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INFORMED CONSENT: A MALPRACTICE HEADACHE

I. INTRODUCTION

In my own work I can never quite escape the shadow of malpractice. Although internal medicine has been less plagued by lawsuits than surgery and its subspecialties, I still live with the subliminal awareness that every phone call, every "minor" office visit may culminate in a suit.

I live with this consciousness, and the way I practice is subtly affected by it. It is difficult to distinguish between the thoroughness and good sense dictated by sound medical practice and that required to ward off lawsuits, "yet I think the line can at times be drawn."¹

This feeling of frustration belongs to Dr. Michael J. Halberstam of Washington, D.C., who echoes the sentiments of many members of the medical community. Until recently, the main concern of the practicing physician was the proper care and treatment of his patient's illness. Today, however, more and more doctors are becoming litigation-conscious instead of duty-conscious.² The sharp rise in malpractice cases and the increase in the size of judgments and settlements have forced many physicians "to practice what they call defensive medicine, viewing each patient as a potential malpractice claimant."³ Physicians are accepting less and less responsibility in operations which might entail a risk of patient injury.⁴ There is a growing breakdown in the physician-patient relationship. Dr. Halberstam feels that "medicine, like law, is becoming an adversary proceeding, with doctor and patient cautiously eyeing each other, one side alert to signs of error, the other to evidence of contentiousness or dissatisfaction."⁵

One recent development in the field of medical malpractice which certainly has added to the growing discontent among physicians is the theory of informed consent. Recovery under this theory is based on the physician's failure to fully disclose the dangers inherent in the proposed treatment before obtaining the patient's consent to the procedure involved. The theory is based on the long standing principle that every person has the right to refuse medical treatment even though his physician advises him that it is in his best interest to consent.⁶ "Every human being of adult years and sound mind has the right to determine what shall be done with his own body. . . ."⁷

¹ Halberstam, *The Doctor's New Dilemma—Will I Be Sued?*, N.Y. Times, Feb. 14, 1971, at 9.

² See *Barnett v. Bachrach*, 34 A.2d 626 (D.C. Mun. Ct. App. 1943).

³ Ribicoff, *Medical Malpractice: the Patient vs. the Physician*, Trial Magazine, Feb/Mar 1970 at 10.

⁴ *Id.*

⁵ Halberstam, *supra* note 1, at 8. Results of a recent investigation into the increase in medical malpractice litigation conducted by Senator Abraham Ribicoff, Chairman of the Senate Subcommittee on Executive Reorganization, also concluded that the physician-patient relationship was rapidly becoming an adversary proceeding. See generally, Ribicoff, *Medical Malpractice: the Patient v. the Physician*, Trial Magazine, Feb/Mar 1970.

⁶ 2 D. Louisell and H. Williams, *Medical Malpractice*, ¶ 22,01 (1969).

⁷ *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125 at 128, 105 N.E. 92 at 93 (1914).

While the theory of informed consent has given physicians cause for additional concern, it has also brought about a great deal of controversy in legal circles. Numerous questions about the topic have been raised with much discussion about possible answers. The main problems center around two areas: (1) the nature of the tort action—battery or negligence; and (2) adequate disclosure by the physician—the requirements necessary to satisfy his legal obligation to the patient. The purpose of this comment is to analyze these problems and to review the solutions offered in recent court decisions.

II. NATURE OF THE TORT—BATTERY OR NEGLIGENCE

Informed consent arose from a number of early cases in which the patient never consented at all to the medical treatment. The leading case is *Mohr v. Williams*.⁸ In *Mohr* the plaintiff had consented to an operation on her right ear. While under the influence of anesthetics, the defendant doctor examined her left ear and found it in worse condition than the right. The doctor then performed the operation on the left ear. The court held that since the defendant performed the operation on the left ear without the plaintiff's consent, his unauthorized act, even though it was free from negligence, was wrongful and constituted battery on her person.⁹ The court also noted that, unlike a criminal action, unlawful intent need not be shown. It was sufficient to prove that the operation was performed without consent.¹⁰

