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INFORMED CONSENT LIABILITY IN A "MATERIAL INFORMATION" JURISDICTION: WHAT DOES THE FUTURE PORTEND?

WILLIAM J. MCNICHOLS*

I. Introduction

In 1979, in Scott v. Bradford,1 the Oklahoma Supreme Court for the first time recognized a negligence cause of action against a health care provider based upon lack of informed consent. The Scott case became a landmark decision nationally.2 This was partly because the court rejected professional medical practice as the standard for determining what a physician must disclose to her patient. Instead, the court adopted a liberal material information standard, determined by focusing on what a patient needs to know to make an informed decision about his medical care.3 The main reason for the Scott opinion's national noteworthiness, however, was its adoption of a subjective standard for determining causation.4 This was contrary to the near unanimous judicial agreement that the informed consent causation issue should be

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1. 606 P.2d 554 (Okla. 1979).

2. The Scott opinion has also achieved noteworthy status in academic circles. For example, it is a principal case in the current edition of the Prosser torts casebook. JOHN W. WADE, ET AL., PROSSER, WADE AND SCHWARTZ'S CASES AND MATERIALS ON TORTS, (9th ed. 1994). A number of jurisdictions have cited Scott with varying degrees of approval. See Bloskas v. Murry, 618 P.2d 719, 722 (Colo. 1982) (calling Scott a "significant case" in the informed consent area); Bernard v. Char, 903 P.2d 667, 671 (Haw. 1995) (deeming Scott the best representation of the subjective causation standard, while itself opting for an objective approach); Sherwood v. Carter, 805 P.2d 452, 463 (Idaho 1991) (following Oklahoma's subjective causation standard); Areana v. Gingrich, 733 P.2d 75, 79 (Or. Ct. App. 1987) (adopting Scott's subjective causation test, but allowing evidence of what a "reasonable patient" would have done for purposes of evaluating the plaintiff's credibility); Reikes v. Martin, 471 So. 2d 385, 392-93 (Miss. 1985) (declining to follow Oklahoma's subjective causation standard); Skripek v. Bergamo, 491 A.2d 1336, 1346 (N.J. Super. Ct. App. Div. 1985) (declining to follow a subjective causation standard); Bussell v. Libi, 340 N.W.2d 36, 40-41 (N.D. 1983) (citing Scott with approval with respect to subjective causation issue as to plaintiff's admission that plaintiff would have undergone treatment but retaining decision on which standard, subjective or objective, to adopt in the case of a plaintiff's testimony that he or she would have refused the proposed treatment if aware of the risks); Hook v. Rothstein, 316 S.E.2d 690, 698 (S.C. Ct. App.) (rejecting the patient-oriented standard of disclosure adopted in Scott), writ denied, 320 S.E.2d 35 (S.C. 1984).


4. Id. at 559.
determined by the objective standard of what a reasonable patient would have decided if properly informed.\textsuperscript{5}

Following the \textit{Scott} decision, the Oklahoma Supreme Court gave indications that the scope of the doctrine was as broad as the \textit{Scott} opinion implied.\textsuperscript{6} This article will:

1. examine the Oklahoma doctrine;
2. analyze the informed consent national trends, placing Oklahoma's doctrine in context; and
3. discuss some complexities in informed consent doctrine generally, especially those arising in jurisdictions with a liberal "material information" disclosure standard.\textsuperscript{7}

\textbf{II. Historical Development of the Informed Consent Doctrine: the Move From Battery to Negligence in Inadequate Disclosure Cases}

The paradigmatic fact situation which triggers a modern informed consent case is this: a physician has obtained her patient's consent to some medical intervention which has resulted in injury to the patient; the patient says her physician provided inadequate information for her to make a well-informed decision about her treatment; and the patient seeks damages for the harm caused by the procedure, saying that she would

\textsuperscript{5} See infra note 105 and accompanying text.
not have been injured by the treatment because she would have refused it if adequate information had been provided.

