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IS THERE A DOCTOR IN THE HOUSE?: THE DUTY OF A SUBSTITUTE PHYSICIAN TO DISCLOSE THE RISKS OF MEDICAL TREATMENT

*Sanguolo v. Leventhal*¹

Legal medicine embodies a variety of subjects including informed consent and the legal effect of relationships between physicians. Viewed separately, arrangements made between physicians caring for each other's patients and the doctrine of informed consent generate an abundance of discussion among legal scholars and members of the medical profession alike.² When these two areas are combined, their importance to medicolegal jurisprudence increases dramatically.

The New York Supreme Court in *Sanguolo v. Leventhal*³ held that a substitute physician is liable to a patient for failure to inform that patient of the risks, benefits and alternatives of a treatment originated by another physician.⁴ In so holding, the court in *Leventhal* merged the doctrine of informed consent with that of the legal effect of an arrangement made by a physician and his substitute. This novel merger⁵ presents several issues that must be

1. 132 Misc. 2d 680, 505 N.Y.S.2d 507 (N.Y. Sup. Ct. 1986).

2. In *Graddy v. New York Medical College*, 19 A.D.2d 426, 428, 243 N.Y.S.2d 940, 942 (1963), the court discussed the importance of determining the legal effect of arrangements made between physicians for the treatment of the other physician's patients. The New York Supreme Court, Appellate Division, stated that "[t]he problem presented is of significance in the practice of medicine and in affecting liability resting on the arrangements made by physicians for the care and treatment of each others' patients." *Id.*

One discussion on the import of the doctrine of informed consent noted: "The growth and importance of informed consent has been so very significant that some commentators have observed that it has prompted 'a spate of legal articles that is probably unequalled in the history of medicolegal jurisprudence.'" Comment, *Patients' Rights and Informed Consent: An Emergency Case for Hospitals?*, 12 CAL. W.L. REV. 406, 411 n.23 (1976).

3. 132 Misc. 2d 680, 505 N.Y.S.2d 507 (N.Y. Sup. Ct. 1986).

4. *Id.* at 684-85, 505 N.Y.S.2d at 508, 510.

5. In *Leventhal*, the court noted that "[n]either counsel nor the court have found any American case on the issue of the liability of the substituting physician to provide informed consent." *Id.* at 684, 505 N.Y.S.2d at 510.

Further support for the contention that the merger between the doctrine of informed consent and a substitute's liability is novel is warranted by the complete absence of any discussion on the matter by such frequently cited works as American Jurisprudence 2d and Corpus Juris Secundum. Although these works do contain discus-

addressed by New York and other jurisdictions following the decision.

Leventhal involved a defendant doctor's motion for summary judgment in a medical malpractice action. The events preceding the motion began on January 30, 1978, when Dr. Gerald Leventhal conferred with Ms. Josephine Sangiuolo concerning complaints of pain in her joints. Dr. Leventhal diagnosed the pain as rheumatoid arthritis.⁶

In an effort to curb the disease and prevent further consequences of rheumatoid arthritis, Dr. Leventhal prescribed gold therapy.⁷ A note in the office records of Dr. Leventhal stated: "Patient advised of possible Gold complications⁸ but agreeable to Rx."⁹ Dr. Leventhal then began administering gold injections by utilizing the drug Solganol on April 19, 1978.¹⁰

Several weeks later, Dr. Jeffrey Postman agreed to treat Ms. Sangiuolo while Dr. Leventhal was on vacation. Dr. Postman saw Ms. Sangiuolo on four occasions—June 29, July 6, July 11, and July 17, 1978.¹¹ When he first saw Ms. Sangiuolo in his office, Dr. Postman inquired about her condition, per-

sion on both informed consent and the arrangement between a physician and his substitute, they completely lack discussion exists concerning a substitute's duty to inform a patient of the risks of a treatment started by another physician.

6. *Leventhal*, 132 Misc. 2d at 681, 505 N.Y.S.2d at 508. Rheumatoid arthritis is a chronic disease which affects multiple joints of the body creating such effects as debility, weakness and weight loss. Rheumatoid arthritis is accompanied by pain, limitation of motion, deformity and sometimes bony ankylosis which is a complete fixation of a joint due to the fusion of the bones. BLACKISTON'S NEW GOULD MEDICAL DICTIONARY 71, 96 (1949).

7. Because rheumatoid arthritis is a chronic disease which has the potential effect of severely crippling its victims, mere treatment of the symptoms is insufficient. The main purpose in the care and treatment of rheumatoid arthritis should be the prevention or retardation of joint destruction. Luukkainen, *Gold in Rheumatoid Arthritis Therapy Today. Early Treatment*, 51 SCAND. J. RHEUMATOL. SUPP. 118 (1983).

Gold therapy involves the use of gold, a disease modifying drug. A standardized regime for gold treatment of rheumatoid arthritis patients who have not previously been given gold includes: 1) an initial trial period with weekly injections of 10 mg., 25 mg., and 50 mg. respectively; 2) the main phase of the treatment with weekly injections of 50 mg. which continues until a total gold dose of approximately 1000 mg. is given (If the treatment fails to produce any apparent effect, such as retardation of joint destruction, it is stopped); and 3) the maintenance period with intervals of two to four weeks between each injection of 50 mg. This part of the treatment can last as long as the treatment is seen as beneficial. Husby, *Gold in Rheumatoid Arthritis Therapy Today. Dosage*, 51 SCAND. J. RHEUMATOL. SUPP. 122 (1983).

8. The complications of gold therapy include the following: dermatitis, thickening of the tongue, inflammation of the upper respiratory tract, fainting, dizziness, sweating, nausea, vomiting, abdominal cramps, diarrhea, as well as several others. PHYSICIAN'S DESK REFERENCE 1808 (38th ed. 1984).

9. *Leventhal*, 132 Misc. 2d at 681, 505 N.Y.S.2d at 508.

10. *Leventhal*, 132 Misc. 2d at 681, 505 N.Y.S.2d at 508. Solganol is a sterile dispersion of a solid particle through a liquid, for intramuscular injection only. Each ml. of Solganol contains 50 mg. of aurothioglucose. Aurothioglucose contains approximately 50% gold by weight. PHYSICIAN'S DESK REFERENCE 1808 (38th ed. 1984).

