical custom, the applicable standard is well within the province of a jury.<sup>60</sup> The patient-oriented standard of disclosure clearly offers plaintiffs better prospects for recovery. "[F]actors extraneous to the actual rules of decisions—most notably the egregiousness of the plaintiff's injuries—may more directly enter into the jurors' individual and collective decisionmaking process."<sup>61</sup>

The patient-oriented standard of disclosure comports with the theoretical underpinnings of the doctrine of informed consent. It gives meaning to the patient's right of self-determination in a manner consistent with the character of tort law by setting a legal standard for deciding what constitutes due care. Furthermore, since inadequate disclosure is essentially a misrepresentation rather than

57. *Id.*; see also *Henderson v. Milobsky*, 595 F.2d 654 (D.C. Cir. 1978). *But cf.* *Salis v. United States*, 522 F. Supp. 998, 999 (M.D. Pa. 1981) (1 to 2% risk of serious complications); *Hartke v. McKelway*, 526 F. Supp. 97, 102 (D.D.C. 1981) (0.1% to 0.3% risk of pregnancy after sterilization).

58. 41 Wash. App. 565, 705 P.2d 781 (1985).

59. *Id.* at 571, 705 P.2d at 786 (citation omitted).

60. See, e.g., *Wilkinson v. Vesey*, 110 R.L. 606, 625-26, 295 A.2d 676, 688 (1972); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 15, 227 N.W.2d 647, 655 (1975).

61. Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51, 99 (1977).

an act of medical malpractice, the minority standard of disclosure is more suited to the cause of action.

### C. *Informed Consent in Montana*

The Montana Supreme Court recognized the doctrine of informed consent and applied the physician-oriented standard of disclosure in a 1968 dental malpractice case, *Negaard v. Fedra*.<sup>62</sup> Writing for a unanimous court, Justice Haswell laid the foundation:

The gist of the "informed consent" theory of liability is that a physician is under a duty *under some circumstances* to warn his patient of the known risks of proposed treatment so that the patient will be in a position to make an intelligent decision as to whether he will submit to such treatment.<sup>63</sup>

The *Negaard* court specifically adopted the *Natanson* rule and held that the scope of disclosure is primarily a matter of medical judgment to be established by expert testimony.<sup>64</sup>

Two years later, the Montana Supreme Court began to build upon that foundation. In *Doerr v. Movius*,<sup>65</sup> the court qualified the physician's duty of disclosure. In that case the plaintiff had appealed a directed verdict against his claim that the defendant had misdiagnosed his daughter's condition, failed to obtain his informed consent, and performed unnecessary abdominal surgery on the girl.<sup>66</sup> The court observed that the "circumstances under which the doctrine of informed consent is most often applied are those . . . where dire consequences are a possible result of the treatment."<sup>67</sup> The court reviewed the trial record, and not finding any dire consequences it upheld the directed verdict.<sup>68</sup> Read literally, *Doerr* added a "dire risk" qualification to the duty of disclosure in Montana.

Having recognized the physician's duty to disclose risks in some circumstances, the Montana Supreme Court further defined those circumstances a few years later in *Collins v. Itoh*.<sup>69</sup> The question in that case was whether the physician should have disclosed a small risk of future cramping, numbness, and muscle

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62. 152 Mont. 47, 446 P.2d 436 (1968).

63. *Id.* at 54-55, 446 P.2d at 441 (emphasis added).

64. *Id.* at 56, 446 P.2d at 441.

65. 154 Mont. 346, 463 P.2d 477 (1970).

66. *Id.* at 348-49, 463 P.2d at 478.

67. *Id.* at 349, 463 P.2d at 479.

68. *Id.* at 350, 463 P.2d at 479.

69. 160 Mont. 461, 503 P.2d 36 (1972).

spasms associated with a thyroidectomy. Expert testimony concerning the customary disclosure practices of other physicians was inconclusive, but the court found for the defendant anyway.