Thus, most informed consent cases involve situations where the patient claims that she was inadequately informed about the risks connected with treatment recommended by her physician, which would constitute a medical battery had she not consented. However, today, most courts have extended the doctrine to include situations where plaintiff claims that her physician inadequately informed her about the alternatives to the recommended treatment, as opposed to the treatment itself. Many courts say that patients should also be informed about the option of nontreatment and its risks. On that basis, at least one court has found liability in a case of "informed refusal" where the patient refused the recommended procedure but said she would have chosen it if adequately informed about the risk of nontreatment. At the boundary of the theory, a few courts have recognized liability where the information which plaintiff claims was wrongfully withheld was not about the risks or benefits of the treatment or its alternatives, but was collateral information that would have persuaded her not to agree to the medical intervention which injured her. Partly in response to a perceived

10. See, e.g., Scott v. Bradford, 606 P.2d at 555 (Syllabus 1).
11. See Truman v. Thomas, 611 P.2d 902 (Cal. 1980) (error not to instruct that physician could be liable for death of patient who was not informed of the potentially fatal cancer risk of failing to have an indicated "pap smear" diagnostic test.)
12. See, e.g., Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990) (physician of leukemia patient in physician's experimental research project stated informed consent cause of action for physician's failure to disclose a potential conflict of interest arising from physician's unconsented use of patient's unique cells to develop and patent a genetic cell line for commercial purposes); Hidding v. Williams, 578 So. 2d 1192 (La. Ct. App. 1991) (affirmed informed consent liability of physician for failing to disclose to surgery patient that he was an alcoholic); Faya v. Almaraz, 620 A.2d 327 (Md. 1991) (surgery patients stated informed consent cause of action for anxiety they suffered while being tested for AIDS when surgery failed to inform them that he was HIV positive); Estate of Behringer v. Medical Ctr. of Princeton, 592 A.2d 1251 (N.J. Super. Ct. Law Div. 1991) (hospital did not violate the confidentiality of a staff surgeon who tested positive for HIV at the hospital by requiring the surgeon to inform his patients that he was HIV positive in obtaining their informed consent for surgery); Johnson v. Kokemoor, 545 N.W. 2d 495 (Wis. 1995) (trial court properly held that, under a statutory informed consent duty to inform patient of alternative treatments and their risks, evidence was admissible as to the treating surgeon's inexperience with the particular procedure recommended, the statistical evidence concerning morbidity and mortality when the procedure was performed by physicians of limited experience like defendant, as opposed to masters in the field, and evidence of the alternative possibility of having the surgery performed by a more experienced surgeon at a better-equipped facility). But see Arato v Avedon, 858 P. 2d 598 (Cal. 1993) (rejecting plaintiff's contention that "material information" extended to information about statistical information about the life expectancy of plaintiff's type of pancreatic cancer so that plaintiff could properly decide about a proposed course of chemotherapy and could properly attend to placing his business affairs in order). See generally Twerski & Cohen, New Era, supra note 7 (predicting that courts will expand informed consent doctrine to include information about provider specific risk information, such as lack of experience and the like); Daar, Informed Consent, supra note 7 (discussing Faya and Arato as both being harbingers of extension future extensions of the concept of "material information" to information that might influence a patient's decision to accept
judicial liberal expansion of the doctrine, many jurisdictions have passed statutes covering the scope of permissible informed consent liability in their states.\textsuperscript{13}

Most informed consent cases involve surgical procedures, usually where the patient has been injured because of a foreseeable inherent complication of the surgery.\textsuperscript{14} An increasing number of courts have applied the doctrine to diagnostic tests and procedures which went awry.\textsuperscript{15} At the boundaries, a few courts have applied the doctrine to more routine procedures such as prescription of medication,\textsuperscript{16} blood tests,\textsuperscript{17} and the like.