11. *Leventhal*, 132 Misc. 2d at 681, 505 N.Y.S.2d at 508.

formed a urinalysis, conducted a complete blood count analysis (CBC),¹² and administered Solganol.¹³

The remaining consultations between Dr. Postman and Ms. Sanguiolo began on July 6, when Dr. Postman performed another urinalysis and administered another injection of Solganol. On July 11, Ms. Sanguiolo complained of a rash. Dr. Postman told her the gold therapy had to stop. He did not administer any further injections. On that same date he also treated her with several medications and did another CBC analysis. Finally, Dr. Postman last examined Ms. Sanguiolo on July 17, at which time he adjusted her medication.¹⁴

Ms. Sanguiolo eventually sued both Dr. Leventhal and Dr. Postman, claiming that the doctors were guilty of negligence by failing to inform her of the risks of gold therapy despite the note in Dr. Leventhal's records stating that the patient had been so advised.¹⁵ Ms. Sanguiolo also sued Dr. Postman for medical malpractice, claiming that he acted negligently when he failed to do a CBC analysis on July 6.¹⁶ The New York court granted summary judgment for Dr. Postman on this issue, noting the absence of any genuine issue of material effect concerning negligence in Dr. Postman's conduct on July 6.¹⁷

Dr. Postman suggested two arguments in support of his request for summary judgment on the issue of his negligence in failing to inform Ms. Sanguiolo of the risks of gold therapy. First, Dr. Postman insisted that he was entitled to rely upon the notation in Dr. Leventhal's records that Ms. Sanguiolo had been advised of the complications that might accompany the gold treatment.¹⁸ Dr. Postman further argued that a decision forcing substitutes to inform patients of risks of a treatment started by another physician would make it increasingly difficult for vacationing doctors to procure substitutes.¹⁹

The New York court rejected both arguments, concluding that a substitute has a duty to inform.²⁰ The case is the first American decision to discuss

12. A complete blood count analysis is a blood count made from a combination of the following determinations: red blood cell count, white blood cell count, erythrocyte indices, hematocrit and differential blood count. *STEDMAN'S MEDICAL DICTIONARY* (5th Unabridged Lawyer's ed. 1982).

13. *Leventhal*, 132 Misc. 2d at 681, 505 N.Y.S.2d at 508.

14. *Id.*

15. *See supra* note 8 and accompanying text.

16. *Leventhal*, 132 Misc. 2d at 681, 505 N.Y.S.2d 508.

17. The court reasoned that the failure to take blood on that date:

could not have been a proximate cause of plaintiff's rash because the CBC analysis of the blood taken on June 29 was normal, so that [Dr. Postman] was justified in giving the July 6 injection. The next time he saw plaintiff, the rash had already appeared, and he did not administer any further injections.

Id. The malpractice part of the case was quickly dismissed by the New York Supreme Court and will not be discussed further in this Note. What is of noteworthy significance is the court's treatment of the informed consent issue.

18. *Id.*

19. *Id.* at 684, 505 N.Y.S.2d at 510.

20. *Id.*

and recognize a substitute physician's duty to inform a patient of the risks of treatment that the substitute administers while covering for the original physician.²¹

The doctrine of informed consent is founded on the strong contemporary concern for the right of the individual to be the sole determiner of his own destiny.²² The court in *Leventhal* demonstrated its recognition of this concern when it relied upon the statement of Justice Cardozo in *Schloendorff v. Society of New York Hospital*: "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."²³ Individuals have an interest in their own destiny and this interest is as applicable in medical matters as it is in any other aspect of human activity.²⁴

To ensure that the patient is allowed to control his own destiny, a physician must obtain not merely the consent of his patient, but the patient's informed consent.²⁵ The issue thus concerns what information a patient requires to enable him to make an informed decision. That issue was addressed in the landmark case of *Salgo v. Leland Stanford Jr. University Board of Trustees*.²⁶ The *Salgo* court concluded that "the facts necessary to form the basis of an intelligent consent" are the ones which must be disclosed to the patient.²⁷ However, claiming that those "facts necessary to form the basis of an intelligent consent" must be disclosed only begs the question. What facts are necessary to form the basis of an intelligent consent?²⁸

21. See *supra* note 5.

22. Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 Wis. L. Rev. 413, 422.

23. *Leventhal*, 132 Misc. 2d at 683, 505 N.Y.S.2d at 509 (quoting *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), *rev'd sub nom.* *Bing v. Thunig*, 2 N.Y.2d 656, 665 (1957)).

24. Meisel, *supra* note 22, at 418.

25. *Scaria v. St. Paul Fire & Marine Ins. Co.*, 68 Wis. 2d 1, 11, 227 N.W.2d 647, 652 (1975). The *Scaria* court stated that "a patient [has] a right to know of significant potential risks involved in proposed treatment or surgery so that he [can] make a rational and informed decision of whether he would undergo the proposed procedures." *Id.*; see also Meisel, *supra* note 22, at 420-21.

26. 154 Cal. App. 2d 560, 317 P.2d 170 (1957).

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

28. See N.Y. PUB. HEALTH LAW § 2805-d(1) (McKinney 1985); *Charley v. Cameron*, 215 Kan. 750, 756, 528 P.2d 1205, 1210 (1974) ("the duty of a physician is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances"); *Ze Barth v. Swedish Hosp.*, 81 Wash. 2d 12, 24, 499 P.2d 1, 8 (1972) ("Informed consent, therefore, is the name for a general principle of law that a physician has a duty to disclose what a reasonably prudent physician in the medical community, in the exercise of reasonable care, would disclose to his patient."); see also *Garone v. Robert's Technical & Trade School, Inc.*, 47 A.D.2d 306, 308, 366 N.Y.S.2d 129, 131 (1975). The *Garone* court said: "[The physician] is under an affirmative duty to make a reasonable disclosure to his patient of the known dangers which are incident to or possible in the proposed treatment; if he fails in that duty he can be liable for malpractice. . . ." *Id.*

In the *Leventhal* case the court noted that the doctrine of informed consent had been incorporated in New York Public Health Law section 2805-d(1).²⁹ The doctrine of informed consent, as it pertains to the law governing the *Leventhal* decision, places liability upon a physician who fails to disclose those risks which a reasonable medical practitioner would have disclosed under similar circumstances.³⁰

According to the court in *Leventhal*, liability has generally been premised upon two theories: 1) nonconsensual touching of the body; and 2) a form of medical malpractice.³¹ If liability is premised upon a nonconsensual touching of the body, recovery may be had even where an operation is successful.³² Generally, however, a physician's failure to procure a patient's informed consent is regarded as a species of malpractice.³³

Regardless of the theory used, a physician who fails to inform a patient of the risks, benefits and alternatives to a proposed treatment subjects himself to liability.³⁴ This liability, however, is not absolute.³⁵ In *Prooth v. Walsh*,³⁶ the court held that the duty to inform must be limited regardless of the theory used to find liability. If the nonconsensual touching theory is applied, the

29. The statute provides that:

Lack of informed consent means the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits involved as a reasonable medical practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation.

N.Y. PUB. HEALTH LAW § 2805-d(1) (McKinney 1985).

30. See *supra* notes 28-29.

31. *Leventhal*, 132 Misc. 2d at 683, 505 N.Y.S.2d at 509; see also *Prooth v. Walsh*, 105 Misc. 2d 603, 432 N.Y.S.2d 663 (N.Y. Sup. Ct. 1980).

32. The court in *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1965) stated: "If the consent given to the operation in question was ineffectual, every phase of this operation, from initial anesthesia to final suture was a continuing battery for which recovery should be allowed, even if the operation had been successful." *Id.* at 366, 409 P.2d at 82.

33. 132 Misc. 2d at 683, 505 N.Y.S.2d at 509.

34. "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." *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957); see *supra* notes 28-29.

35. Liability is not absolute despite the fact that:

Traditionally, the law of informed consent has been seen by jurists through 'tunnel vision' eyes. Regardless of the presence of extenuating circumstances, courts have held that the physician is bound by an absolute duty to disclose all relevant information to his patient concerning the proposed surgical operation or course of treatment.