Whether the physician is under a duty to disclose depends upon the facts of each case; no hard and fast rule can be stated as to what should be disclosed and what can be withheld. The statistical evidence presented, even when viewed in the light most favorable to plaintiff, does not demonstrate an urgent need to disclose such information to the patient.<sup>70</sup>

Noticeably absent from the court's analysis in *Collins* was the dire risk qualification enunciated two years earlier in *Doerr*. That omission, only two years after *Doerr*, suggests that the dire risk qualification may have been an anomaly. The *Collins* court also explained the role of expert testimony: "The custom and practice of one particular doctor, without knowledge of the general custom and practice among the profession, cannot establish a reasonable basis to infer that defendant departed from that practice. Nor does it infer that a doctor who does not follow that particular practice was negligent."<sup>71</sup>

In 1976, the Montana Supreme Court reaffirmed the physician-oriented standard in *Llera v. Wisner*,<sup>72</sup> upholding summary judgment in favor of an oral surgeon and an orthodontist after the trial court found that neither the depositions nor any other documents presented by the plaintiff alleged a standard of disclosure.<sup>73</sup>

Informed consent cases often involve disputes over the so-called "locality rule."<sup>74</sup> That rule requires physicians to possess and exercise the reasonable and ordinary degree of knowledge, skill, and care possessed and exercised by physicians of good standing of the same kind of practice in the same or similar locality.<sup>75</sup> The Montana Supreme Court has defined a "similar locality" as one of similar geographical location, size, and character in a medical context.<sup>76</sup>

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70. *Id.* at 468, 503 P.2d at 40 (citations omitted). Furthermore, a physician's admission that, in retrospect, he did not provide the standard of care that he should have, does not establish a standard of care or violation of it for purposes of making a prima facie case. *Hill v. Squibb & Sons E.R.*, 181 Mont. 199, 208, 592 P.2d 1383, 1389 (1979). See also *Montana Deaconess Hosp. v. Gratton*, 169 Mont. 185, 189, 545 P.2d 670, 672 (1976) (the medical standard of care must be established by expert medical testimony).

71. *Collins*, 160 Mont. at 469, 503 P.2d at 41.

72. 171 Mont. 254, 557 P.2d 805 (1976).

73. *Id.* at 261, 557 P.2d at 812.

74. See, e.g., *Collins*, 160 Mont. at 469, 503 P.2d at 41.

75. *Tallbull v. Whitney*, 172 Mont. 326, 335, 564 P.2d 162, 166 (1977).

76. *Id.* at 335, 564 P.2d at 166-67.

However, the Montana Supreme Court abandoned the locality rule in cases involving certified specialists. In *Aasheim v. Humbert*<sup>77</sup> it observed that the locality rule was an outgrowth of disparity in the quality of community medical practice, and since that disparity has largely been eliminated by medical training and certification, the rule bears no rational relationship to the standards used to evaluate certified specialists.<sup>78</sup> Where board certified specialists are concerned, the applicable standard of care is determined by reference to the skill and learning used in like cases by other physicians practicing the same specialty and who hold the same board certification.<sup>79</sup>

Montana clearly follows the majority standard of disclosure. A physician may be liable for failing to disclose risks only if he or she departed from medical custom. Accordingly, expert testimony is indispensable in Montana informed consent cases.

The Montana Supreme Court has not reviewed the physician-oriented standard of disclosure since 1970. Since then, the Montana Supreme Court has shown a willingness to facilitate the compensatory and deterrent purposes of tort law in other areas,<sup>80</sup> and the people of Montana have adopted a new state constitution, which states in part: "All persons are born free and have certain inalienable rights. They include the . . . rights of pursuing life's basic necessities . . . and seeking their safety, health and happiness in all lawful ways. In enjoying these rights, all persons recognize corresponding responsibilities."<sup>81</sup> Perhaps, given constitutional reasons for recognizing a greater duty of disclosure, the Montana Supreme Court would join the growing number of courts in other jurisdictions which apply a patient-oriented standard in informed consent cases.

