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INFORMED CONSENT: A PLAINTIFF'S MEDICAL MALPRACTICE "WONDER DRUG"

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I. TWO CONFLICTING DUTIES

A. *Duty Not To Unduly Alarm*

The medical profession has been alerted to a new hazard of dealing with their patients as a result of the decision in *Ferrara v. Galluchio*,[1] where the New York Court of Appeals affirmed (four to three) the supreme court's judgment for the plaintiff on a rather unique set of facts. The action was medical malpractice against radiologists who in 1949 treated plaintiff with X-ray therapy for bursitis. An eruption in the treated area left a marginated area of skin exhibiting telangiectasia, hyperpigmentation, depigmentation and a suggestion of atrophy. By 1951, the plaintiff was sufficiently concerned to consult a dermatologist, who suggested that she continue to have the area checked about every six months because it could become cancerous. Plaintiff's lawsuit against the radiologists sought, *inter alia,* damages for cancerphobia (fear of future development of cancer) which she claimed as a possible permanent injury. Of the $25,000 awarded, $15,000 was for cancerphobia, and the validity of this part of the award was the point raised on appeal. The majority opinion reasoned that the original wrongdoer (the radiologists) is liable for the ultimate result though the subsequent acts of another (the dermatologist) may have increased the damage which would have otherwise resulted. The court refused to make a distinction between mental and physical injury, seeing no sound reason for doing so. In support of its decision the majority cited *Milks v. McIver*,[2] which held that "liability for damages caused by wrong ceases at a point dictated by public policy or common sense."[3]

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1. 5 N.Y.2d 16, 176 N.Y.S.2d 996 (1958), noted in 37 TEXAS L. REV. 796 (1959); *Contra,* Kraus v. Spielberg, 37 Misc. 2d 519, 236 N.Y.S.2d 143 (Sup. Ct. 1962) in which no recovery was allowed. The patient claimed psychic injury when her doctor in order to induce her to agree to chemotherapy at once, warned her that tuberculosis germs may have invaded her intestines.
2. 264 N.Y. 267, 190 N.E. 487 (1934).
3. *Id.* at 269, 190 N.E. at 488.

The lesson of *Ferrara* for the physician might well be that warning a patient of a possible future ailment may subject the doctor to liability for the mental anguish produced by unduly alarming him. This was *not* the result of the *Ferrara* case, probably only because the patient's attorney lacked the foresight or was unable to join the dermatologist as co-defendant.

B. *Duty To Warn—Informed Consent*

Only two years later, the Missouri Supreme Court announced the rule in *Mitchell v. Robinson*:[4]

> In the particular circumstances of this record, considering the nature of Mitchell's illness and this rather new and radical procedure with its rather high incidence of serious and permanent injuries not connected with the illness, the doctors owed their patient in possession of his faculties the duty to inform him generally of the possible serious collateral hazards; and in the detailed circumstances there was a submissible fact issue of whether the doctors were negligent in failing to inform him of the dangers of shock therapy.[5]

The opinion also pointed out that expert testimony was not required to establish whether or not such a warning was given.

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4. 334 S.W.2d 11 (Mo. 1960).

5. *Id.* at 19. See Annot., 79 A.L.R.2d 1028 (1961); see also Annot., 99 A.L.R.2d 599, 614 (1965); 1 AVERBACH & BELLI, TORT AND MEDICAL YEARBOOK 455 and 631 (1961); Bellamy, *Malpractice Risks Confronting the Psychiatrist: Nationwide Fifteen-Year Study of Appellate Court Cases 1946-1961*, 118 AM. J. PSYCHIATRY 769 (1962), following which Dr. Wilse Robinson in a brief commentary refers to himself as the "most sued psychiatrist in the world;" Franklin, *Medical Mass Screening Programs: A Legal Appraisal*, 47 CORNELL L. Q. 205, 218 (1962); Hendrix, *Informed Consent—New Area of Malpractice Liability*, June, 1960 MEDICOLEGAL DIGEST 11; Johnson, *Medical Malpractice Doctrines of Res Ipsa Loquitur and Informed Consent*, 27 COLO. L. REV. 182 (1965); McCleary, *Torts in Missouri*, 27 MO. L. REV. 81, 87-88 (1962); Oppenheim, *Informed Consent to Medical Treatment*, 11 CLEVE.-MAR. L. REV. 249 (1962); Note, *Doctors Held to Have Duty to Disclose Risk Inherent in Proposed Treatment*, 60 COLUM. L. REV. 1193 (1960); Note, *Informed Consent—Reluctance of Doctors to Inform Patients Often Renders Them Liable In Malpractice for Lack of "Informed Consent"*, 11 CURRENT MEDICINE FOR ATTORNEYS 24 (1964); Note, *Informed Consent—New Theory of Liability—Doctor's Nightmare in Malpractice*, 8 CURRENT MEDICINE FOR ATTORNEYS 35 (1961); Note, *Physicians and Surgeons—Physician's Duty to Warn of Possible Adverse Results of Proposed Treatment Depends Upon General Practice Followed by Medical Profession in the Community*, 75 HARV. L. REV. 1445 (1962); Note, *Malpractice—Doctors Under Duty to Disclose Risk Inherent in Proposed Treatment*, 26-27 NACCA L.J. 134 (1960-1961); Note, *Malpractice—Physician Has a Duty to Inform Patient of Risk Inherent in Proposed Treatment*, 109 U. PA. L. REV. 768 (1961); Comment, *The Law of Medical Malpractice in Missouri*, 1962 W.U.L.Q. 402, 414-15.

C. *The Conflict*

One of the greatest obstacles that a plaintiff must overcome in the usual medical malpractice suit is the necessity of producing expert testimony as to the standard of care and causation,[6] which has been complicated by what Mr. Melvin Belli has referred to as the "conspiracy of silence" among medical practitioners, signifying the difficulty of persuading one physician to testify against another.[7] Surgeons and physicians in a community work quite closely with one another, and have no desire to be ostracized by members of their own profession. Further, by testifying against another medical practitioner, they might find pressures brought to bar them from the local medical society, the local hospitals, and even the normal social relationships between the families of physicians. Even more devastating is the possible inability to obtain medical malpractice insurance. Such policies usually contain a clause permitting the company to cancel at any time without giving a reason for doing so. The leverage of threatened cancellation is an effective tool to seal the lips of many medical men, for in view of the frequent and sizable malpractice awards, it is foolhardy even to attempt the practice of medicine without adequate protection.[8] Appli-

6. Hornbeck v. Homeopathic Hospital Ass'n, 197 A.2d 461 (Super. Ct. Del. 1964); Hasemeier v. Smith, 361 S.W.2d 697, 700 (Mo. En Banc 1962); Williams v. Chamberlain, 316 S.W.2d 505, 511 (Mo. 1958). See also Annot., 13 A.L.R.2d 11, 31 (1950).

In Friedman, *Handling the Unique Problems of Medical Malpractice Actions*, 10 S.D.L. REV. 137, 151 (1965), it is suggested: "Under the 'informed consent' cases the question of who a doctor should inform might be within the province of a jury, but what he should have told them is a subject for expert testimony. In their quest to avoid the necessity of expert testimony some courts have failed to recognize the distinction."

7. BELLI, READY FOR THE PLAINTIFF, ch. 8.

8. See Schroeder, *Insurance Protection and Damage Awards in Medical Malpractice*, 25 OHIO ST. L.J. 323 (1964), warning at 334 that many policies do not include coverage for assault and battery which is the true nature of a suit based on lack of consent, informed or otherwise, and that larger awards are predicated on an assumption made by juries that all doctors are wealthy.