In the years following the *Mohr* decision, most courts which handled similar cases involving lack of consent followed the battery theory. In *Pratt v. Davis*¹¹ the Illinois Supreme Court held it was a trespass to the person. Other court decisions, citing the soundness of the rule in *Mohr*, held it was a technical assault and battery.¹² The eminent Justice Cardozo, while sitting on the bench of the Court of Appeals of New York, commented on the matter in the case of *Schloendorff v. Society of New York Hospital*.¹³ He said, "a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages."¹⁴

Some legal scholars claim the cause of action based on a battery in these cases is not totally acceptable because in traditional battery cases the defendant usually acts out of malice.¹⁵ The argument often posed is that the physician is acting in good faith for the betterment of his patient.¹⁶ But the fact remains, whether the doctor is acting in good faith or not, treating the patient without

⁸ 95 Minn. 261, 104 N.W. 12 (1905).

⁹ *Id.* at 271, 104 N.W. at 16.

¹⁰ *Id.*

¹¹ 224 Ill. 300, 79 N.E. 562 (1906).

¹² *Rolater v. Strain*, 137 P. 96 (Okla. 1913); *Hively v. Higgs*, 120 Ore. 588, 253 P. 363 (1927).

¹³ 211 N.Y. 125, 105 N.E. 92 (1914).

¹⁴ *Id.* at 128, 105 N.E. at 93.

¹⁵ McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 Minn. L. Rev. 381 (1957).

¹⁶ *Id.* at 424.

having obtained the necessary consent is wrongful. The unlawful touching of a person's body is a battery.¹⁷ Therefore, in situations where there is no consent whatsoever and where there is a limited consent which is violated, the battery theory is entirely satisfactory.

The real problem is presented when the patient has given his consent to the treatment specified without having been informed of the dangers involved. Here the feasibility of the battery theory can be questioned and the necessity of informed consent becomes applicable. The courts have differed in their handling of cases predicated on the informed consent theory. Some hold that when the physician does not provide sufficient information, the patient's consent is negated and therefore a technical battery is committed on the plaintiff.¹⁸ Other jurisdictions grant relief under a theory of negligence. These courts hold it is the doctor's duty to disclose pertinent facts about the procedure to the patient. Failure on the part of the physician to provide this information is deemed to be negligence on his part.¹⁹

One case in which the court applied the battery theory was *Bowers v. Talmage*.²⁰ In *Bowers* the injured plaintiff was a nine year old boy who suffered from seizures or spells. His parents took him to Dr. Von Storch, a neurologist, who was in doubt whether the boy's trouble was emotional or organic. The doctor suggested that an arteriogram (an exploratory surgical process) be performed. Evidence was presented which tended to show that Dr. Von Storch did not inform the boy's parents of the dangers of the operation. Three per cent of such operations were known to result in death, and other surgery of this type could result in paralysis. After his operation the plaintiff suffered from partial paralysis. The court held that the evidence presented an issue for the jury regarding the material question of whether informed consent for the operation was obtained from the parents. The court went on to say, "Unless a person who gives consent to an operation knows its dangers and the degree of danger, a consent does not represent a choice and is ineffectual."²¹

Another case in which the patient based his recovery on an alleged battery was *Bang v. Charles T. Miller Hospital*.²² Although the court did not specifically label the plaintiff's case as involving informed consent, this was the main issue presented by the facts. The plaintiff was having urinary trouble and sought his physician's advice on the matter. After initial examination, Dr. Foley recommended that the plaintiff be admitted to the Charles T. Miller Hospital for further investigation into his condition with a view to performing a prostate

¹⁷ W. Prosser, *Law of Torts* p. 34 (3d ed. 1964).

¹⁸ *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965); *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1965).

¹⁹ *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, rehearing denied with clarification, 187 Kan. 186, 354 P.2d 670 (1960); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965).

²⁰ 159 So. 2d 888 (Fla. Ct. App. 1963).

²¹ *Id.* at 889.