### III. UNINFORMED CONSENT AND CAUSATION

After establishing a physician's breach of the duty to disclose, a plaintiff must also demonstrate that the undisclosed risk ripened into injury, and that nondisclosure was the legal cause of that injury. There are two different tests used to determine whether non-

77. \_\_\_ Mont. \_\_\_, 695 P.2d 824 (1985).

78. *Id.* at \_\_\_, 695 P.2d at 827.

79. *Id.* at \_\_\_, 695 P.2d at 826-27.

80. See generally *Versland v. Caron Transp.*, \_\_\_ Mont. \_\_\_, 671 P.2d 583 (1983) (negligent infliction of emotional distress); *Gates v. Life of Mont. Ins. Co.*, \_\_\_ Mont. \_\_\_, 668 P.2d 213 (1983) (bad faith in employment relations); *Lipinski v. Title Ins. Co.*, 202 Mont. 1, 655 P.2d 970 (1982) (insurance bad faith).

81. MONT. CONST. art. II, § 3.

disclosure was a cause of the plaintiff's injuries. The so-called objective test considers whether or not a reasonable person in the patient's position would have consented to treatment if informed of the risk that ripened into injury.

If disclosure of all material risks would not have changed the decision of a reasonable person in the position of the patient, there is no causal connection between nondisclosure and his damage. If, however, disclosure of all material risks would have caused a reasonable person in the position of the patient to refuse the surgery or therapy, a causal connection is shown. Under this rule, the patient's hindsight testimony as to what he would have hypothetically done, though relevant, is not determinative of the issue.<sup>82</sup>

The analysis of causation is unavoidably hypothetical. Courts that apply the objective standard and employ the reasonable person claim good reason for doing so.<sup>83</sup> The objective test prevents the plaintiff's hindsight from controlling the inquiry and yielding a foregone conclusion. As the *Canterbury* court stated:

We think a technique which ties the factual conclusion on causation simply to the assessment of the patient's credibility is unsatisfactory . . . [a]nd the answer which the patient supplies hardly represents more than a guess, perhaps tinged by the circumstance that the uncommunicated hazard has in fact materialized. . . .

Better it is, we believe, to resolve the causality issue on an objective basis: in terms of what a prudent person . . . would have [done] . . . .<sup>84</sup>

However, the objective test is not universal. The Oklahoma Supreme Court adopted a subjective test that consists solely of the plaintiff's testimony.<sup>85</sup> The relevant inquiry focuses on whether the plaintiff would have submitted to treatment if informed of the risk that ripened into injury. The court in *Scott v. Bradford*<sup>86</sup> explained this test:

Although the *Canterbury* rule is probably that of the majority, its "reasonable man" approach has been criticized by some commen-

82. *Sard v. Hardy*, 281 Md. 423, 450, 379 A.2d 1014, 1025 (1977).

83. *See, e.g., Cobbs*, 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515-16 ("it would be surprising if the patient-plaintiff did not claim that had he been informed of the dangers he would have declined treatment."); *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 15, 227 N.W.2d 647, 655 (1975) (objective test does not depend solely on a test of the plaintiff's credibility); *Cornfeldt v. Tongen*, 262 N.W.2d 684, 701 (Minn. 1977) (jury probably uses an objective test anyway).

84. *Canterbury v. Spence*, 464 F.2d 772, 790-91 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

85. *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979).

86. *Id.*

tators as backtracking on its own theory of self-determination. The *Canterbury* view certainly severely limits the protection granted an injured patient. To the extent the plaintiff, given an adequate disclosure, would have declined the proposed treatment, and a reasonable person in similar circumstances would have consented, a patient's right of self-determination is *irrevocably lost*. This basic right to know and decide is the reason for the full-disclosure rule. Accordingly, we decline to jeopardize this right by the imposition of the "reasonable man" standard.