In Steincipher, *Survey of Medical Professional Liability in Washington*, 39 WASH. L. REV. 704 (1964), the author notes that there are approximately 9000 claims per year at an annual cost exceeding $45,000,000 and that one in every seven doctors has been involved. A footnote calls attention to Disraeli's caveat on the three kinds of lies—"lies, damn lies, and statistics." The author's figures were taken from Silverman, *Medicine's Legal Nightmare*, Saturday Evening Post, Apr. 11, 1959 pp. 13, 14, first of a series of three articles appearing in No. 41 at 13, No. 42 at 31, and No. 43 at 36 (1959). Silverman says that the cost is even greater because doctors are calling for more and more diagnostic procedures, consultations, laboratory tests, hospitalization, and nursing care, when not demanded by good medical practice, but only to protect against malpractice claims. He quotes one California physician who confessed, "God help me, I'm beginning to decide my treatments not on the basis of what's best for the patient, but what will look best in court."

cations for policies normally ask whether or not a comparable policy has ever been cancelled by any other company, and an affirmative answer to this inquiry almost invariably results in a refusal to issue a policy to the applicant. Cancellation is tantamount to branding the physician as a bad risk.

In a jurisdiction following the Missouri doctrine, the attorney for the plaintiff in a medical malpractice action may be able to avoid the necessity of obtaining expert testimony by utilizing the theory of failure to obtain an "informed consent" from the patient. The result of *Mitchell* has been that in many recent medical malpractice actions there has been a specific allegation of negligence in failing to obtain the patient's informed consent.[9]

Considering the *Ferrara* and *Mitchell* cases together, the doctor is faced with a dilemma: should he risk the failure to warn a patient of possible collateral hazards of treatment (*Quaere* whether this would include hazards of *non*-treatment) and be liable under *Mitchell,* or should he make a full and complete disclosure of the risks and possibly incur responsibility for the results suggested as possible under *Ferrara*? Underlying this whole area is the basic concept that a doctor's first duty is to do what is best for his patient under the particular circumstances.[10] The problem seems insoluble; perhaps the most informative approach would be to consider

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9. Note that even Dr. Ben Casey of TV fame was charged with failure to obtain an informed consent in his malpractice trial aired during the fall of 1965. Dr. Casey avoided liability when the plaintiff dismissed after the jury advised the court it was unable to reach a verdict.

10. In Roberts v. Woods, 206 F. Supp. 579 (S.D. Ala. 1962) the patient claimed she was not warned of the seriousness of the operation, though she had had a comparable operation by the same surgeon five years previously. The court, affirming a judgment for defendant, said at 583: "I do not mean to suggest that defendant should have told plaintiff of all the hazards involved, including risk of injury to the recurrent laryngeal nerve. Doctors frequently tailor the extent of their pre-operative warnings to the particular patient, and with this I can find no fault. Not only is much of the risk of a technical nature beyond the patient's understanding, but the anxiety, apprehension, and fear generated by a full disclosure thereof may have a very detrimental effect on some patients. In this case the defendant told the patient, among other things, that the operation would be similar to the one she had undergone in 1954. In view of the patient's emotional state and her concern over this operation as well as a gynecological operation to be performed at the same time, in addition to having previously experienced a thyroidectomy, I am of the opinion the patient was properly advised of the seriousness of the operation." See also, McCleary, *Torts in Missouri,* 27 Mo. L. Rev. 81, 88 (1962); Oberst, *1960 Annual Survey of American Law—Torts,* 36 N.Y.U.L. Rev. 416, 426 (1961) explaining: "While courts frequently state the obligation as one of full and frank disclosure, they have invariably waived the requirement upon some showing by the physician that it was done to avoid depressing or exciting the patient." See 109 U. Pa. L. Rev. 768, 773 (1961) *supra* note 5.

what courts have said and done when faced with the "informed consent" problem and what legal and medical scholars have to say about it.

II. The American Decisions

Only two days after the Missouri Supreme Court announced the *Mitchell* decision, the Kansas Supreme Court rendered its opinion in *Natanson v. Kline*,[11] which involved a doctor administering cobalt irradiation treatment that caused injury to the patient. On appeal from a judgment for the defendants, the Kansas court said:

> [W]here the patient fully appreciates the danger involved, the failure of the physician in his duty to make a reasonable disclosure to the patient would have no causal relation to the injury. In such event the consent of the patient to the proposed treatment is an informed consent.[12]

Reversing for error in instructions, the opinion reads:

> The appellant's requested instruction on the duty of a physician to make a disclosure to his patient was too broad. . . . On retrial the instruction should be modified to inform the jury that a physician has such discretion, as heretofore indicated, consistent with the full disclosure of facts necessary to assure an informed consent by the patient.[13]

In denying the application for rehearing, the court seized the opportunity to clarify its earlier opinion:

> Conceivably, in a given case as indicated in the opinion, no disclosures to a patient may be justified where such practice, under given facts and circumstances, is established by expert testimony to be in accordance with that of a reasonable medical practitioner under the same or similar circumstances. . . .
>
> Whether or not a physician has advised his patient of the inherent risks and hazards in a proposed form of treatment is a question of fact concerning which lay witnesses are competent to testify, and the establishment of such fact is not dependent upon expert medical testimony. It is only when the facts concerning the actual disclosures made to the patient are ascertained, or ascertainable by the trier of facts, that the expert testimony of medical

11. 186 Kan. 393, 350 P.2d 1093, *rehearing denied with clarification* 187 Kan. 186, 354 P.2d 670 (1960).
12. *Id.* 186 Kan. at 410, 350 P.2d at 1106.
13. *Id.* 186 Kan. at 411, 350 P.2d at 1107.

> witnesses is required to establish whether such disclosures are in accordance with those which a reasonable medical practitioner would make under the same or similar circumstances.
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> . . . .
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> If, of course, the appellant would have taken the cobalt irradiation treatments even though Dr. Kline had warned her that the treatments he undertook to administer involved great risk of bodily injury or death, it could not be said that the failure of Dr. Kline to so inform the appellant was the proximate cause of her injury. While the appellant did not directly testify that she would have refused to take the proposed cobalt irradiation treatments had she been properly informed, we think the evidence presented by the record *taken as a whole* is sufficient and would authorize a jury to infer that had she been properly informed, the appellant would not have taken the cobalt irradiation treatments.[14]

The Kansas court in 1963 was presented the opportunity to further explain "informed consent" in deciding the case of *Williams v. Menehan*,[15] in which both parties relied on the *Natanson* decision, each placing a different construction on what the court had said. The conflict was resolved when the court stated that a physician's duty to disclose is limited to disclosures which a reasonable medical practitioner would make under the same or similar circumstances and that in the *Williams* case, the trial court did not err in granting the defendant's motion to dismiss because plaintiff offered no evidence of what reasonable physicians would do under like circumstances.[16] Surely it is clear that where Missouri has said expert testimony is not necessary to show that the doctor failed to warn, Kansas will require expert medical testimony that the standard of care of reasonable physicians would include giving a warning. These propositions would not necessarily conflict except that the *Mitchell* decision makes the doctor's duty appear to be a matter of law, while in *Natanson* and *Williams*, it would seem that the duty of the doctor, based on the standard of care, must be established by expert medical testimony in each case. Because of the greatly divergent factual situations in the malpractice cases, and because medical practitioners do not guarantee cures, but only have a duty to use the skill and exercise the care that other reasonable medical practitioners would utilize in the same or similar circumstances, it is submitted that the Kansas doctrine offers greater flexibility and seems to be a more equitable principle of law.

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14. 187 Kan. 186, 189-91, 354 P.2d 670, 673-74 (1960).
15. 191 Kan. 6, 379 P.2d 292 (1963).
16. *Id.* at 10-11, 379 P.2d at 295.