A. The Pre-1970s Period

Beginning in the late 1950s, the first cases began to appear in which the courts allowed patients to recover tort damages when physicians wrongfully failed to disclose information about the risks involved in a proposed course of medical treatment.\textsuperscript{18} The theory, however, was battery. Such courts viewed consent to treatment obtained without adequate risk disclosure as legally ineffective consent.\textsuperscript{19} They viewed risk nondisclosure situations as analogous to and an extension of those battery cases where consent was fraudulently obtained.\textsuperscript{20} Allowing a patient to recover under a battery theory, rather than under a negligent malpractice theory, had several important advan-


\textsuperscript{14} See, e.g., Scott v. Bradford, 606 P.2d 554 (Okla. 1979) (leak from bladder caused during hysterectomy); see Shultz, supra note 7, § 1.3, at 9-10. Schultz usefully describes the pre-1990s expansion of informed consent as being one from situations that would be tort batteries if there were no consent to the procedure involving touchings of the body to situations where the physician intervened with professional conduct that would not constitute battery if there were no consent. The uninformed refusal of diagnostic testing is an example. See, e.g., Truman v. Thomas, 621 P.2d 902 (Cal. 1980). She argues that this implies that the "interest" being protected by the doctrine thus changes from deciding about bodily touchings (the battery model) to deciding about medical services and other aspects of the physician's activities within the doctor-patient relationship.


\textsuperscript{16} E.g., Niemiera v. Schneider, 555 A.2d 1112 (N.J. 1989) (applying "prudent person" standard as disclosure duty); see Gerald F. Tietz, Informed Consent in the Prescription Drug Context: The Special Case, 61 WASH. L. REV. 367 (1986) (advocating that a subjective standard disclosure duty is particularly appropriate for determining the adequacy of informed consent for prescription drugs).


\textsuperscript{18} See, e.g., Chambers v. Nottebaum, 56 So. 2d 716 (Fla. Ct. App. 1957).

\textsuperscript{19} Id. at 674.

\textsuperscript{20} See, e.g., DeMay v. Roberts, 9 N.W. 146 (Mich. 1881). In DeMay, a woman who consented to the presence of, and touching of her body by, a physician's assistant while she was in labor stated cause of action for damages. Her consent was legally ineffective because the physician, in obtaining her consent, intended to deceive her into thinking his lay assistant was a licensed medical person.
tages. First, and most importantly, battery did not require the patient to prove by an expert medical witness that the defendant had deviated from an accepted medical standard of care. Second, battery did not require the patient to prove that he would have refused the treatment if he had been given the proper information. Third, battery would entitle the patient to recover damages even if the operation did not have a "bad result." Fourth, as an intentional tort, battery might have entitled the patient to an instruction on punitive damages, which would not be available in an action based upon negligence.  

In the early 1960s, almost immediately after they exposed physicians to liability for inadequate risk disclosure, the courts made an abrupt doctrinal about face. They sensed that the battery theory would subject the medical profession to widespread and unwarranted liability. The courts began to say that the "inadequate disclosure" cases were really just another form of negligent malpractice (by analogy to negligent failure to warn cases). Hence, they should be subject to all the physician-protective doctrines of negligent malpractice, including the expert witness and professional standard of care rules.

Vindicating patient autonomy is at the heart of all inadequate consent cases, whether the theory is based on battery or negligence. Strong judicial respect for the fundamental ethical value of autonomy has been consistently voiced by the courts. The leading example is Justice Cardozo's stirring call in 1914 that "every adult of sound mind has the right to determine what shall be done with his own body."  

However, the medical profession has been very slow to make the patient a partner in decision making as this judicial exhortation would require. The long medical tradition of keeping one's patient in the dark about the risks of surgery and other medical interventions was bolstered by the medical ethics of the Hippocratic tradition. The ethical value of respect for autonomy has always been in significant tension with the competing ethical value of beneficence — doing what is in the patient's best interests. The Hippocratic Oath's admonition, "Above All Do No Harm," is an exhortation to the physician always to act in his patient's best interests, not his own or that of others. This translates easily into doing always what is medically best for his patient. It is a short slide from acceptance of this obligation (to act in the patient's best interests) to acceptance of the idea that it is the physician who best knows what is medically best for the patient. This tradition of medical paternalism

21. See generally PROSSER & KEETON, TORTS supra note 7, § 2, at 10.
25. Katz, Fairy Tale, supra note 7, at 73 (quoting the Hippocratic Oath ("I swear by Apollo and Aesculapius that I will follow that system of regimen which according to my ability and judgment I consider for the benefit of my patients.").
continues to be at odds with the tort law's attempts to vindicate patient autonomy. That tension is reflected in the way courts have attempted to use a negligence informed consent doctrine to balance legitimate patient autonomy expectations with legitimate practitioner expectations of independence in medical judgment.