If a plaintiff testifies he would have continued with the proposed treatment had he been adequately informed, the trial is over under either the subjective or objective approach. If he testifies he would not, then the causation problem must be resolved by examining the credibility of plaintiff's testimony. The jury must be instructed that it must find the plaintiff would have refused the treatment if he is to prevail.<sup>87</sup>

In another, perhaps more realistic variation, a Hawaiian court recently held "it is impossible to determine what [the plaintiff] would have done had he been properly informed," and adopted a modified standard that determines causation from the perspective of the actual patient acting rationally and reasonably.<sup>88</sup>

Proponents of the subjective test argue that the objective test undercuts patients' rights of self-determination. They have a valid point. The objective standard is unfair to the extent that it deprives patients of the right to make their own decision for whatever reasons they deem appropriate.<sup>89</sup>

On the other hand, the objective test is preferable in cases where the patient has died, because it permits recovery even when the patient is unavailable to testify.<sup>90</sup> This, and the obvious potential that a plaintiff's self-serving testimony will lead to undeserved recovery, have led a majority of courts to adopt the objective test of causation in informed consent cases.<sup>91</sup>

## V. CONCLUSION

Traditionally, treatment without a patient's consent gave rise

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87. *Id.* at 559.

88. *Leyson v. Stevermann*, \_\_\_ Haw. App. \_\_\_, 705 P.2d 37, 47 n.10 (1985).

89. *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 15, 227 N.W.2d 647, 655 (1975).

90. *See, e.g., Bowers v. Garfield*, 382 F. Supp. 503, 506 (E.D. Pa. 1974), *aff'd mem.*, 503 F.2d 1398 (3d Cir. 1974).

91. *See, e.g., Karp v. Cooley*, 493 F.2d 408, 422 (5th Cir. 1974); *Hamilton v. Hardy*, 37 Colo. App. 375, 381, 549 P.2d 1099, 1105 (1976); *Schroeder v. Lawrence*, 372 Mass. 1, 5, 359 N.E.2d 1301, 1303 (1977).

to a cause of action for battery, while negligent diagnosis or treatment gave rise to one for medical malpractice. The doctrine of informed consent adds a remedy for patients with injuries that result from undisclosed risks, even though they consented to treatment and are unable to show negligent diagnosis or treatment.

The law of informed consent varies widely from state to state. A majority of courts apply a physician-oriented standard of disclosure. Unfortunately, that standard often yields results that contravene the fundamental premise that every patient has the right to make his or her own health care decisions. An increasing number of courts enforce a standard of disclosure that entitles patients to whatever information a reasonably prudent patient would consider material to his or her health care decision.

Claims based on inadequate disclosure are particularly significant to the victims of unavoidable medical accidents.<sup>92</sup> Every kind of treatment carries some kind of statistical risk that may ripen into injury, even when performed with care. Victims of such statistical risks may not be able to recover for medical negligence but may nonetheless obtain recovery if they can establish that the physician failed to disclose the risk.

In 1970, when the Montana Supreme Court scrutinized the doctrine of informed consent and adopted the physician-oriented standard, few courts had even considered, much less adopted, a patient-oriented standard. Since then much has changed. Fully one-third of the states have adopted the patient-oriented standard. The Montana Supreme Court has demonstrated a willingness to facilitate the compensatory and deterrent purposes of tort law, and the citizens of this state have adopted a new constitution boldly asserting every citizen's right to self-determination. In view of these developments, the physician-oriented standard of disclosure seems outdated. The Montana Supreme Court should now consider adopting the patient-oriented standard of disclosure in informed consent cases.

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92. An accident is considered "unavoidable" if it is not proximately caused by the negligence of any party to the accident. W. PROSSER & W. KEETON, *THE LAW OF TORTS* § 29, at 162-64 (5th ed. 1984).