One writer has suggested that *Mitchell* means a doctor must itemize in detail every conceivable and imaginable result, and if he omits one which takes place, he will be subject to liability.[17] In *Williams*, however, the opinion stated:

> But this does not mean that a doctor is under an obligation to describe in detail all of the possible consequences of treatment. To make a complete disclosure of all facts, diagnoses and alternatives or possibilities which might occur to the doctor could so alarm the patient that it would, in fact, constitute bad medical practice.[18]

The Kansas court would permit the doctor to be exempt from liability if he was motivated in not warning only by the patient's best therapeutic interests and proceeded as other competent medical men would have done in such a situation.

Possibly another distinction should be drawn: *Mitchell* was concerned with electroshock therapy and *Natanson* dealt with cobalt irradiation treatment, both extremely hazardous treatments at the time they were given, but *Williams* was not an instance of such a new and dangerous procedure. It is arguable that with the present widespread laymen's knowledge of medicine, the hazards of the more dangerous treatments are best known to the patient, and require no warning. On the other hand, this premise would produce the result that the doctor's duty to warn would be greatest in the least hazardous procedures, and this is illogical on its face. Superimposed on the problem of when the doctor should warn is the question of whether or not the patient is under a duty to ask of the hazards, to demand an explanation if it is not offered, and whether in not doing so, the patient can be said to have assumed the risk or to have been contributorily negligent.[19]

In *Fischer v. Wilmington General Hospital*,[20] the patient contracted

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17. Comment, *The Law of Medical Malpractice in Missouri*, 1962 W.U.L.Q. 402, 416, n.75.

18. *Supra* note 14, at 8, 379 P.2d at 294.

19. Carroll v. Chapman, 139 So. 2d 61, 66 (La. App. 1962) *cert. denied;* Crippen v. Pulliam, 61 Wash.2d 725, 380 P.2d 475, 479 (1963); See Lund, *The Doctor, The Patient, and The Truth*, 19 TENN. L. REV. 344 (1946) at 345 where the physician-author says: "In any group of patients with identical surgical or medical conditions, there will be a wide variation in their mental states, physical states, social circumstances, and in the amount of information or misinformation concerning disease in their possession." *But see*, in reply, H. W. Smith, *Therapeutic Privilege to Withhold Specific Diagnosis From Patient Sick with Serious or Fatal Illness*, 19 TENN. L. REV. 349 (1946), maintaining that disclosure in each case is a matter of professional judgment.

20. 51 Del. 554, 149 A.2d 749 (Super. Ct. Del. 1959).

serum hepatitis from a whole blood transfusion given to her when she arrived at the hospital after having an abortion elsewhere, and she was not warned of this possible adverse result. There was evidence that it was not the general practice in the local medical profession to give such a warning and that the incidence of this disease following transfusion was between .45 and 1.00 per cent. The court held this was not even a jury question, but, as a matter of law, the hospital had not been negligent.

Hall v. United States[21] involved the wife of a serviceman who went to a naval hospital to be delivered of her child. She suffered harmful effects when given a spinal anaesthetic, and alleged she had not been warned of the possible injury. The court announced:

> I hold there was no duty upon defendant's agents *in this case* to warn Mrs. Hall of *possible* consequences or to obtain her specific consent to a spinal anaesthetic. (emphasis by the court.)[22]

It was further said that it is common knowledge that anaesthetic is used in childbirth, and that by entering the hospital for that specific purpose, she impliedly consented to standard procedure.

While the case does not deal with informed consent, the language of *Dietze v. King*[23] may be applicable. The physician performed a radical mastectomy on the plaintiff, left a surgical sponge in her body, and failed to tell her of this when he knew she was leaving for England. The judge signified the defendant's duty by saying:

> The physician owes a duty to his patient to make reasonable disclosures of all significant facts under the circumstances of the then situation. This duty is, however, limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances, and the failure to disclose in all instances does not necessarily suggest a neglect of duty.[24]

In the area of consent to medical treatment, the landmark case is a Minnesota decision,[25] and thus the case of *Bang v. Charles T. Miller*

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21. 136 F. Supp. 187 (W.D. La. 1955), *aff'd per curiam* 234 F.2d 811 (5th Cir. 1956).
22. *Id.* 136 F. Supp. at 193.
23. 184 F. Supp. 944 (E.D. Va. 1960).
24. *Id.* at 949.
25. Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905); overruled on another point in 248 Minn. 527, 80 N.W.2d 854 (1957). See Annot., 76 A.L.R. 562 (1932). On the topic of consent to medical treatment or surgery, see generally Kelly, *The Physician, The Patient, and The Consent,* 8 KAN. L. REV. 405 (1960); Comment, *Consent to Surgical Operations,* 26 ALBANY L. REV. 25 (1962); Comment, *Consent*

Hosp.[26] is of particular interest. The patient was suffering from prostate trouble and the physician performed a transurethal prostatic resection that

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to Medical and Surgical Treatment, 14 DRAKE L. REV. 101 (1965); Note, *Medical Surgical Consent,* 20 N.Y.U. INTRA. L. REV. 114 (1965); and McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment,* 41 MINN. L. REV. 381 (1957), relied on heavily in the *Mitchell* opinion, particularly at 427 where the author states: "[T]he doctor owes a duty to his patient to make reasonable disclosures of all significant facts, *i.e.,* the nature of the infirmity (so far as reasonably possible), the nature of the operation and some of the more probable consequences and difficulties inherent in the proposed operation. It may be said that a doctor who fails to perform this duty is guilty of malpractice." The suggestion is made at 434: "One particular obligation which the law may properly exact or impose, however, is the obligation to make a reasonable disclosure to the patient of the nature of his illness or infirmity, the nature of the treatment proposed and the danger of using such treatment or alternative treatment, and then permit the patient to decide whether to submit to the treatment or not. To overcome any difficulties of proof, the law may also properly create a presumption that where the patient has not given express consent to the operation or treatment, there has been a deviation from the standard of proper medical care, which presumption will impose upon the doctor the onus of coming forward with justification of his conduct by the use of qualified medical evidence."

But in McCoid, *The Care Required of Medical Practitioners,* 12 VAND. L. REV. 549, 590-91 (1959) McCoid wrote: "But this does not mean that a doctor is under an obligation to describe in great detail all of the possible consequences of treatment. Indeed it might be argued that to make a complete disclosure of all facts, diagnoses and alternatives or possibilities which may occur to the doctor could so unduly alarm the patient that it would constitute bad medical practice . . . The 'golden mean' between the two extremes of absolute silence and exhaustive discussion is well described in *Salgo v. Leland Stanford, Jr. Univ. Bd. of Trustees* [154 Cal. App. 2d 560, 317 P.2d 170 (1957):] . . .

> 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. 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 must sometimes 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 psychological result 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 the full disclosure necessary for an informed consent.

". . . [T]he duty to disclose may be limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances, possibly with a presumption on the part of the courts that disclosure will be made where the consequences are serious and substantially certain to occur."

See Bradford v. Winter, 215 Cal. App. 2d 448, 30 Cal. Rptr. 243 (1963); Rothe v. Hull, 352 Mo. 926, 180 S.W.2d 7 (1944). That consent can be given by conduct, see O'Brien v. Cunard S. S. Co., 154 Mass. 272, 28 N.E. 266 (1891) hold-

resulted in sterilization of the patient. The ailment could have been treated medically or surgically, and the court held the doctor was under a duty to inform the patient of the alternative procedures available and let the patient make the choice. The decision is not the best authority for an informed consent case, though it is frequently used, because the injury suffered was not a collateral hazard of the operation, but a part of the procedure to be accomplished. Moreover, if plaintiff was a man of advanced age, it would seem questionable what actual damages he might have shown.