Meisel, *supra* note 22, at 417 n.17 (quoting Abbuhl & Gerking, *Informed Consent of the Emotionally Disturbed Patient*, 1975 LEGAL MED. ANN. 217, 220 (C. Wecht ed. 1976)). Meisel points out that the case, *Nishi v. Hartwell*, 52 Haw. 188, 473 P.2d 116 (1970), which was used to support the absolute duty to disclose, does not hold that there is an absolute duty of disclosure. Meisel, *supra* note 22, at 417 n.17.

36. 105 Misc. 2d 603, 432 N.Y.S.2d 663 (N.Y. Sup. Ct. 1980).

Prooth court said that only the party who actually touches or directs such touching should be liable.³⁷ If the malpractice theory is applied, then every participant in a procedure may be liable to explain the particular risks of his part of the treatment, but not necessarily the risks of another participant's treatment.³⁸

In addition to the limitations of the informed consent doctrine set forth by the *Prooth* court, several other limitations in the form of exceptions have been developed.³⁹ These exceptions include: 1) emergencies precluding the obtaining of consent; 2) incompetent patients who are not capable of giving an intelligent consent; 3) waiver of the information needed for consent by the patient; and 4) the therapeutic privilege, which allows an exception to the doctrine where withholding the requisite information is actually beneficial to the patient.⁴⁰ One court has also concluded that informed consent is required before a surgical operation but that the doctrine does not apply to therapeutic treatment.⁴¹

In its most basic form, the doctrine of informed consent places upon a physician the duty to disclose information which a reasonably prudent physician would disclose.⁴² The *Leventhal* decision does not change the doctrine. Instead, *Leventhal* applies the doctrine of informed consent to a new area—a substitute's duty to disclose. Understanding this doctrine and its exceptions is, therefore, an essential step in properly analyzing the *Leventhal* decision.

Since the decision in *Leventhal* also depends in part upon the legal effect of an arrangement between physicians caring for each others' patients,⁴³ more than an understanding of the doctrine of informed consent is necessary. One must also comprehend the different legal effects that surround arrangements between physicians.⁴⁴

The courts of New York and other states have considered the relationship between the original treating physician and his substitute.⁴⁵ These courts rely

37. *Id.*

38. *Id.*

39. For a detailed examination of these exceptions, see Meisel, *supra* note 22.

40. *Id.*

41. In *Malloy v. Shanahan*, 421 A.2d 803 (Pa. Super. Ct. 1980), the court stated, "[Informed consent] has not been extended to therapeutic treatment, which is usually an ongoing treatment upon examination by the treating physician, where any change of condition can be diagnosed and controlled." *Id.* at 804.

42. See *supra* notes 28-29.

43. See *supra* notes 4-5 and accompanying text.

44. The term "legal effects," as used here, refers to the relationship that the arrangement creates and the liability, if any, stemming from such relationship (i.e. master-servant, partnership or independent contractor).

45. *Leventhal*, 132 Misc. 2d at 684, 505 N.Y.S.2d at 510; see, e.g., *Nash v. Royster*, 189 N.C. 408, 127 S.E. 356 (1935); *Impastato v. DeGirolamo*, 117 Misc. 2d 786, 459 N.Y.S.2d 512, *aff'd*, 464 N.Y.S.2d 382 (1983); *Prooth v. Wallsh*, 105 Misc. 2d 603, 432 N.Y.S.2d 663 (N.Y. Sup. Ct. 1980); *Graddy v. New York Medical College*, 19 A.D.2d 426, 243 N.Y.S.2d 940 (1963); *Moulten v. Huckleberry*, 150 Or. 538, 46 P.2d 589 (1935); *McCay v. Mitchell*, 463 S.W.2d 710 (Tenn. 1970).

upon a number of factors in determining whether the relationship between the two physicians is one of partners, master-servant, or independent practitioners.⁴⁶ A determination of the type of relationship existing between the physicians is essential since the degree of liability turns upon the nature of that relationship.⁴⁷

In determining whether a partnership exists, courts will look to see whether there is a pro rata sharing of profits and losses of the enterprise and pro rata contribution to the capital of the enterprise.⁴⁸ In addition, other factors suggesting the existence of a partnership between the physicians include joint ownership and interest in the enterprise assets, intent of the parties to be partners, and equal voice in the management of the enterprise by the parties.⁴⁹ Where the substitute physician has no obligation to bear the burden of any loss suffered by the original physician no partnership or joint venture is established.⁵⁰

The New York Supreme Court relied upon these factors in *Impastato v. DeGirolamo*⁵¹ to determine whether a partnership existed between a physician and his substitute. In that case, Frances Impastato took her eleven year old son to Dr. Paul Citrin in January, 1979.⁵² On June 19, 1979, she took her son back to see Dr. Citrin but Dr. Citrin was on vacation. Dr. Mehta was seeing Citrin's patients.⁵³ Dr. Mehta examined Mrs. Impastato's son and diagnosed his condition as acute gastritis. Mrs. Impastato's son was actually suffering from appendicitis and died June 21, 1979, from a perforated appendix.⁵⁴

Mrs. Impastato sued both Dr. Citrin and Dr. Mehta, contending, among other things, that the relationship between Citrin and Mehta had evolved to the level of a partnership.⁵⁵ The court relied upon the factors discussed above in determining that Mehta and Citrin were not partners. The *Impastato* court found that Dr. Mehta did not have an obligation to incur any losses that Citrin's practice might suffer.⁵⁶ In addition, the court determined that Mehta did not have any control over Dr. Citrin's office or practice.⁵⁷ Based on these conclusions, the court held that Mehta and Citrin were not involved in a partnership.⁵⁸

Just as the factors suggesting a partnership are numerous, so too are the

46. *Leventhal*, 132 Misc. 2d at 684, 505 N.Y.S.2d at 510; see, e.g., *Impastato*, 117 Misc. 2d 786, 459 N.Y.S.2d 512; *Huckleberry*, 150 Or. 538, 46 P.2d 589.

47. See *infra* note 71 and accompanying text.

48. *Impastato*, 117 Misc. 2d at 789, 459 N.Y.S.2d at 514.

49. *Id.*

50. *Id.* at 786, 459 N.Y.S.2d at 515.

51. 117 Misc. 2d 786, 459 N.Y.S.2d 512 (1983).

52. *Id.* at 786, 459 N.Y.S.2d at 513.

53. *Id.*

54. *Id.*

55. *Id.* at 787, 459 N.Y.S.2d at 513.

56. *Id.* at 789, 459 N.Y.S.2d at 515.