²² 251 Minn. 427, 88 N.W.2d 186 (1958).

operation if further examination revealed this was necessary. After being admitted to the hospital and going through further tests, the plaintiff was told by Dr. Foley a prostate operation was required. From that moment forward, according to evidence presented by the plaintiff, Dr. Foley never informed his patient that part of the prostate operation involved cutting his spermatic cords, thus making him sterile. During his testimony, Dr. Foley revealed that he could not remember if he had told the plaintiff about the cutting of the spermatic cords. The Supreme Court of Minnesota in reversing the lower court's dismissal of the plaintiff's action held that the evidence presented a question of fact for the jury to decide. While the court made no specific comment as to the validity of the consent, the reference to the *Mohr* decision and other cases decided on a battery theory implied that if there had not been an evidentiary question the court would have negated the consent and held the defendant liable for assault and battery.

In *Woods v. Brumlop*²³ the physician failed to give full and frank disclosure of all pertinent facts to the patient before being granted consent to go ahead with the prescribed treatment. The court stated that without proper disclosure any consent which was attained would be ineffectual.²⁴ In *Shetter v. Rochelle*²⁵ the court held that a consent to a surgical procedure is valid if the consenting party "understands substantially the nature of the surgical procedure attempted and the probable results of the operation. This as a matter of law constitutes an informed consent. Lacking this the operation is a battery."²⁶ In *Scott v. Wilson*²⁷ the plaintiff consented to an operation which was supposed to restore his impaired hearing. The court held that the physician was required to warn the plaintiff of known hazards and chances of favorable or unfavorable results. Without such information, the consent given is of no effect and the physician is guilty of battery.²⁸ In situations where consent was induced by false representations, the courts have held that such consent is not valid and that a battery was committed on the person.²⁹

In choosing the cause of action, whether it be battery, negligence, or both, the plaintiff should be aware of the differences in pleading and proof between the two theories. If the complaint is based solely on a battery theory, then it would make no difference that the defendant performed the treatment with skill and care because he lacked the consent necessary to undertake the operation in the first place. "The gist of the action for battery is not the hostile intent of the defendant, but rather the absence of consent to the conduct on the part of the plaintiff."³⁰ Furthermore, the plaintiff need not prove any harm or actual

²³ 71 N.M. 221, 377 P.2d 520 (1962).

²⁴ *Id.* at 227, 377 P.2d at 524.

²⁵ 2 Ariz. App. 358, 409 P.2d 74 (1965).

²⁶ *Id.* at 374, 409 P.2d at 86.

²⁷ 396 S.W.2d 532 (Tex. Civ. App. 1965).

²⁸ *Id.* at 538.

²⁹ *Wall v. Brim*, 138 F.2d 478 (5th Cir. 1943); *Paulsen v. Gundersen*, 218 Wis. 578, 260 N.W. 448.

³⁰ W. Prosser, *Law of Torts* p. 35 (3d ed. 1964).

damage in an action for battery,³¹ while in a negligence action actual damage must be shown.³²

The plaintiff in a malpractice suit for negligence must prove that the defendant failed to exercise that degree of skill and care that is possessed by members of the profession in good standing.³³ Expert testimony must be provided, in the absence of which there can be no finding of negligence.³⁴ Whereas, in an action brought on a battery theory expert testimony may not be required.³⁵ The plaintiff in a negligence action must also show that the injury in question was proximately caused by the act or omission of the defendant.³⁶