Over a hundred years ago, it was held in *Twombly v. Leach*,[27] that it is good medical practice in some cases for physicians to withhold from a patient the extent of their disease and their actual condition, and that testimony of expert and experienced medical practitioners on this point is material and peculiarly appropriate.

An attempt was made to use the informed consent doctrine in *Block v. McVay*.[28] There the doctor made a non-negligent mistake in diagnosis when he determined the patient had a lymph node tumor, the removal of which is a simple, ordinary and frequently performed procedure usually producing no ill effects. After removing the tumor, the defendant discovered that it was a neurofibroma, the removal of which does involve risk. The trial court's directed verdict for the doctor was affirmed on appeal.

A patient was the subject of a thyroidectomy by a doctor in *DeFilippo v. Preston*,[29] following which it was alleged that failure to obtain an informed consent of the patient caused injury to the plaintiff. The Delaware court held that whether such a duty existed depends upon the circumstances of the particular case, and the general practice of the medical profession in giving warnings in such a case. The evidence showed a custom of the profession to warn did not exist for thyroidectomies and the court made it clear that such evidence can only come from experts in the medical profession.

A directed verdict for the doctor was appealed in *Govin v. Hunter*[30] (surgery to correct varicose veins in the legs more severe than the patient had anticipated) where no expert testimony was adduced at trial. The court explained:

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ing that where plaintiff held out her arm for a vaccination, she consented to it being given by the doctor.

26. 251 Minn. 427, 88 N.W.2d 186 (1958).
27. 65 Mass. (Cushing XI) 397 (1853).
28. 126 N.W.2d 808 (S.D. 1964).
29. 53 Del. 539, 173 A.2d 333 (1961).
30. 374 P.2d 421 (Wyo. 1962).

> We realize that under certain circumstances a physician has a duty to reveal any serious risks which are involved in a contemplated operation. But, how a physician chooses to discharge his obligation to a patient involves a question of medical judgment. As long as his disclosure is sufficient to assure an informed consent, and if it appears that he proceeded as competent medical men would have done in a similar situation, the physician's actions should not be called into question.[31]

The following page of the opinion paraphrased much of what had been said in *DeFilippo* and *Natanson.*

A case quite like *Mitchell* on the facts was *Woods v. Brumlop,*[32] which involved a fracture resulting from electro-shock therapy, but also included a loss of hearing. The plaintiff claimed she was told there would be no harmful results. Possibly her action might better have been for misrepresentation, but she based her suit on professional negligence in failing to obtain the informed consent of the patient. The New Mexico court announced the rule for that jurisdiction, recognizing that some courts make exceptions in cases (1) of emergency and (2) where an explanation of every risk would unduly alarm an already apprehensive patient who might as a result refuse treatment even though the risk involved is minimal or where the disclosure might actually increase the risk due to psychological results of the apprehension. Each patient should be treated as a separate problem dependent on his mental and emotional condition, the court said, but it left open the questions of who shall make the determination in a given case and what standards the doctor was safe in using if the decision was allocated to him. The judgment for plaintiff was reversed on appeal because the jury was not instructed on the exceptions to the general rule and the plaintiff had not successfully borne the burden of proof on the issue of causation. The court explained that if the doctor did not give honest answers about the risks he is liable unless he falls within one of the exceptions and whether or not he warned was a fact issue for the jury to decide without the assistance of expert testimony.

Crippen v. Pulliam[33] dealt with a fifteen year old delinquent girl who had been made a ward of the court and placed in the Home of the Good Shepherd in Seattle. After a written consent was obtained from her father, she was operated on for a hearing defect, but was left with facial paralysis

31. *Id.* at 423.
32. 71 N.M. 221, 377 P.2d 520 (1962).
33. 61 Wash. 2d 725, 380 P.2d 475 (1963).

and a schizophrenic condition. The plaintiff contended at trial that the consent was obtained by misrepresentation, but the court on appeal affirmed a judgment for the doctor:

> Moreover, the father was not limited in any way in making inquiry concerning the details of the surgery. It was his prerogative to rely on the professional judgment of the defendant without making further inquiry.[34]

Alaska too, has had to contend with this relatively new legal theory. In *Patrick v. Sedwick*,[35] the trial court rendered a judgment for defendant which was appealed. Alaska's Supreme Court reversed and ordered a finding for plaintiff on grounds other than "informed consent." Following a subtotal thyroidectomy, plaintiff's vocal cords were paralyzed and she experienced difficulty in breathing. She maintained that the doctor, in obtaining her consent did not warn of the possible hazards. She had asked the doctor if there was any possible danger of her goiter returning, and he told her there was no guarantee about it. Her brief contended that had she been warned of the possibility of this injury, she would not have consented to the operation, but there was no evidence to that effect at trial. The doctor said he made it a practice to see patients before surgery, at which time he made a decision of whether information concerning serious risks should be disclosed or withheld, based upon the disposition and psychological makeup of the patient. On the informed consent theory, the court commented:

> There is good law in support of the argument made by defendant in his brief that the doctor need not inform the patient of all the hazards involved in an operation; that doctors frequently tailor the extent of their preoperative warnings to the particular patient to avoid the unnecessary anxiety and apprehension which such appraisal might arouse in the mind of the patient. In the light of the evidence in this case and the law bearing on informed consent, we cannot say that the failure of the trial court to make a finding of informed consent was clearly erroneous.[36]

Kansas had another opportunity to clarify its position in *Yeates v. Harms*,[37] a malpractice action resulting from cataract surgery. Affirming the judgment for the doctor, the court explained:

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34. *Id.* at 732, 380 P.2d at 479.
35. 387 P.2d 294 and 391 P.2d 453 (Alaska 1964) noted in 38 TEMP. L.Q. 238 (1965).
36. 391 P.2d 453, 458 (Alaska 1964).
37. 193 Kan. 320, 393 P.2d 982 (1964).

> A careful examination of plaintiff's requested instructions reveals that in his concept of the case he goes too far and would have this court extend the duty of a physician or surgeon to the extreme where he would have to apprise his patient not only of the known risks but also of each infinitesimal, imaginative, or speculative element that would go into making up such risks. This is another hurdle we simply cannot make. Here we are faced with a record that does not disclose any competent substantial evidence as to the *actual cause* of infection in plaintiff's right eye, and we cannot indulge in conjecture on this pivotal point.[38]

One problem of properly informing a patient is demonstrated by *Corn v. French*,[39] where the doctor told the patient he was going to perform a mastectomy and had her sign a consent form for this procedure. When the anaesthetic wore off and the plaintiff discovered her breast had been removed, she sued because she said she had told the doctor repeatedly she did not want the breast removed an that he never explained to her the meaning of the word "mastectomy." The trial court granted the doctor's motion to dismiss, but the Nevada Supreme Court held it was for the jury to determine whether or not there had been a consent given for the operation when the evidence was in conflict.

If the medical practitioner who attempts to follow the *Mitchell* doctrine is aware of the plaintiff's theory in *Corn*, he not only will be under a duty to explain each and every risk of injury that might be associated with a proposed treatment, but he also will be obliged to ascertain that the patient has a complete understanding of every technical medical term employed in the warning given. It would seem that in some procedures this could amount to medical education and instruction in subjects which require years of study and practice for a doctor to master. As a matter of social policy, there must be a choice between having physicians take the time to make such a detailed and thorough analysis for every patient, which will result in fewer patients treated by each doctor, and the risk of having an occasional patient suffer an adverse result to which he would not otherwise have exposed himself had he been aware of the risk of that consequence. With the minimal number of physicians available, the choice seems clear. And if the first proposition were adopted, is the average layman sufficiently well versed in medical experience to evaluate properly all the technical information given to him even if he does understand it? It seems

38. *Id.* at 333, 393 P.2d at 991.
39. 71 Nev. 280, 289 P.2d 173 (1955).

less than reasonable to so maintain when we admit that even a doctor is not responsible for non-negligent errors of judgment because medicine is not an exact science.[40]

Of course, no argument is being made that physicians should not be held liable for practices such as those of the defendant in *Theodore v. Ellis*.[41] There the patient consented to an operation in reliance on what the doctor told him when the doctor knew or should have known the procedure was unnecessary, and the same result could be obtained without surgery.