57. *Id.*

58. *Id.*

factors supporting an agency or master-servant relationship.⁵⁹ The factors relied upon in determining whether the arrangement between a physician and his substitute is one of master-servant or agency include the arrangements made for payment between the original physician and his substitute; whether the substitute makes use of the original physician's premises, materials, equipment, appliances and staff; the contract made between the parties; the original physician's right to terminate the employment; the original physician's right to direct how the work should be done; and whether the substitute was employed to handle a specific case as opposed to being hired to do all the work of the original physician.⁶⁰ If the original physician turns over his office, equipment, staff and files, and the substitute turns over the fees collected, then a master-servant relationship is created.⁶¹

The *Impastato* court considered these factors in determining whether a master-servant relationship existed. While the court held a partnership did not exist,⁶² the court did find a master-servant relationship.⁶³ That finding was based on the fact that Dr. Mehta, who was substituting for Dr. Citrin, used Dr. Citrin's equipment to perform her services.⁶⁴ Dr. Mehta did not have any tools or equipment of her own. She even used the prescription pads furnished by Dr. Citrin.⁶⁵ In addition, Dr. Mehta was obliged to use Citrin's staff. The patients she treated were to remain Citrin's patients. Furthermore, she only received a portion of the compensation paid by insured patients (i.e. Medicaid, Blue Cross, Blue Shield). Finally, Dr. Citrin could dismiss Dr. Mehta at any time.⁶⁶ The *Impastato* court held that the combination of these factors was evidence that Dr. Mehta was an employee of Dr. Citrin.⁶⁷

In the absence of any factors suggesting a special relationship between the original physician and his substitute, it must be assumed that the physicians are independent contractors.⁶⁸ In *Moore v. Lee*,⁶⁹ the Texas Supreme

59. "Although the words agent and servant are not wholly synonymous there is no fundamental distinction between the liability of a principal for the tort of an agent and the liability of a master for the tort of a servant." *Id.* at 790, 459 N.Y.S.2d at 515.

60. *Moulten v. Huckleberry*, 150 Or. 538, 46 P.2d 589 (1935).

61. *Impastato v. DeGirolamo*, 117 Misc. 2d 786, 793, 459 N.Y.S.2d 512, 517 (1983); see also *McCay v. Mitchell*, 62 Tenn. App. 424, 463 S.W.2d 710 (1970) (the court found a master-servant relationship). In *Mitchell*, the original physician had been hired to treat the plaintiff during her pregnancy and childbirth. When the plaintiff was hospitalized for her accouchement, the original physician was absent. He had arranged for the plaintiff to be cared for by another doctor, who was not known to the plaintiff. The court held that these facts permitted the inference of an agency. *Id.* at 433, 463 S.W.2d at 715.

62. See *supra* notes 51-58 and accompanying text.

63. *Impastato*, 117 Misc. 2d at 791, 459 N.Y.S.2d at 515.

64. *Id.* at 791, 459 N.Y.S.2d at 516.

65. *Id.*

66. *Id.*

67. *Id.* at 791, 459 N.Y.S.2d at 515.

68. *Leventhal*, 132 Misc. 2d at 684, 505 N.Y.S.2d at 510.

69. 109 Tex. 391, 211 S.W. 214 (1919).

Court stated that “[f]rom the very nature of the employment, the physician who takes the place of another must, while he alone is treating the patient, exercise his own judgment and his own skill; and he is truly an independent contractor.”⁷⁰

The legal effect of an arrangement between a physician and his substitute (i.e. partnership, master-servant, independent contractor) affects the liability of those involved.⁷¹ The determination of the legal effect of the arrangement is, therefore, a vital step in determining the liability of a substitute for failure to disclose risks of a treatment.

If the physicians are partners, or are jointly employed, both the substitute and the original physician will be liable if the original physician failed to disclose the information needed for a patient’s informed consent.⁷² This rule requires the substitute, who is a partner with the original physician, to establish that the risks of the treatment were disclosed to the patient. Under the theory that failure to inform results in a nonconsensual touching, the substitute is liable for the original physician’s failure to disclose the required information, even if the substitute later provides the patient with the information necessary for making an intelligent decision concerning consent.⁷³ The partnership arrangement, then, charges the substitute with a duty to make sure the risks of the treatment were disclosed to the patient.

Even if there were no partnership between the doctors, the substitute could still be liable for the failure of the original physician to inform the patient if the physicians were jointly employed. The general rule is that physicians employed together by the patient and diagnosing or treating the case together owe the same duty and are jointly liable for any negligence.⁷⁴

70. *Id.* at 395, 211 S.W. at 215.

71. While the proposition that liability is dependent upon the nature of the relationship will undoubtedly be established through the cases that follow, the proposition is also suggested by the court’s earlier invitation to the parties in the *Leventhal* case to explore the relation between Dr. Leventhal and Dr. Postman. Such an invitation seems useless unless the court thought the nature of the relationship had some bearing on liability.

72. While it will be seen from the pertinent cases that the reverse of this statement is true — that the original physician is liable for negligent omissions made by the substitute — this Note does not address the original physician’s liability for a substitute’s negligence. That issue is adequately addressed elsewhere. *See, e.g.*, Annotation, *Liability of One Physician or Surgeon for Malpractice of Another*, 85 A.L.R.2d 889 (1962); Annotation, *Vicarious Liability of Physicians for Negligence of Another*, 38 AM. JUR. 2d *Proof of Facts* 445 (1984). Instead, this Note is only concerned with a substitute’s duty to dispense information concerning the risks, benefits and alternatives of the prescribed treatment.

73. *Graddy v. New York Medical College*, 19 A.D.2d 426, 243 N.Y.S.2d 940 (1963); *see also supra* note 32 (suggesting liability under the battery approach even if the operation were successful). Thus, recovery would be allowed from the time the original physician should have informed his patient to the time the substitute actually did inform the patient.

74. “Where physicians actually participate together in diagnosis and treatment,

Where the physicians are jointly employed or are partners, the fact that the substitute provides the patient with the information becomes irrelevant if the original physician failed in his duty.⁷⁵ A different result occurs if the relationship is characterized as one of a master-servant. The decision in *Prooth v. Wallsh*,⁷⁶ for instance, noted that although "many participants touched the patient's body during the course of the operative procedure . . . [i]t cannot be seriously contended that each participant has a duty to inform the patient of the risks, prior to obtaining consent to the procedure."⁷⁷

That the substitute may not have a duty to disclose information if he is a servant is particularly true under the theory that the doctrine of informed consent is grounded in nonconsensual touching of the body.⁷⁸ Under that theory, liability is limited to the person touching or *directing* the touching.⁷⁹ While at first glance it may appear that mere touching is enough to establish liability, the *Prooth* decision held that touching alone should not warrant liability.⁸⁰ Since under the master-servant theory the original physician directs the touching, the argument may be made that a substitute, who is following another doctor's orders, is not liable.

The relationships previously discussed involve situations where the original physician and the substitute worked together in some capacity (i.e. partners, joint employees, or master-servant). Another possible relationship between the physician and his substitute is that of independent contractors. If the arrangement is one of independent contractors the duty, and therefore liability, is different from that of the partnership or master-servant relationship.

The general rule concerning independent contractors is that "one is not liable for the malpractice of the other, in the absence of evidence that he observed the wrongful act or omission [of the other], or in the exercise of ordinary care, should have observed it."⁸¹ Since the substitute is an independent

they may each incur a liability for the negligence of the other even though a more active part in the treatment may have been taken by one of them. . . ." *Graddy*, 19 A.D.2d at 429, 243 N.Y.S.2d at 943.

75. The substitute's actions are irrelevant in the sense that he will still be liable. See *supra* notes 72-74.

76. 105 Misc. 2d 603, 432 N.Y.S.2d 663 (N.Y. Sup. Ct. 1980).

77. *Id.* at 605, 432 N.Y.S.2d at 664-55; see also *Bell v. Umstattd*, 401 S.W.2d 306 (Tex. Civ. App. 1966). The *Bell* court stated:

Surgical operation may consist of many steps and involve many specialists. It would, indeed, be unreasonable and undesirable to place a burden of full and complete disclosure upon each and every specialist involved as to the specific methods intended to be used in an operation and all of the possible risks involved in each step of an operation.