An illustration of the different results which may come about depending on the choice of remedy is found in *Hunt v. Bradshaw*.³⁷ In *Hunt* the plaintiff predicated his malpractice action on a negligence theory and was denied recovery. The testimony at the trial established that while the plaintiff was working in an auto repair shop a small piece of steel broke off the end of an automobile axle under a sledge-hammer blow and penetrated the body of the plaintiff, entering the left front side of his neck just above the collarbone. After an initial examination, Dr. Bradshaw recommended to the plaintiff that the metal fragment be removed by surgery. The plaintiff questioned Dr. Bradshaw about the seriousness of the operation and was told it was a simple one, that there was nothing to it. The plaintiff then consented to the operation. During surgery, however, Dr. Bradshaw could not locate the small fragment in order to remove it. In addition to this failure, the plaintiff's left arm became completely paralyzed as a result of the operation. Expert testimony at trial established that this type of exploratory operation was indeed difficult due to the small size of the foreign matter. Testimony also established that partial paralysis could result from such an operation. The plaintiff alleged that the doctor was negligent, not that he was deficient in his skill or ability as a surgeon, but that he was not reasonably diligent in applying his medical knowledge in advising plaintiff about the nature of the operation and possible consequences. The court concluded that the operation was definitely of a serious nature. But, while the opinion questioned Dr. Bradshaw's wisdom in withholding certain information, it did not hold that his conduct constituted negligence. His "failure to explain the risk involved, therefore, may be considered a mistake on the part of the surgeon, but under the facts cannot be deemed such want of ordinary care as to import liability."³⁸

³¹ *Id.*

³² *Id.* at 146.

³³ See *Harns v. Graham*, 124 Okla. 196, 255 P. 710 (1926); *Butter v. Rule*, 29 Ariz. 405, 242 P. 436 (1926). See also W. Prosser, *Law of Torts* p. 165 (3rd ed. 1964).

³⁴ See *Beane v. Perley*, 99 N.H. 309, 109 A.2d 848 (1954); *Boyce v. Brown*, 51 Ariz. 416, 77 P.2d 455 (1938). See also W. Prosser, *Law of Torts* p. 167 (3rd ed. 1964).

³⁵ See *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962). The court in *Woods* held that expert testimony was not required to prove lack of an informed consent.

³⁶ W. Prosser, *Law of Torts* p. 146 (3d ed. 1964).

³⁷ 242 N.C. 517, 88 S.E.2d 762 (1955).

³⁸ *Id.* at 523, 88 S.E.2d at 766.

The concurring opinion in the *Hunt* case agreed that the cause of action based on negligence should fail. However, if the plaintiff had charged Dr. Bradshaw with battery, Justice Bobbitt hinted that this cause of action might have succeeded. He said:

True, plaintiff alleges that when defendant recommended that the operation be performed, defendant *negligently* represented to him that the "operation was a simple one which entailed and involved no danger to the plaintiff's health and body" and that "but for said representations . . . the plaintiff would not have submitted to said operation." But plaintiff did not allege that said representations were false to the knowledge of the defendant or other facts that might nullify his consent to the operation. In short, plaintiff's action is not for assault and battery, or trespass to the person, predicated upon allegations of an unauthorized operation.³⁹

A number of other cases based on a negligence theory have treated the question as one involving professional standards of conduct.⁴⁰ In *Salgo v. Leland Stanford Jr. University Board of Trustees*⁴¹ the court held that a physician who withholds information which is necessary to form the basis of an "intelligent consent"⁴² violates his duty as a physician. In *Mitchell v. Robinson*⁴³ the plaintiff submitted to insulin shock therapy and as a result of this treatment suffered compression fractures of the spine. Plaintiff later claimed that if he had been informed of the risks involved in the treatment he would not have consented. The court held that since this was a relatively new procedure the doctor owed his patient the duty to inform him of the possible serious hazards.⁴⁴ In *Natanson v. Kline*⁴⁵ the Kansas Supreme Court held that the lower court's failure to instruct the jury on the obligation of the physician to disclose to the patient the dangers incident to radioactive cobalt therapy constituted reversible error. In *DiFilippo v. Preston*⁴⁶ plaintiff claimed that the defendant was under a duty to disclose possible harmful results of a thyroidectomy.⁴⁷ Expert medical testimony at trial established the fact that it was not the practice of surgeons in the area to warn patients of the possibility of resultant injury from a thyroidectomy. The court, relying on this testimony, held that there was no duty of disclosure because it was not the practice of local physicians to inform patients in such situations. Since the outcome in the *DiFilippo* case depended upon the practice

³⁹ *Id.* at 524, 88 S.E.2d at 767.