A distinction also should be made between failure to warn and misrepresentation. In *Hunter v. Burroughs*,[42] it was held that a physician's failure to warn a patient that use of a particular remedy possibly could have adverse consequences is not negligence *per se*, but where a physician not only fails to warn of dangers of a certain treatment but also gives positive assurance of a cure, he is liable for harmful consequences of the treatment, where, if such warning had been given, the patient would not have taken the treatment. The evil to be avoided is the combination of misleading the plaintiff as to the risks involved and also warranting a cure.

Lester v. Aetna Casualty & Surety Co.[43] held that a psychiatrist who administered electroshock therapy relying on consent of the wife of the patient was not negligent because under the circumstances, he properly obtained consent from someone who could act for the patient while he was incompetent to consent for himself. A Missouri decision[44] on which the Missouri Supreme Court relied heavily for the decision in *Mitchell* attains the same result as *Lester*. In the *Lester* opinion, there is also language indicating that by soliciting treatment, the patient assented to all treatment proffered by the doctor which the patient did not resist.[45]

The doctor was not held negligent in *Harwick v. Harris*[46] when the patient sued for failure to obtain an informed consent for surgery performed by another physician (Dr. Russell) to whom defendant had referred the plaintiff. In the companion case of *Russell v. Harwick*,[47] the dissent points out:

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40. See 10 S.D. L. REV. 137, 151 n.96 (1965), *supra* note 6: "For excellent illustrations of the inexactness of medical science and the role chance plays in res ipsa loquitur cases, see C. L. Wilson, M. C. Wilson & Heilbron, *Malpractice—Negligence or Misfortune?*, [1962 MED. TRIAL TECH. Q. 83]."
41. 141 La. 709, 75 So. 655 (1917).
42. 123 Va. 113, 96 S.E. 360 (1918).
43. 240 F.2d 676 (5th Cir. 1957), *rehearing denied.*
44. Steele v. Woods, 327 S.W.2d 187 (Mo. 1959).
45. *Supra* note 43, at 679.
46. 166 So. 2d 912 (Fla. App. 1964).
47. 166 So. 2d 904 (Fla. App. 1964).

> The patient in most cases has no desires to have the physician describe all the details. However, if the patient wishes to have such a description, it would be his duty to inquire and the physician's duty to give reasonable and prudent answers.[48]

The majority affirmed the trial court's holding that there was sufficient evidence to go to the jury.

In *Kennedy v. Parrott*,[49] the opinion affirming a non-suit of the plaintiff raises a cautionary note:

> [T]he law should encourage self-reliant surgeons to whom patients may safely entrust their bodies and not men who may be tempted to shirk from duty for fear of a law suit. . . . The law does not insist that a surgeon perform every operation according to plans and specifications approved in advance by the patient, and carefully tucked away in his office-safe for courtroom purposes.[50]
>
> . . . .
>
> Where one has voluntarily submitted himself to a physician or surgeon for diagnosis and treatment of an ailment it, in the absence of evidence to the contrary, will be presumed that what the doctor did was either expressly or by implication authorized to be done.[51]

Kennedy was an operation for what the doctor thought was only to be an appendectomy. In the course of the surgery, he found and removed cysts on the patient's ovaries, as a result of which she filed this action. The doctor's operating room quandry was presented thus:

> Was it his duty to leave her unconscious on the operating table, doff his operating habiliments, and go forth to find someone with authority to consent to the extended operation, and then return, go through the process of disinfecting, don again his operating habiliments, and then puncture the cysts; or was he compelled, against his best judgment to close the incision and then, after the plaintiff had fully recovered from the effects of the anesthesia, inform her as to what he had found . . . . Reason and common sense dictated that he should do just what he did do.[52]

It was held in *Roberts v. Young*[53] that whether a surgeon before operating should advise the patient of all possible results and risks must be

48. *Id.* at 912.
49. 243 N.C. 355, 90 S.E.2d 754 (1956).
50. *Id.* at 361, 90 S.E.2d at 758.
51. *Id.* at 363, 90 S.E.2d at 759.
52. *Id.* at 362-63, 90 S.E.2d 760.
53. 369 Mich. 133, 119 N.W.2d 627 (1963).

determined with reference to the general practice customarily followed by the medical profession in the locality. The judgment for defendant in that case was affirmed with the comment "[W]e are not dealing with a known existing condition, but rather with a mere possibility . . . ."[54] The *Bang* case, discussed above, was distinguished as a case where there was a result certain to happen as opposed to a mere possibility here.

Dentists also have been charged with failure to disclose possible risks of treatment. In *Ericksen v. Wilson*[55] the defendant agreed to remove two of plaintiff's teeth, but did not tell the patient that since one of the teeth to be extracted extended into plaintiff's sinus, a medical operation might be necessary afterwards to close the sinus, although the defendant anticipated this would be likely. After the extraction, he performed necessary suturing and an oral fistula developed for which plaintiff filed suit. On appeal, the trial court's judgment for the dentist was affirmed; he was not required to advise plaintiff in advance of this risk, and further, the burden of proof on the issue of causation[56] belonged to plaintiff and expert testimony was lacking to establish this point.

Two lawsuits resulted from what transpired after the patient's mother took him, a nine year old boy, to Dr. Baxter who recommended that the patient be examined by Dr. Storch, a neurologist. Dr. Storch recommended an arteriogram as an alternative to psychiatric treatment. There was evidence that three per cent of such procedures were known to result in death. In this case, partial paralysis was produced. Dr. Storch had arranged for Dr. Talmage to administer the necessary anaesthetic. Plaintiff filed suits against both Storch and Talmage and the companion cases of *Bowers v. Talmage* and *Bowers v. Storch* were consolidated for purposes of appeal[57] after both doctors prevailed below. Dr. Talmage's lack of negligence was affirmed, but Dr. Storch's judgment was reversed and remanded on the theory that he failed to get an informed consent when medical testimony of neurosurgeons showed it was customary to warn patients of the risks of this dangerous procedure. There was conflict in the evidence as to

54. *Id.* at 139, 119 N.W.2d at 630.
55. 266 Minn. 401, 123 N.W.2d 687 (1963).
56. Glazer v. Adams, 391 P.2d 195 (Wash. 1964) was an affirmance in favor of the doctor on the basis that the plaintiff failed to prove causation. One of the allegations in the complaint was failure to obtain an informed consent. *Accord,* Reder v. Hanson, 338 F.2d (8th Cir. 1964); Barnes v. Bovenmyer, 255 Iowa 220, 122 N.W.2d 312 (1963); Thomas v. Beckering, 391 S.W.2d 771 (Tex. Civ. App. 1965); Hart v. VanZandt, 17 Negl. Cas.2d 13 (Tex. Civ. App. 1964); Roberts v. Gale, 139 S.E.2d 272 (W. Va. 1964).
57. 159 So. 2d 888 (Fla. App. 1964).

whether or not Dr. Storch had given a warning and thus there was a question of fact which should have gone to the jury, and the directed verdict was error.