Id. at 313.

78. See *supra* text accompanying note 31-32.

79. See *supra* text accompanying note 37.

80. *Prooth v. Wallsh*, 105 Misc. 2d 603, 432 N.Y.S.2d 663 (N.Y. Sup. Ct. 1980).

81. See, e.g., *Brooker v. Hunter*, 22 Ariz. App. 510, 515, 528 P.2d 1269, 1274 (1975); *Graddy v. New York Medical College*, 19 A.D.2d 426, 428, 243 N.Y.S.2d 940,

contractor, any new treatment prescribed by him must be accompanied with disclosure of the risks of such treatment to the patient.⁸² Consider the situation of a woman who is being treated by a substitute physician for an eye infection. If the substitute should also decide the woman needs ear surgery, it would be incumbent upon him, as an independent practitioner, to inform her of the risks of such surgery. The ear surgery is a new treatment prescribed by him and as such requires his disclosure of the risks associated with that surgery.⁸³

Having considered the legal nature of the doctrine of informed consent and the legal effects of the relationship between practicing physicians,⁸⁴ this Note now examines the *Leventhal* case to see how the New York court applied current law to the fact situation presented.

The court in *Leventhal* first declared Dr. Postman to be an independent "practitioner."⁸⁵ The court made this decision without any input from the parties involved in this relationship.⁸⁶ The only information the court had in attempting to determine the type of relationship was that Dr. Leventhal and Dr. Postman had offices in the same building and that Ms. Sangiuolo made payments directly to Dr. Postman.⁸⁷ Based upon these limited facts, the court reasonably concluded that Leventhal and Postman were independent practitioners.⁸⁸

From the facts given, finding a partnership between Leventhal and Postman would require a great deal of imagination.⁸⁹ First, the facts give no indication that the doctors shared profits.⁹⁰ Second, there is no indication that

942 (1963).

82. *Prooth v. Wallsh*, 105 Misc. 2d 603, 432 N.Y.S.2d 663 (N.Y. Sup. Ct. 1980); see also *Nisenholtz v. Mt. Sinai Hosp.*, 126 Misc. 2d 658, 483 N.Y.S.2d 568 (N.Y. Sup. Ct. 1984). The court in *Nisenholtz* noted:

[I]t is clearly not necessary that every physician or health care provider who becomes involved with a patient obtain informed consent to every medical procedure to which the patient submits. Rather, it is the responsibility of a physician to obtain informed consent to those procedures and treatments which the physician actually prescribes or performs.

Id. at 663, 483 N.Y.S.2d at 572.

83. See *supra* note 81 and accompanying text.

84. See *supra* notes 42-44 and accompanying text.

85. *Leventhal*, 132 Misc. 2d at 684, 505 N.Y.S.2d at 510.

86. The court invited the parties to explore the relationship. The parties, however, did not claim the existence of any special relationship between Dr. Postman and Dr. Leventhal. *Id.*

87. *Id.*

88. *Id.*

89. See *supra* notes 46-50 and accompanying text (discussing factors used in establishing a partnership).

90. The fact that Ms. Sangiuolo paid Dr. Leventhal while he was treating her and then paid Dr. Postman while he was substituting for Dr. Leventhal is some indication that they did not share profits. Rather, each received compensation for the work each did.

Leventhal and Postman were joint owners in the enterprise assets.⁹¹ In addition, the other factors often considered in finding a partnership were not present in the *Leventhal* case. The evidence did not show any intent to form a partnership. There did not appear to be equal voice in management as there were no common managerial duties. Finally, there was no basis for believing that Dr. Postman, acting as a substitute, had any obligation to bear any loss suffered by Dr. Leventhal.⁹² If a relationship existed between Dr. Postman and Dr. Leventhal, it was not a partnership.

The court also determined the relationship was not one of master-servant.⁹³ The court's conclusion, again, appears to be a correct analysis when one considers the factors that establish a master-servant relationship.⁹⁴ First, payments were made directly to Dr. Postman, not Dr. Leventhal.⁹⁵ Furthermore, the facts give no indication that Dr. Postman used any of Dr. Leventhal's equipment.⁹⁶ In fact, when Dr. Postman saw Ms. Sangiuolo, he saw her in *his* office and not in Dr. Leventhal's office.⁹⁷ The facts support the court's conclusion that no master-servant relationship existed.

What the New York court did find in *Leventhal* were two independent practitioners who had made arrangements that one would take care of the other's patients.⁹⁸ This finding seems proper in light of the analysis used in *Moore v. Lee*.⁹⁹ In the *Leventhal* case, the facts suggest that when Dr. Postman took the place of Dr. Leventhal, Dr. Postman alone was treating the patient.¹⁰⁰ Dr. Postman was exercising his own judgment and his own skill and was truly an independent contractor.¹⁰¹

After determining that Dr. Leventhal and Dr. Postman were independent practitioners, the court turned its attention to the duty of Dr. Postman to disclose the risks of gold therapy to Ms. Sangiuolo.¹⁰² The New York court then stated that "the rationales that have been considered to underly the informed consent doctrine mandate this court's holding that Dr. Postman, as an independent provider of medical care, had the obligation to inform Ms. Sangiuolo

91. The very fact that the doctors had separate offices in the same building might suggest an absence of joint ownership. In fact, it would appear that each doctor had ownership in a separate enterprise.

92. *Leventhal*, 132 Misc. 2d at 684, 505 N.Y.S.2d at 510.

93. *Id.*

94. These factors are discussed *supra* in notes 60-61 and accompanying text.

95. *Leventhal*, 132 Misc. 2d at 684, 505 N.Y.S.2d at 510.

96. *Id.*

97. *Id.* at 681, 505 N.Y.S.2d at 508.

98. *Id.* at 681, 505 N.Y.S.2d at 510.

99. *See supra* note 70 and accompanying text.

100. *Leventhal*, 132 Misc. 2d at 681, 505 N.Y.S.2d at 510.

101. That Dr. Postman was exercising his own judgment and skill is evidenced in part by the fact that upon hearing of the complaints of a rash, he told Ms. Sangiuolo that the gold therapy had to stop. In addition, Dr. Postman treated her with several medications and adjusted the medication without any evidence that Dr. Leventhal was advising him on how to treat Ms. Sangiuolo. *Id.* at 681, 505 N.Y.S.2d at 508.