⁴⁰ See *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960), rehearing denied with clarification, 187 Kan. 186, 354 P.2d 670 (1960); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); *Salgo v. Leland Stanford Jr. University Board of Trustees*, 154 Cal. App. 2d 560 317 P.2d 170 (1957).

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

⁴² *Id.* at 578, 317 P.2d at 181.

⁴³ 334 S.W.2d 11 (Mo. 1960).

⁴⁴ *Id.* at 19.

⁴⁵ 186 Kan. 393, 350 P.2d 1093 (1960), rehearing denied with clarification, 187 Kan. 196, 354 P.2d 670 (1960).

⁴⁶ 173 A.2d 333 (Del. 1961).

⁴⁷ Gould's Medical Dictionary defines a thyroidectomy as an excision of the thyroid gland.

of the physicians in the particular community involved, the court apparently did not recognize the physician's duty to disclose as the overriding factor in informed consent cases.

In *Green v. Hussey*⁴⁸ the appellate court of the State of Illinois was for the first time confronted with the theory of informed consent. The result of the case is significant in that the plaintiff sought recovery mainly under a theory of battery, while the defendant argued the failure of the plaintiff to prove a cause of action in negligence. In *Green* the plaintiff consented to the removal of a malignant tumor from her breast. Following the operation she was turned over to the hospital's radiology department for radiation therapy. As a result of this treatment plaintiff claimed her heart and right lung were damaged. She also denied giving her consent to the treatment alleging that she was never informed of the hazards of this procedure. In her complaint the plaintiff alleged that the defendant's failure to inform her of the risks involved in cobalt therapy constituted a failure to obtain the necessary consent. Plaintiff also included in her complaint the duty to disclose argument based on a negligence theory. She alleged that the defendant breached his duty by not informing her of the hazards of the proposed treatment.

One of the requirements in malpractice cases, in the absence of which the plaintiff cannot prove negligence, is the giving of expert medical testimony.⁴⁹ The defendant in *Green*, after noting there were no cases involving informed consent in Illinois, stated that the plaintiff had failed to offer the expert testimony required in order to sustain the cause of action. Citing *Aiken v. Clary*⁵⁰ as authority for his claim that cases involving informed consent should be dealt with under a negligence theory, the defendant in his answer (and the appellate court in its opinion) quoted a passage from that case which required the giving of expert testimony:

[W]e hold that plaintiff, in order to sustain his burden of proof, is required to offer expert testimony to show what disclosures a reasonable medical practitioner, under the same or similar circumstances, would have made, or stated another way, that the disclosures as made by the defendant do not meet the standard of what a reasonable medical practitioner would have disclosed under the same or similar circumstances.⁵¹

The Illinois appellate court affirmed the lower court's directed verdict for the defendant. According to the opinion, not only had the plaintiff failed to provide the necessary expert testimony, but she failed to prove that the defendant's actions were the proximate cause of her injury.⁵² Consciously or subconsciously, the court in reaching its decision could have been affected by the drastic rise

⁴⁸ 127 Ill. App. 2d 174, 262 N.E.2d 156 (1970).

⁴⁹ W. Prosser, *Law of Torts* p. 165 (3d ed. 1964).

⁵⁰ 396 S.W.2d 668 (Mo. 1965).

⁵¹ *Id.* at 675.

⁵² 127 Ill. App. 2d at 184-185, 262 N.E.2d at 161.

in malpractice suits in that it required expert medical testimony when this may not have been necessary. If at the outset the plaintiff never consented to the radiation therapy, then expert testimony on the nature of the treatment might not even be pertinent because permission to proceed with the therapy had not been obtained in the first place.

The Illinois appellate court's opinion in *Green* was unclear regarding the disposition of the plaintiff's complaint of lack of consent to the treatment. The court apparently felt no need to discuss the question of consent in light of the lack of expert medical testimony. No distinction between recovery predicated on a battery theory or negligence concept, such as was pointed out in the concurring opinion in *Hunt v. Bradshaw*,⁵³ was noted in the *Green* case. The court reviewed the case entirely under a negligence theory and seemed more concerned with the inadequate disclosure element than with the specific underlying theory of recovery based on both battery and negligence.