Wilson v. Lehman[58] concerned a patient who lost his memory as a result of electroshock therapy. The patient alleged the doctor was negligent in failing to warn of this risk and thus did not obtain an informed consent. The trial court's judgment for the doctor was affirmed on appeal because plaintiff failed to introduce evidence of causation connecting the alleged negligence and loss of memory. The opinion cites 70 C.J.S. *Physicians and Surgeons* § 62, p. 991 (1951): "In the absence of evidence showing that the patient was the victim of false representations, his consent to treatment or to an operation will be presumed from the fact that he voluntarily submitted to it."[59]

Ball v. Mallinkrodt Chemical Works[60] was appealed on the issue of whether it was error to instruct the jury that the physician had a duty to obtain an informed consent. The instruction contained much language from the case of *Salgo v. Leland Stanford Jr., Univ. Bd. of Trustees*[61] in which the seeds for the doctrine of informed consent were sown. The charge was held to be correct, for it was based on expert evidence of causation before the jury and the jury was also instructed that the reason justifying a physician's faliure to warn the patient in every case is the possibility of upsetting the patient and that each patient must be judged by he physician in charge.

One of the more limited views on "informed consent" was expressed in *Watson v. Clutts*[62] (subtotal thyroidectomy in which the doctor told the plaintiff the procedure was "not without risk") where it was said that in an average case, the doctor need only disclose dangers peculiar to the treatment proposed and of which it is likely that the patient is unaware. Furthermore, the doctor's duty is to do what is best for his patient, and any conflict between that duty and making a frightening disclosure ordinarily should be resolved in favor of the primary duty.

That it requires expert testimony to establish that a definable and substantial risk exists in the circumstances, and that this was or should have been known to the surgeon in attendance, was the holding of the court in

58. 379 S.W.2d 478 (Ky. App. 1964).
59. *Id.* at 480.
60. 381 S.W.2d 583 (Tenn. App. 1964).
61. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).
62. 262 N.C. 153, 136 S.E.2d 617 (1964).

Haggerty v. McCarthy.[63] The opinion cautioned that only upon such a showing can a duty be found to discuss and disclose the risk.

Patients often try to recover for breach of contract[64] where a doctor is so lacking in caution that he promises a result. Arguably, under the informed consent doctrine, a case could arise where the plaintiff would maintain that the doctor failed to warn of the danger that the contracted-for procedure might not succeed.[65] Typical of the contract attack was *Ball v. Mudge*,[66] where the plaintiffs (husband and wife) contracted with the defendant doctor for sterilization of the husband by means of a vasectomy to protect the wife against the dangers of another Caesarean section (she had undergone three in as many years) and to protect the family against an increase they could not economically afford. The operation was performed November 1, 1957, and four to six weeks later, the husband was instructed by defendant that he could safely resume sexual relations with his wife and need not employ any contraceptives. In November, 1958, the wife learned that she was pregnant. She bore a healthy child by Caesarean section in August, 1959, with no adverse effect on mother or child. The court affirmed the jury's finding that any negligence or breach of warranty on the part of defendant was not the proximate cause of the plaintiff-husband's fertility on or immediately prior to November, 1958. Moreover, it was held that plaintiffs could show no damage from the birth of a normal, healthy child.[67]

Where plaintiff was an involutional psychosis paranoid type who signed a voluntary admission paper, it was held in *Belger v. Arnot*[68] that:

> The plaintiff's signature to the voluntary admission paper was a consent to all treatment given subsequent to November 12, it not being contended that she was in no condition to sign or that she did so because of any misrepresentation.[69]

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63. 344 Mass. 136, 181 N.E.2d 562 (1962).

64. See Note, *Obligations—Doctor-Patient Suits—Possibility of Contractual Recovery for Malpractice*, 39 TUL. L. REV. 143 (1964).

65. *Cf.* Welch, *Medical Testimony and Professional Liability*, 1964 INSURANCE L.J. 673, 676: "No one would seriously suggest that a trial judge acting in the exercise of his best judgment should be personally responsible for the cost of appeal to a higher court because his decision is held to be erroneous. Likewise, there is no legitimate basis for imposing legal liability upon a physician for the mistakes in judgment which are inherent in the practice of an inexact science even though he possesses reasonable competence and exercises reasonable care."

66. 391 P.2d 201 (Wash. 1964).

67. The opinion fails to state whether the question of the paternity of the child was raised by the defendant.

68. 344 Mass. 679, 183 N.E.2d 866 (1962).

69. *Id.* at 686, 183 N.E.2d at 870.

In *Carroll v. Chapman*,[70] this caveat appears:

> It is not to be presumed that as a general rule a patient would submit to major surgery without inquiring into the risk involved and the possible after-effects. The presumption is contrariwise with reference to a minor operation where the probability of ill consequences is rather remote.
>
> . . . .
>
> We may observe that the relationship between a doctor and his patient is such that exact agreements are the exception rather than the rule. This is certainly true in cases where minor surgery and professional services are rendered and which do not involve a major affliction. We opine that in the latter situations the courts have no intention of placing a handicap upon the ordinary functions performed by the professional medic nor to disturb the proper relationship between him and his patient.
>
> . . . . We have concluded she gave her implied consent and that her real grievance is occasioned by the result of the operation, which, however, does not sustain liability.[71]

That a doctor has a duty to impress upon a patient the need for an operation and the reasons therefor, provided, of course, the operation is really necessary, was the holding in *State v. Fishel*.[72]

A passenger in defendant's bus was injured when the bus driver went off the road. The case styled *Kaiser v. Suburban Transportation System*[73] was a suit by the passenger against the transportation company, the bus driver, and a doctor who had treated the driver. The doctor had prescribed Pyribenzamine for his patient (the bus driver) without warning him of the possible side-effects (one of which was drowsiness) which affect about twenty per cent of all persons using this medication. It was held on appeal that whether or not the doctor was liable for plaintiff's injury was properly a jury question.

Because of the brevity of the memorandum opinion, and because it cites both *Natanson* and *Mitchell*, it is difficult to analyze *Dirosse v. Wein*[74] to determine what position the New York courts have taken. Where that defendant treated the plaintiff's rheumatoid arthritis by administering gold therapy, the trial court gave plaintiff a judgment based on the doctor's failure to make a reasonable disclosure of known dangers incident to such

70. 139 So. 2d 61 (La. App. 1962).
71. *Id.* at 66-67.
72. 228 Md. 189, 179 A.2d 349 (1962).
73. 398 P.2d 14 (Wash. 1965).
74. 24 App. Div. 2d 510, 261 N.Y.S.2d 623 (1965).

treatment. The appellate court affirmed, pointing out (1) the lack of an emergency and (2) that the medical profession recognized the possibility of undesirable reaction. These comments would indicate that there must have been expert testimony on these points, for otherwise the court would not have been warranted in making such assumptions.

III. The Canadian Decisions

In *LaChance v. B.*[75] the Supreme Court of Quebec cites Dalloz:[76]

> The plastic surgeon must draw the attention of the client to the risks of the procedure lacking which he disregards his obligations and commits a professional error for which he owes reparations.