102. *Id.* at 684, 505 N.Y.S.2d at 510.

of the risks, benefits and alternatives to the treatment that he was going to administer."¹⁰³

The *Leventhal* decision makes it clear that a substitute physician has the duty to provide a patient with enough facts necessary to form the basis of an informed consent to the treatment.¹⁰⁴ The court, however, appears to have found this duty by viewing the doctrine of informed consent through "tunnel vision" eyes.¹⁰⁵ In determining whether or not Dr. Postman could be found liable the court stated:

If, at trial, it is determined that Dr. Leventhal appropriately warned Ms. Sanguuolo of the risks of the gold therapy, Dr. Postman will be a beneficiary of that finding. If the finding is one of a lack of informed consent then . . . Dr. Postman will have relied on Dr. Leventhal's entry at his peril.¹⁰⁶

This statement by the court does not allow for extenuating circumstances such as those which would bring the limitations to the doctrine of informed consent into focus.¹⁰⁷ Nor does the statement take into account what a reasonably prudent physician would do under similar circumstances. Instead, the *Leventhal* decision makes Dr. Postman's duty to disclose absolute unless the disclosure was already given by Dr. Leventhal. If Dr. Leventhal failed to warn Ms. Sanguuolo of the risks of gold therapy, then Dr. Postman is liable.¹⁰⁸

If the purpose of the court's ruling is, indeed, to place an absolute duty upon the substitute physician, then vital principles of the informed consent doctrine are ignored. Inherent in the doctrine of informed consent is the idea that the physician must only disclose that information which the reasonable medical practitioner under similar circumstances would have disclosed.¹⁰⁹ To determine what the reasonable medical practitioner under similar circumstances would have disclosed requires medical testimony.¹¹⁰ Yet, the *Leventhal*

103. *Id.*

104. *Id.*

105. *See supra* note 35. While the court does not use the word "absolute," the effect is the same. *See infra* notes 106-07 and accompanying text.

106. *Leventhal*, 132 Misc. 2d at 684-85, 505 N.Y.S.2d at 510.

107. *See supra* notes 34-41 and accompanying text.

108. *Leventhal*, 132 Misc. 2d at 684-85, 505 N.Y.S.2d at 510.

109. *See supra* notes 27-30 and accompanying text. The New York court in *Leventhal* should have been aware that the standard is what the reasonable medical practitioner under similar circumstances would have disclosed. This is stated in N.Y. PUB. HEALTH LAW § 2805-d(1) (McKinney 1985) which the court cites in its opinion. *Leventhal*, 132 Misc. 2d at 683, 505 N.Y.S.2d at 509.

110. The court in *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965), stated: Without the aid of expert medical testimony in this case a jury could not, without resorting to conjecture and surmise or by setting up an arbitrary standard of their own, determine that defendants failed to exercise their skill and use the care exercised by the ordinary skillful, careful and prudent physician acting under the same or similar circumstances.

Id. at 674 (quoting *Fisher v. Wilkinson*, 382 S.W.2d 627, 632 (Mo. 1964)); *see also* *Karp v. Cooley*, 493 F.2d 408 (5th Cir. 1974); *Warner v. New York Cent. Ry.*, 23 A.D.2d 642, 256 N.Y.S.2d 969 (1965); *Johnson v. Whitehurst*, 652 S.W.2d 441 (Tex.

decision seems to hold the substitute liable regardless of what the medical testimony might provide.¹¹¹ That the *Leventhal* decision appears to hold the substitute liable despite any evidence of medical testimony stating otherwise is evidenced by the court's treatment of Dr. Postman's argument that he was entitled to rely on the notation made in Dr. Leventhal's charts which stated that Ms. Sanguolo had been informed of the risks of gold therapy.¹¹²

The court first dismissed Dr. Postman's argument by stating that a right to rely does not matter if there is no duty to inform.¹¹³ The court's comment makes little sense in light of its having already found that Dr. Postman had a duty to inform.¹¹⁴ The court then claimed that if Dr. Postman relied on the notation in Dr. Leventhal's records he did so at his own peril.¹¹⁵ The court provided no authority for its conclusion. The court did not say why Dr. Postman was not entitled to rely; it simply concluded he was not so entitled.¹¹⁶ This conclusion ignores the importance of medical testimony since the question really should be whether the reasonable medical practitioner would rely on a note made in another physician's records that informed consent had been given.

To answer this question, one need search no further than the Federal Rules of Evidence.¹¹⁷ The advisory comments to the Federal Rules of Evidence indicate that doctors rely upon others' charts—even to the extent of making life-and-death decisions.¹¹⁸ Case law also recognizes that physicians frequently rely upon medical notations made by others.¹¹⁹ In *Huffman v. Lindquist*,¹²⁰ a doctor had interns and nurses make reports which he then relied upon to decide treatment. The court held that "[t]here was no showing that defendant

Ct. App. 1983); *Ze Barth v. Swedish Hosp.*, 81 Wash. 2d 12, 499 P.2d 1 (1972).

111. See *supra* notes 104-08 and accompanying text.

112. *Leventhal*, 132 Misc. 2d at 682, 684-85, 505 N.Y.S.2d at 508, 510.

113. *Id.* at 684, 505 N.Y.S.2d at 510.

114. *Id.*

115. *Id.*

116. *Id.*

117. New York follows Federal Rule of Evidence 703. See *People v. Sugden*, 35 N.Y.2d 453, 363 N.Y.S.2d 923 (1974).

118. The exact wording of the comment to Rule 703 is: "[A] physician in his own practice bases his diagnosis on information from numerous sources and of considerable variety, including statements by patients and relatives, reports and opinions from nurses, technicians and other doctors, hospital records, and X rays. . . . The physician makes life-and-death decisions in reliance upon them." FED. R. EVID. 703 advisory comments.

119. See, e.g., *Karp v. Cooley*, 493 F.2d 408 (5th Cir. 1974) (team members of surgical unit are entitled to rely on consent obtained by doctors in charge of operation); *Brooker v. Hunter*, 22 Ariz. App. 510, 528 P.2d 1269 (1975) (court found absolute right to rely on doctor's opinion that patient was fair risk for surgery); *In re G.S.*, 698 P.2d 406 (Mont. 1985) (reliance upon a psychiatrist's report); *Donavant v. Hodspeth*, 318 N.C. 1, 347 S.E.2d 797 (1986) (reliance upon a catheterization report); *Borden v. Brady*, 92 A.D.2d 983, 461 N.Y.S.2d 497 (1983) (Yesawich, J., concurring) (reliance upon a neurologist's report).

120. 37 Cal. 2d 465, 234 P.2d 34 (1951) (en banc).

doctor's reliance on these charts was inconsistent with standard medical practice. . . ."¹²¹

Applying the above analysis to the *Leventhal* decision, Dr. Postman could only be found liable if his reliance on Dr. Leventhal's charts was inconsistent with standard medical practice. No evidence suggests Dr. Postman acted unreasonably when he relied on the information contained in the medical records. Nevertheless, the New York court would find Dr. Postman liable regardless of the standard medical practice.¹²²

The desirability of considering the standard medical practice of relying on another physician's notes is just one of the reasons not to impose an absolute duty of disclosure on a substitute. Other reasons have their foundations in the exceptions to the doctrine of informed consent.¹²³ These exceptions were not discussed in the *Leventhal* case—probably because they were not raised.¹²⁴ Still, the exceptions provide important considerations to those jurisdictions which may follow the *Leventhal* lead.

One exception to the doctrine of informed consent is the doctrine's limitation to surgical operations.¹²⁵ This exception suggests that if the treatment is not a surgical operation—for instance, if the treatment is purely therapeutic in nature—then no duty for informed consent would exist.¹²⁶ On its face, this exception would seem to apply to the facts in *Leventhal*. The treatment in *Leventhal* was gold therapy rather than a surgical operation.¹²⁷ Under the cases cited in *Leventhal*, however, this exception would not relieve a substitute of his duty to inform inasmuch as a prior case had held that there was a duty to disclose the risks of gold therapy.¹²⁸ This exception, while not applicable in

121. *Id.* at 479, 234 P.2d at 43.