III. ADEQUATE DISCLOSURE

Whether recovery is predicated on a battery theory, negligence concept, or both, the essential element which the plaintiff must prove is that the information provided by the physician fell short of the disclosure required to provide an informed consent. There is no measuring stick which can be applied to each case to determine if the information provided by the physician was sufficient. The particular facts and circumstances must govern the finding. In emergency situations, for example, the physician need not stop to disclose pertinent facts to the injured party. The doctor is justified in proceeding with the treatment on the assumption that the patient would consent if he were able.⁵⁴

The problem of adequate disclosure was discussed in the case of *Salgo v. Leland Stanford Jr. University Board of Trustees*.⁵⁵ While the major issue in the opinion was the applicability of the doctrine of *res ipsa loquitur*, the guidelines set forth relating to adequate disclosure are noteworthy. The plaintiff in *Salgo* was suffering from a serious circulatory disturbance which was caused by a blockage in the abdominal aorta. His physician recommended corrective surgery, but as evidence produced at trial demonstrated, the procedure and possible dangers therefrom were not explained to the plaintiff. As a result of the operation the plaintiff suffered permanent paralysis of his lower extremities. In discussing the physician's duty to inform and what specifically constitutes adequate disclosure the court said:

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.

⁵³ 242 N.C. 517, 88 S.E.2d 762 (1955).

⁵⁴ See *Luka v. Lowie*, 171 Mich. 127, 136 N.W. 1106 (1912); *Wells v. McGehee*, 39 So. 2d 196 (La. App. 1949); *Jackovack v. Yocom*, 212 Iowa 914, 237 N.W. 444 (1931).

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

Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with full disclosure of facts necessary to an informed consent. . . .⁵⁶

The statement above encompasses many of the situations under which a question of adequate disclosure may arise. Initially, the court states that complete disclosure of any facts pertinent to the procedure is necessary. Then this position is qualified. The court realizes that complete disclosure would not be medically advisable under certain circumstances. A stricter standard which could be deduced from this statement is that there must be a full disclosure of known dangers *unless* a particular patient's emotional condition requires a more limited disclosure.

Three years after the *Salgo* decision, the Kansas Supreme Court set its standard for adequate disclosure in *Natanson v. Kline*.⁵⁷ The court held the physician was obligated to make a "reasonable disclosure"⁵⁸ to the patient of the nature and probable consequences of the suggested treatment. Comparing the reasonableness theory set forth in *Natanson* with the standard established in *Salgo*, it can be said the two theories are basically compatible. The *Natanson* court was really simplifying the language set forth in *Salgo*. The unfortunate aspect of the reasonableness approach is that it provides no definitive guidelines, and requires a case by case analysis. But, any attempt to set a more rigid standard in light of the drastic rise in malpractice cases could hamper the physician in his effort to cure the patient.

The reasonable disclosure standard has been adopted by several jurisdictions which have dealt with informed consent cases.⁵⁹ The Missouri Supreme Court adopted this standard in *Aiken v. Clary*.⁶⁰ There the plaintiff claimed he consented to insulin shock therapy without having been informed of the hazards

⁵⁶ *Id.* at 578, 317 P.2d at 181.

⁵⁷ 186 Kan. 393, 350 P.2d 1093 (1960), rehearing denied with clarification, 187 Kan. 186, 354 P.2d 670 (1960).

⁵⁸ 186 Kan. at 410, 359 P.2d at 1107.

⁵⁹ See *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962).