An earlier case decided by the same court was *Bordier v. S.*,[77] holding:

> [O]ne must conclude that the defendant did not explain to the plaintiff what he was going to do or if he did give explanations they were so vague and brief that the plaintiff did not understand the import and the meaning and could not as a result give a valid consent.[78]

The rule was stated thus:

> [T]he surgeon is finally the only one capable of deciding the true value and, with all the consequences, whether the procedure is called for and useful or inopportune and needless or even dangerous; and that in consequence he alone must assume the total responsibility excepting always his right to protect himself against all reproach by permitting the patient to make the final decision but not before fully and faithfully having informed the latter of all the risks and all the possible consequences of the operation; . . . .[79]

In Ontario, in the case of *Kinney v. Lockwood Clinic, Ltd.*[80] *rev'd sub nom. Kenney v. Lockwood*,[81] the trial court gave plaintiff a judgment for $3000, holding it is a doctor's duty to enlighten a patient's mind as to

75. [1961] Que. C. S. 625. I am deeply indebted to Mrs. Vera Townsend of the Humanities Department at the University of Missouri for assisting me in the translation of the Canadian cases from the original French to the English shown in the text. Any errors in translation, however, are mine.
76. Cour d'appel, Paris, 13 janv. 1959, D.59.26, n.3, cited at 629.
77. 72 Que. C. S. 316 (1934).
78. *Id.* at 319.
79. *Id.* at 320-21.
80. [1931] Ont. 438, [1931] 4 D.L.R. 906 (Ont. Sup. Ct.).
81. [1932] Ont. 141, [1932] 1 D.L.R. 507 (Ont. App. Div.).

what the ailment is, the risks of operating promptly, of delaying, or not operating at all; and where a surgeon knowingly minimizes the danger of treatment to induce a patient to proceed and refrains from explaining the advantages and disadvantages of an alternative course, he brings himself within the field of liability for untoward results. Plaintiff was told she had Dupuytren's contraction in her hand and that the proper treatment was an operation to remove the cause of the trouble. As a result of the surgery, she lost the full use of her hand and claimed that had she been warned of this hazard, she would not have permitted the operation. On appeal it was said that the duty of a surgeon is to deal honestly with the patient as to the necessity, character and importance of an operation and its probable consequences and whether success might reasonably be expected to ameliorate or remove the trouble, but such duty does not extend to warning the patient of the dangers incident to, or possible in any operation nor to details calculated to frighten or distress the patient. The court cautioned that if a surgeon expresses his own honest belief he ought not to be judged as if he had warranted a perfect cure nor be found derelict in his duty as a result of meticulous criticism of his language, providing he is not guilty of negligence in word or economy of truth.

The Nova Scotia Supreme Court held in *Marshall v. Curry*[82] that trespass would not lie against a surgeon who, in the course of a surgical operation, removes, without his patient's consent, an organ that he reasonably believes should be removed in order to preserve the patient's life or health. In this case, the doctor, in performing a hernia operation, removed a diseased testicle. Experts testified that what defendant did was "good surgery," probably meaning good surgical practice. The case cites many American authorities on consent to medical procedures, but particularly deprecates the theory of *Bennan v. Parsonnet*,[83] which strained to conceptualize the doctor as having been appointed the patient's agent to grant consent to necessary operative procedures that the surgeon became aware of after the patient was under anaesthetic.

IV. The English Decisions

It was said in *Slater v. Baker and Stapleton*:[84]

> [I]ndeed it is reasonable that a patient should be told what is

82. [1933] 3 D.L.R. 260 (Nov. Scot. Sup. Ct.).
83. 83 N.J.L. (54 Vroom) 20, 83 Atl. 948 (1912).
84. 2 Wils. K.B. 360, 95 Eng. Rep. 860, Michaelmas Term, 8 Geo. III 1767.

> about to be done to him that he may take courage and put himself in such a situation as to enable him to undergo the operation.[85]

Undoubtedly, this court spoke before the modern practice of anaesthesiology and felt that warning should be given so a patient would be given the opportunity to steel himself for the shock of having a limb removed or some other medical procedure performed while fully conscious.

More in point is an opinion that especially impressed this writer for its logic, clarity, and brevity. It is the case of *Bolam v. Friern Hospital Management Committee*,[86] in which the defendant administered electroshock therapy and plaintiff incurred severe resulting physical injury. The allegation was that defendant neglected to apprise the patient of the hazards of the treatment in obaining his consent. In instructing, the court directed the jury that (1) a doctor is not negligent if he is acting in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, merely because there is a body of such opinion that takes a contrary view; (2) the jury might well think that when a doctor was dealing with a mentally sick man and had a strong belief that his only hope of cure was submission to electroshock therapy, the doctor could not be criticized if, believing the dangers involved in the treatment to be minimal, he did not stress them to his patient; and (3) in order to recover damages for a failure to give warning, the plaintiff must show not only that the failure was negligent but also that if he had been warned he would not have consented to the treatment. The jury rendered a verdict for the defendant.

A lecturer in Law at the University of Manchester has stated in the official journal of the British Academy of Forensic Sciences:[87]

> If a patient can prove that the nature of the treatment was not explained to him and that a reasonable doctor or surgeon using the skill of his profession would have given him the information he lacked, he may establish a breach of the medical man's duty towards him giving rise to an action in negligence. If he brings his action in negligence, he must, as previously explained, show that he has suffered damage and must therefore prove to the satisfaction of the court that if he had been entrusted with the knowledge of what the operation involved he would not have agreed to undergo it.[88]

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85. *Id.* at 362, 95 Eng. Rep. at 862.
86. 2 All E.R. 118 (Q.B.D. 1957).
87. Kloss, *Consent to Medical Treatment*, 5 MED., SCI. & LAW 89 (1965).
88. *Id.* at 97.

V. The Problem

Because courts have generally insisted upon expert medical testimony to prove the standard of care that a medical practitioner must observe,[89] and have generally held that it also takes expert testimony to prove causation in medical malpractice actions,[90] the legal profession more often than not has been thwarted in attempts to guide such litigation to a successful conclusion due to the conspiracy of silence among doctors plus the social and economic pressures brought to bear on them not to testify against another doctor.[91] To escape these obstructions, the legal profession has prosecuted medical malpractice cases on theories which have been held to require no expert testimony: (1) *res ipsa loquitur*,[92] which presently is accepted in a minority of states in malpractice actions; (2) breach of warranty or contract,[93] (3) the common knowledge doctrine in instances where any layman can tell that what has happened is below the standard of care of the medical profession,[94] and now (4) informed consent.[95]

Whether the doctrine of informed consent should completely eliminate the need for expert testimony in all medical malpractice cases is a question

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89. See authorities cited in note 6, *supra*. See also Myers, *"The Battle of the Experts"; A New Approach to an Old Problem in Medical Testimony*, 44 Neb. L. Rev. 539 (1965).

90. Burke v. Miners Memorial Hosp. Ass'n, 381 S.W.2d 758 (Ky. App. 1964); Dowling v. Mut. Life Ins. Co., 168 So.2d 107 (La. App. 1964); Morgan v. Rosenberg, 370 S.W.2d 685 (St. L. Mo. App. 1963); Puryear v. Porter, 153 Texas 82, 264 S.W.2d 689 (1954); Bowles v. Bourdon, 148 Texas 1, 219 S.W.2d 779 (1949); *Cf.* Hasemeier v. Smith, 361 S.W.2d 697 (Mo. En Banc 1962).

91. McCleary, *Torts in Missouri*, 27 Mo. L. Rev. 81, 87 (1962) suggests: "Each medical case involves many factors which must be balanced, so that better results may be achieved by not laying down strict legal rules which the medical profession must follow."

92. Hasemeier v. Smith, *supra* note 91. Johnson, *Medical Malpractice Doctrines of Res Ipsa Loquitur and Informed Consent*, 37 Colo. L. Rev. 182 (1965).

93. Ball v. Mudge, *supra* note 66; Pearl v. Lesnick, 20 App. Div. 2d 761, 247 N.Y.S.2d 561 (Sup. Ct. 1964).

94. Larrimore v. Homeopathic Hosp. Ass'n, 181 A.2d 573 (Del. 1962); Rauschelbach v. Benincasa, 372 S.W.2d 120 (Mo. 1963).