122. *See supra* notes 105-08 and accompanying text. If Dr. Postman knew that Dr. Leventhal had, upon previous occasions, failed to disclose risks of a treatment to a patient, Dr. Postman could then be liable. This is true without regard to what was written in Dr. Leventhal's notes. *See Fiorentino v. Wenger*, 19 N.Y.2d 407, 227 N.E.2d 296 (1967). In *Fiorentino*, the court refused to find a hospital liable for the failure of an independently retained healer to provide pertinent information concerning treatment unless the hospital had reason to know the malpractice would take place. *Id.* at 415, 227 N.E.2d at 299. The *Fiorentino* court stated, "Nor would it be fair to impose such an unprecedented liability on a hospital in the absence of facts bringing home to the hospital . . . that in previous instances the surgeon had failed to obtain informed consent." *Id.* at 417, 227 N.E.2d at 301.

123. *See supra* notes 35-41 and accompanying text.

124. Dr. Postman only raised two issues in his motion for summary judgment. First, he claimed he was entitled to rely on Dr. Leventhal's records. Second, he argued that vacationing doctors would find it more difficult to secure substitutes. *Leventhal*, 132 Misc. 2d at 684, 505 N.Y.S.2d at 509-10. The *Leventhal* case gives no indication that Dr. Postman raised any other issues than those mentioned above.

125. *See supra* note 41 and accompanying text.

126. *Id.*

127. *Leventhal*, 132 Misc. 2d at 681, 505 N.Y.S.2d at 508.

128. *See DiRosse v. Wein*, 24 A.D.2d 510, 261 N.Y.S.2d 623 (1965).

New York,¹²⁹ may still apply in those jurisdictions which limit the doctrine of informed consent to surgical operations.

One exception which does seem applicable is that of the "therapeutic privilege."¹³⁰ The "therapeutic privilege" allows the physician to withhold information if disclosure would be harmful to the patient.¹³¹ The privilege is applicable to all physicians in cases where appropriate circumstances mandate withholding the information, such as where the patient is mentally disturbed or is abnormally apprehensive.¹³² The therapeutic exception might be particularly applicable in the situation where the substitute is continuing a treatment. In these cases, the substitute would probably disclose information which had already been disclosed by the original physician, thereby increasing the chance of frightening the patient.¹³³

Under the therapeutic exception there is no duty to inform if the patient becomes overly frightened to the point that disclosure is harmful.¹³⁴ "The doctrine of informed consent does not require the doctor to risk frightening the patient out of a course of treatment which sound medical judgment dictates the patient should undertake."¹³⁵ By implying that the substitute's duty to disclose is absolute, the *Leventhal* decision ignores the principle that there is no duty to disclose if such disclosure would frighten the patient to the point that he forecloses rational decision making.

Not only is a physician protected if he fails to provide facts of a treatment when knowledge of such facts may be harmful to the patient, the physician may actually be liable for damages if he discloses those harmful facts. That a physician may be liable for informing a patient of medical risks is evidenced by the case of *Ferrara v. Galluchio*.¹³⁶ In *Ferrara*, the court affirmed a judgment which included \$15,000 for anguish incurred by the plaintiff when a

129. *Id.*

130. *See supra* notes 40-41 and accompanying text.

131. Meisel, *supra* note 22, at 460.

132. *Id.* at 462.

133. After the *Leventhal* decision, the substitute, in order to protect himself against liability, would have to disclose the risks of the treatment regardless of the original physician's actions. Thus, under situations where the substitute merely continues the treatment, he informs the patient of risks the patient has probably been made aware of. This overdose of disclosure may frighten the patient to the point that he forecloses a rational decision. *See, e.g., Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972). "[I]t is recognized that patients occasionally become so ill or emotionally distraught on disclosure so as to foreclose a rational decision." *Id.* at 779.

134. Meisel, *supra* note 22, at 460.

135. *Ze Barth v. Swedish Hosp.*, 81 Wash. 2d 12, 25-26, 499 P.2d 1, 9-10 (1972); *see also Watson v. Clutts*, 262 N.C. 153, 136 S.E.2d 617 (1964). In *Watson*, the plaintiff had been advised of the risks of the operation by her family physician. The court found that the surgeon did not need to provide more information, stating that "to send a patient to the operating room nervous from fright is not often desirable." *Id.* at 159, 136 S.E.2d at 621.

136. 5 N.Y.2d 16, 152 N.E.2d 249 (1958).

second physician informed the patient that skin lesions, resulting from a first physician's malpractice, could become cancerous.¹³⁷ Under *Ferrara*, a substitute physician could actually become liable for any additional disclosure by him which frightened the patient.

Two other situations exist where the therapeutic privilege might effect the substitute's liability. The first one of these is where the original physician decides not to disclose under the therapeutic privilege.¹³⁸ While no case law exists on the subject, reason would suggest that if an original physician is entitled to rely upon the therapeutic privilege, a substitute would also be entitled to rely on the privilege. Under a strict reading of the *Leventhal* decision, however, a substitute would be liable even if the disclosure of information would frighten the patient.¹³⁹ Holding a substitute liable under this situation would produce the strange result that the original physician who started the treatment would be free from liability while his substitute would bear total responsibility should the patient become frightened.

The other situation where the therapeutic privilege is applicable to a substitute's liability occurs when the original physician actually discloses the risks of the treatment and the patient becomes extremely upset.¹⁴⁰ No better scenario exists for application of the therapeutic privilege. Yet, if the *Leventhal* decision stands for the proposition that a substitute has an absolute duty to disclose, then the substitute would be liable.¹⁴¹

The last issue the *Leventhal* court addressed in its opinion concerned Dr. Postman's argument that "the imposition of liability on a substituting doctor will make it more difficult for physicians to find others to cover for them. . . ."¹⁴² The court viewed this argument as unrealistic for two reasons. First, the court said that most substitute situations involve handling new problems. Second, the court stated that the burden of advising of the risks of a continued course of treatment is minimal.¹⁴³ Even though the court asserted that most substitute situations involve handling new problems, the court provided no authority for this conclusion. Still, the court claimed that where there are new problems the physician's duty to inform is unaffected.¹⁴⁴

The court's analysis is consistent with the doctrine of informed consent and independent practitioners.¹⁴⁵ The general rule is that where an indepen-

137. *Id.*

138. *See, e.g., Nishi v. Hartwell*, 52 Haw. 188, 473 P.2d 116 (1970).

139. *See supra* text immediately following note 135.

140. No case law yet exists addressing the situation in which a patient becomes upset upon disclosure and a substitute must decide whether to provide further disclosure. Nevertheless, the scenario should be addressed because of the possibility that the situation could occur.

141. *See supra* text immediately following note 135.

142. *Leventhal*, 132 Misc. 2d at 685, 505 N.Y.S.2d at 510.

143. *Id.*

144. *Id.*

145. *See supra* note 82 and accompanying text.

dent practitioner begins a new treatment the practitioner providing that treatment has a duty to disclose the risks of that treatment.¹⁴⁶ No reason exists for applying a different rule for substitutes who begin a treatment different from that which was started by the original physician. If the original physician is not starting the treatment, he should not be required to provide the disclosure.¹⁴⁷ If the patient is to be informed, that information must come from the substitute.