⁶⁰ 396 S.W.2d 668 (Mo. 1965).

involved. As a result of the treatment plaintiff suffered organic brain damage. As part of his defense to charges of lack of an informed consent, Dr. Clary raised an issue which should be included by every physician in his answer to charges of malpractice based on informed consent. Defendant claimed that even if the patient was informed of the risks involved he still would have consented to the treatment. The court in taking notice of this contention said, "[I]f the jury was convinced from all the evidence that a more complete disclosure would have made no difference to plaintiff, and that he still would have consented to the therapy or procedure, then plaintiff has not established a right of recovery."⁶¹ The court in this instance was recognizing the importance of the plaintiff's attitude and state of mind at the time of the original consent. While the recognition of the importance of the plaintiff's attitude may be questionable since it mainly depends upon hindsight, still there is merit in the conclusion. If the plaintiff had been fully informed of possible injuries and later admitted that he still would have consented to the treatment, then he should be made to abide by his original decision consenting to the therapy.

The *Aiken* case also clarified the matter concerning the need for expert testimony in informed consent cases. The plaintiff in *Aiken*, relying on the Missouri Supreme Court's decision in *Mitchell v. Robinson*,⁶² did not produce expert testimony in support of his case. The court, after expressing disapproval of its earlier decision in *Mitchell*, held that such testimony was required in informed consent cases. The opinion stated that matters involving surgery or treatment are normally not within the common knowledge of an ordinary juror.⁶³ The court also stated that lack of adequate disclosure was comparable to negligence in other malpractice cases which always require expert testimony.⁶⁴

Most courts have concurred with the *Aiken* decision.⁶⁵ In *Woods v. Bromlop*,⁶⁶ however, the New Mexico Supreme Court held there was no need for expert testimony in informed consent cases. In *Woods* the defendant advised the plaintiff to submit to electroshock treatments. The plaintiff consented, then later complained that as a result of the treatment she suffered a loss of hearing. First, she alleged that Dr. Bromlop failed to inform her of the risks involved in the treatment. Second, she claimed that after having asked the doctor directly about the possibility of harmful results, she was told that no serious consequences would occur. At trial, the plaintiff failed to provide expert testimony which would have established what medically constituted adequate disclosure in her case. On this matter the court said, "Under the circumstances of this case, a fact issue was presented for determination by the jury upon which there was no

⁶¹ *Id.* at 676.

⁶² 334 S.W.2d 11 (Mo. 1960).

⁶³ *Aiken v. Clary*, 396 S.W.2d 668 at 674 (Mo. 1965).

⁶⁴ *Id.*

⁶⁵ See *DiFilippo v. Preston*, 173 A.2d 333 (Del. 1961); *Williams v. Menahan*, 191 Kan. 6, 379 P.2d 292 (1963); *Green v. Hussey*, 127 Ill. App. 2d 174, 262 N.E.2d 156 (1970).

⁶⁶ 71 N.M. 221, 377 P.2d 520 (1962).

necessity for expert medical testimony."⁶⁷ While the court did limit the scope of the statement to the facts presented in this particular case, it was nevertheless resolved that expert testimony is not an absolute requirement in informed consent cases.

IV. CONCLUSION

A standard of disclosure has been developed in informed consent cases which is both necessary and proper. If each individual is truly the final arbiter in decisions involving his health and livelihood, then it must follow that he is entitled to be provided with sufficient information to help him reach any decision vital to his health. It is not unreasonable to ask a physician to take the time and patience to explain the risks of the proposed treatment to his patient. In cases involving chance of death or serious permanent injury in which the immediate life of the patient is not in danger, complete disclosure should be required. When disclosure of risks of treatment may hinder the patient's chance for recovery, physicians can reasonably conclude that details need not be furnished and treatment can be administered.

In dealing with cases involving informed consent the courts have accepted theories of recovery based on both battery and negligence. The essential element which the plaintiff must prove, whether recovery is predicated on a battery theory, negligence concept, or both, is that the information provided by the physician fell short of the disclosure required to provide an informed consent.

The normal response of any party injured by the acts or omissions of another is to seek reparations. This is especially likely to occur in the case of a person who made an important decision based upon the advice of one whom he trusted and later discovered that he was not told all the pertinent facts. This is the problem of every patient who, in retrospect, must consider whether the consent he gave was informed.

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⁶⁷ *Id.* at 229, 377 P.2d at 525.