95. Oppenheim, *Informed Consent to Medical Treatment*, 11 Cleve.-Mar. L. Rev. 249 (1962) discusses Woods v. Pommerening, 44 Wash. 2d 867, 271 P.2d 705 (1954) where medical testimony was in evidence that it was not the custom of the profession to warn and that in advising of the risk involved, the judgment of the individual doctor had to be exercised in the light of the mental and psychosomatic makeup of the patient. The physician-author comments at 261: "The absurdity of the trend towards a "more informed patient" is evident in the attempts of physicians to comply, even where compliance is not in conformance with good medical practice. This required 'informed' consent may create delay, apprehension, and restrictions on the use of new techniques that will impair the progress of medicine. It is questionable whether the 'average prudent man' will understand and comprehend the following examples of informed consent forms used by a prominent neurosurgeon in his practice: [followed by sample forms]."

on which the courts have not yet agreed, but it appears that the majority tend to side with the decisions of the Kansas Supreme Court rather than the Missouri Supreme Court, preferring the *Natanson* and *Williams* views (expert testimony required) to the *Mitchell view* (expert testimony not required). Regardless of whether or not expert testimony is required to prove negligence, the doctrine of informed consent does, at least in some cases, abolish the necessity of proving a causal relation between negligence and injury by expert testimony. Once negligence[96] has been established and injury has been shown, if the plaintiff states that if he had been warned he would have refused the treatment, it would appear that substantial evidence of causation is in the case.[97] Thus, if the patient is left mentally incompetent or dies prior to trial so that he can not testify on the issue of causation, there would be no way to prove the issue without an admission on the part of defendant unless jurors are to be permitted to speculate and conjecture as to what plaintiff might have done had he been warned.

VI. The Solution

In the final analysis, it probably would be preferable for the medical profession to provide the legal profession with a source of unbiased medical experts who will testify freely for a plaintiff in a malpractice suit. Then

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96. The term was best explained by Judge Learned Hand in Conway v. O'Brien, 111 F.2d 611, 612 (2d Cir. 1940) when he defined how the degree of care is established: "The degree of care demanded of a person by an occasion is the resultant of three factors: the liklihood that his conduct will injure others, taken with the seriousness of the injury if it happens, and balanced against the interest which he must sacrifice to avoid the risk. All these are practically not susceptible of any quantitative estimate, and the second two are generally not so, even theoretically. For this reason a solution always involves some preference, a choice between incommensurables, and it is consigned to a jury because their decision is thought most likely to accord with commonly accepted standards, real or fancied."

97. In Watson v. Clutts, 262 N.C. 153, 160-61, 136 S.E.2d 617, 622 (1964) the court said: "The plaintiff attempted to testify that if the defendant had advised her the operation might involve paralysis of the vocal cords she would have withdrawn the consent. The court excluded this testimony which presented a case of looking backward. Perhaps the defendant with the benefit of the backward look would not have performed the operation; but at the time decision was made to operate the surgeon was dealing with a patient who had a diseased gland which failed to secrete the proper amount of hormone. The medical experts, plaintiff's witnesses, say surgery in such event is indicated. All cutting operations involve some risks. Possible dangers of an operation had to be balanced against the certain danger of a diseased thyroid. Decision had to be made before the operation. To permit the plaintiff to change the decision afterwards is equivalent to looking at the answer without solving the problem." The court affirmed the trial court's sustaining of a demurrer.

the doctrines most despised by the medical fraternity—*res ipsa loquitur* and "Informed Consent"—could be abandoned as vestigial structures, at least for malpractice actions. The need being erased, the special rules can be excised as well.

Unless the physicians provide the solution, they will have to learn to live with the results of the common law's efforts to provide relief for the injured, and the latest "wonder drug" prescription seems to be:

"INFORMED CONSENT" P. R. N.[98]

ADDENDUM

After this article had been completed, the Missouri Supreme Court rendered its opinion after approximately seven months' consideration of the case of *Aiken v. Clary*,[99] in which plaintiff appealed a unanimous jury verdict for the doctor in litigation between a patient and his psychiatrist after the patient had severely adverse results (a delayed awakening and resultant organic brain damage) from insulin shock therapy. The case went to trial solely on the issue of the doctor's alleged negligence in failing to obtain an informed consent as required by *Mitchell v. Robinson*.[100]

Judge Finch, in a unanimous opinion of division two, said:

> The question to be determined by the jury is whether defendant doctor in that particular situation failed to adhere to a standard of reasonable care. These are not matters of common knowledge or within experience of laymen. Expert medical evidence thereon is just as necessary as is such testimony on the correctness of handling in cases involving surgery or treatment.[101]

The decision proceeds to itemize the many considerations to be taken into account in making a determination of how much warning of collateral hazards should be given to a patient by a physician before the patient's consent to treatment or surgery is "educated" or "informed." The opinion concedes that proper warnings might range from "full disclosure of all risks which had any reasonable likelihood of occurring" to "guarded or limited disclosure," but regardless of the difficulty of the conclusion to be reached "it would be a medical judgment."[102]

98. A medical term used in prescriptions to designate a dosage to be taken "according as circumstances may require."
99. No. 50,792, Mo., December 13, 1965.
100. 334 S.W.2d 11 (Mo. 1960).
101. *Supra* note 99, at 8-9 of the original opinion.
102. *Id.* at 10.

The holding of the case can be summarized by paraphrasing the opinion as follows:

> Expert testimony to show what disclosure a reasonable medical practitioner would have made under the same or similar circumstances is a prerequisite to the plaintiff making a submissible case, and, to the extent *Mitchell* is in conflict, it is disapproved.

Footnote six of the opinion suggests that it is conceivable for a doctor in informing his patient to go so far as to indicate what other practitioners would do, thus waiving the need for expert testimony. It should be noted that any such waiver should be limited to the extent of the warnings given. To follow any other rule would be to tell the practitioner that he is only safe in minimal or no disclosure at one extreme, to avoid the waiver, or the most complete and full disclosure at the other extreme, to insure that he has proceeded as other competent doctors in his specialized field might under the same or similar circumstances.

Because counsel for plaintiff had relied on the somewhat ambiguous language of *Mitchell* in not producing expert testimony, *Aiken* was remanded for retrial giving the patient opportunity to do so. Apparently the court thought fairness required this result.[103] Appellate practice in Missouri (and elsewhere) has normally followed the principle of deciding the instant case and all future cases according to the rules of law developed in the instant case even though that decision may have overruled a prior decision upon which one of the parties relied at trial and even though this result gives a somewhat retroactive effect to the appellate court's decision. The theory probably is based on a public policy of allowing a litigant to be the beneficiary of a change in the law which he has brought about, it being felt that to do otherwise would offer no encouragement to a potential appellant seeking to improve the law by asking the court to reverse itself when he could not derive any benefit in his own litigation though he had borne the expense. Few are so altruistic as to be concerned only that others shall enjoy the benefits of a constantly developing and improving legal system. This, however, is the subject of some other writer at a later date.

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103. *Id.* at 12. In the abstract, a plaintff who has successfully established a prima facie case under the prior law but subsequently lost the jury verdict can in no way be prejudiced by a ruling on appeal that more is required for a prima facie case. Therefore fairness does not require the case to be remanded.

In conclusion, after *Aiken,* it would appear that the only remaining case not requiring expert testimony in this area of the law is Wood v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962), which relied on *Mitchell* for authority.[104] With *Mitchell* overruled by *Aiken, Woods* is left not only alone, but unsupported, and it is now contrary to the majority of the legal writers and to the decided cases of all of the state, English and Canadian Courts.

104. *But see* Scott v. Wilson, 396 S.W.2d 532 (Tex. Civ. App. 1965).