B. The Post 1970s Period

The 1970s witnessed a significant expansion of the informed consent doctrine. The key issue was whether a professional standard of care should limit the physician's duty to disclose information to her patient. The landmark case was *Canterbury v. Spence* in 1972. In a highly influential opinion which was to become the cornerstone of Oklahoma's doctrine, Judge Spottwood Robinson persuasively argued that the question of whether a patient should be told about the risks of his treatment and its alternatives was not really a medical question, but one which lay persons could and should determine if the important value of patient autonomy was to be given proper protection in the face of the long tradition of medical paternalism. The *Canterbury* court rejected the professional standard and adopted a patient-oriented standard measured by what is a "reasonable disclosure" under the circumstances.

Today, the courts are split on the issue. Many courts retain the professional standard. In several states, statutes prescribe the professional standard to curb judicial expansion of the doctrine. An almost equal number of states reject the professional standard of disclosure. Most use an objective layperson-oriented


27. Cf. 1 President's Comm'n, Making Health Care Decisions, A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship 36 (1982) ("Both positions [(medical paternalism and patient sovereignty)] attempt to vest exclusive moral agency, ethical wisdom, and decision-making authority on one side of the relationship, while assigning the other side a dependent role. . . . [N]either extreme adequately reflects the current nature and needs of health care.").


29. *Canterbury*, 464 F. 2d at 785.


32. See infra notes 33-35. A few legislatures have also rejected the professional standard in favor of one determined by the informational need of patients. See, e.g., PA. STAT. ANN. tit. 40, § 1301.103 (Purdon Supp. 1985); REV. CODE WASH. § 7.770.050 (2) (Supp. 1985). Oregon has codified a "laundry list" of statutorily mandated disclosures, see OR. REV. STAT. § 677.097 (1977), but it is unclear under what standard compliance with these requirements is evaluated. The statute clearly rejects professional medical standards by itself mandating specific disclosures.
standard, measured by what a "reasonable patient" would want to know, as opposed to what a reasonable physician would disclose. A few opt for a subjective standard which asks what the particular patient would want to know. Recently, there have been attempts to articulate a compromise position which combines both the subjective and the objective approaches in order to take into account a patient's individual idiosyncrasies. California has adopted a hybrid-type variation. A layperson-oriented material information standard applies to disclosures about known risks of death or serious bodily harm inherent in the procedure. The professional standard applies to determine what other information a physician might have to disclose to meet the legal requirements of informed consent. A different type of compromise position is a rule which holds that a lay person standard applies to proof of the prima facie case, but recognizes a complete defense of conformity to a professional medical standard of care.

III. The Oklahoma Informed Consent Doctrine

A. Scott v. Bradford

Norma Jo Scott experienced urinary incontinence following a hysterectomy procedure. The complication proved to be a tear in her vaginal wall (vesicovaginal fistula) which caused urine to leak from her bladder into her vagina. Three additional operations corrected the problem. She brought suit against the surgeon who performed the hysterectomy, alleging that he failed to advise her of: (1) the risks connected with


34. See cases cited supra note 30.

35. See, e.g., Scott v. Bradford, 606 P.2d 554 (Okla. 1979). See discussion infra at notes 57-62, 64 (suggesting that some commentators favor a subjective standard, but noting general rejection of it by courts and legislatures).

36. One state in effect arrives at a subjective standard by building the plaintiff's idiosyncrasies into the profile of the reasonable person. Fain v. Smith 479 So. 2d 1150, 1155 (Ala. 1985) (causation standard considers what "a reasonable person with all the characteristics of plaintiff including, [his] idiosyncrasies and religious beliefs, would have done under the same circumstances").