Where, however, a treatment is merely being continued by the covering physician, perhaps a different rule should be applied.¹⁴⁸ The court suggests that no different rule should apply and the substitute still have a duty to disclose even though he is merely continuing the treatment originated by another physician.¹⁴⁹ The court's reasoning is that the burden of this further advisement is minimal.¹⁵⁰ The court's reasoning may not withstand careful scrutiny when viewed with other considerations.

First, the burden of the substitute may be increased if he may no longer rely on notations made by the original physician.¹⁵¹ While the *Leventhal* decision applies only to reliance on matters pertaining to disclosures, the court might also apply the same reasoning to such matters as a patient's history or prior health. Case law often develops when a particular holding of a court is expanded by that court or other courts. Thus, what might begin as a holding that physicians are not entitled to rely upon a doctor's medical records in matters pertaining to informed consent may develop as support for the proposition that a physician is not entitled to rely upon any information contained in the records of another physician.

The medical community must, of necessity, be able to rely on medical records of other providers of health care to ensure the continuing care of patients.¹⁵² A patient's health often depends on quick decisions, and rely on medical records to make these decisions.¹⁵³ A patient's health, or even life, could be jeopardized if a physician had to take the time to discover for himself everything already contained in the medical records of another physician.¹⁵⁴ The

146. *Id.*

147. *See Prooth v. Walsh*, 105 Misc. 2d 603, 432 N.Y.S.2d 663 (N.Y. Sup. Ct. 1980).

148. *See infra* text following note 165 (discussing the possibility of holding the substitute harmless when he is merely continuing a treatment initiated by the original physician).

149. *Leventhal*, 132 Misc. 2d at 685, 505 N.Y.S.2d at 510.

150. *Id.*

151. *See supra* notes 113-22 and accompanying text.

152. *In re Jascalevich License Revocation*, 182 N.J. Super. Ct. App. Div. 455, 471, 442 A.2d 635, 643-44 (1981).

153. *See supra* notes 117-21 and accompanying text.

154. The harm to the patient which stems from the substitute's inability to rely on the medical records of another physician is generally worse than the risk that medical records will contain inaccurate information. Incentives exist for the original physician to be completely accurate in making an entry into his records. The incentives

substitute could again be faced with liability. The fact that the substitute would be unable to rely on another doctor's records is, indeed, a burden that is more than minimal.

A second reason why substitutes might become harder to find if liability is imposed on them for failing to disclose risks of a continuing treatment is based on the liability they incur if they frighten the patient.¹⁵⁵ While the chance of frightening a patient exists even where there is no substitute,¹⁵⁶ the chance would increase where there is a substitute continuing the treatment started by another physician.¹⁵⁷ Some physicians might find this enlarged liability too much of a risk.¹⁵⁸ Despite the *Leventhal* court's assertion, the burden on the substitute might be more than minimal.¹⁵⁹

Until the Supreme Court of New York County handed down its decision in *Leventhal*, there was no ruling concerning a substitute's duty to provide disclosure.¹⁶⁰ The *Leventhal* decision clearly established that a substitute, acting as an independent practitioner, has a duty to disclose information pertinent to the treatment.¹⁶¹ When taken in conjunction with the various legal relation-

include the realization that an incorrect entry could result in serious harm to the patient. In addition, a doctor exposes himself to tort liability if he is not accurate in his entries. See Note, *Admissibility of Hospital Records into Evidence*, 21 MD. L. REV. 22, 27 (1967).

155. See *supra* notes 136-41 and accompanying text.

156. An overly anxious or easily frightened person who hears, even for the first time, the risks of the treatment, could suffer mental anguish or no longer be able to think rationally about proceeding with the treatment.

157. Under *Leventhal* the substitute can no longer rely on the original physician's notes. Because of this, the substitute would have to provide every disclosure necessary. If the doctor has already provided the patient with the risks, this second dosage of disclosure logically increases the chance of frightening the patient.

158. See *Graddy v. New York Medical College*, 19 A.D.2d 426, 243 N.Y.S.2d 940 (1963). "The implication of such an enlarged liability would tend to discourage a physician from arranging to have another care for his patients on his illness or absence and thus curtail the availability of medical service." *Id.* at 430, 243 N.Y.S.2d at 944-45.

While this particular statement was in the context of holding the original physician liable for the misdeeds of the substitute, it seems equally applicable in the converse of that situation. If a substitute cannot rely on the original physician's notations, and, if the substitute is going to be held liable even though he is merely continuing the treatment of an original physician, it is reasonable to believe that physicians would be less willing to act as substitutes. This rationale, of course, would not apply to the substitute who begins, rather than continues, the treatment. Where the second physician starts the treatment, he has a duty to disclose the relevant facts. See *supra* note 82 and accompanying text.

159. The extent of the burden placed upon substitute physicians is directly related to the availability of those physicians. "[T]he medical profession insists that a crisis exists . . . [and] that doctors will give up their practice, or not treat certain at-risk patients unless something is done to solve their dilemma." *Another Medical Malpractice Crisis*, N.J. LAW. J., August 15, 1985, at 4, col. 1.

160. See *supra* note 5.

161. *Leventhal*, 132 Misc. 2d at 684, 505 N.Y.S.2d at 510.

ships that physicians may enter into, the *Leventhal* decision provides a framework for establishing the duty of a substitute in areas other than the independent contractor.¹⁶²

A substitute's duty may now be as follows. If the relationship between the physicians is a partnership, or joint employees, the substitute will be liable if the original physician fails to disclose the risks. The substitute is liable even if he informs the patient of the risks because partners, and those jointly employed, are liable for each others' acts.¹⁶³ If the relationship is one of master-servant, the substitute may not have a duty to disclose as he is only doing what someone else directs him to do.¹⁶⁴ If the relationship is one of independent practitioners, the substitute has a duty to inform, and, if he relies on the original physician's notes, he does so at his own risk.¹⁶⁵

While the above classifications appear to be the law after *Leventhal*, a strong case can be made for adding a fourth classification. This category would be made up from a division of the current *Leventhal* decision.

As it stands now, the *Leventhal* case does not make a distinction between the substitute physician who starts a new treatment and the substitute physician who only continues a treatment started by another physician. The distinction would not matter where the physicians are jointly employed or are partners. Physicians within the parameters of these categories are jointly liable. Nor would it matter where a master-servant relationship is established because the substitute is only doing what the original physician directs him to do. The distinction, however, is important in the situation involving independent practitioners.

Imposing a duty to inform upon a substitute who starts a new treatment, yet not imposing that same duty upon the substitute who only continues a treatment, is consistent with the doctrine of informed consent. It allows the substitute who continues the treatment to rely on the original physician's records, while insuring that the substitute who initiates the treatment provides the requisite disclosure. Imposing a duty only upon the substitute who initiates the treatment also decreases the likelihood that substitutes will be liable for frightening the patient. This will have the added benefit of protecting the availability of substitutes—protection essential for the assurance of medical care.

GREGGORY DEAN GROVES

162. See *supra* note 71.

163. See *supra* notes 72-74.

164. See *supra* notes 76-79 and accompanying text.

165. *Leventhal*, 132 Misc. 2d at 684-85, 505 N.Y.S.2d at 510.