37. Cobbs v. Grant, 502 P.2d 1, 11 (Cal. 1972) (a physician must disclose "such additional information as skilled practitioner of good standing would provide under the circumstances"). The Cobbs standard was reaffirmed in Arato v. Avedon, 858 P.2d 598, 603 (Cal. 1993).

38. An intermediate court of appeals in Colorado adopted this approach. See Blades v. DaFoe, 666 P.2d 1126 (Colo. Ct. App. 1983), rev'd on other grounds, 704 P.2d 317 (Colo. 1985). Under this Colorado view, a plaintiff makes out a prima facie case by proving that the defendant failed to disclose material information, judged by a standard measured by what a patient needs to know. However, physicians have a complete defense if they can show that their nondisclosure conformed to medical standards of practice. In practical effect, this scheme amounts to making professional practice the standard but places the burden of proof on the physician to justify his conduct under that standard.
the hysterectomy and (2) the available alternatives to surgery.39 Plaintiff appealed from a jury verdict for defendant, alleging that the instructions given by the trial court on her informed consent cause of action were inadequate.

Saying that it had not previously "officially adopted" an informed consent doctrine,40 the court did so, recognizing it as a form of professional negligence. However, the court affirmed the defendant's verdict rendered below, holding that the instructions given had adequately covered the required elements of the new cause of action.41

I. Rejection of the Professional Standard — The Disclosure Duty

The court first strongly rejected the prevailing professional standard of care under which "a physician needed only to inform a patient in conformance with the prevailing medical practice . . . ."42 The court said that "to bind disclosure obligations to

40. Id. at 557. Prior to Scott there was confusion as to whether the informed consent doctrine was already the law in Oklahoma because the court seemed to give approval to the concept in Martin v. Stratton, 515 P.2d 1366 (Okla. 1973). See also Karriman v. Orthopedic Clinic, 516 P.2d 534 (Okla. 1973). The federal courts thought so and applied the doctrine. See Haley v. United States, 739 F.2d 1502, 1506 (10th Cir. 1984) ("[T]he Oklahoma Supreme Court recognized the doctrine of informed consent in Martin, but left to a future case the choice between the two rules of informed consent [(professional versus lay standard for duty to disclose)] . . . ."); Lambert v. Park, 597 F.2d 236 (10th Cir. 1979). Given this uncertainty, these pre-Scott precedents can be useful in arguing points that Oklahoma law has not yet reached.

41. Scott, 606 P.2d at 559-60. The Scott opinion affirmed the defendant's verdict by holding that instructions given in the trial court adequately informed the jury of the elements of the informed consent case as set forth by the Scott court. The court, however, does not set out in the opinion what those instructions stated. In fact, they appear to have been significantly inadequate. The instructions included the following:

'The Defendant has an obligation to disclose to his patient all material risks with regard to the proposed operation, material risks being determined by the seriousness of the consequences, the probability of occurrence and the feasibility of alternatives. The Plaintiff had the burden of proving, in this regard, what a reasonably prudent physician in the medical community in the exercise of reasonable care would have disclosed to his patient, or evidence from which the jury could reasonably infer material risks were inherent in the proposed procedure in the terms of seriousness, probability of occurrence, and feasibility of alternatives.'

Amended Brief of Appellant at 14, Scott v. Bradford, 606 P.2d 554 (Okla. 1979) (No. 51,208) (emphasis added). The language of the instruction given is clearly that of the professional standard of disclosure; it nowhere approaches the liberal subjective standard duty of disclosure adopted by the court. Furthermore, the crux of plaintiff's argument on appeal was that Scott was not told about the availability of a nonsurgical alternative to the hysterectomy, and that the instructions were misleading. Plaintiff correctly pointed out in its reply brief that telling a jury that it should consider what alternatives exist in determining whether a particular risk about the procedure is material is not the same as telling a jury that it should determine whether a physician should have given the patient information about what those alternatives were. Reply Brief of Appellants at 4-5, Scott (No. 51,208).

It is thus somewhat surprising that the Scott court did not find that the instructions given constituted reversible error under the doctrine it was adopting. The Scott opinion clearly extended the disclosure standard beyond information about the risks of the treatment to include information about the feasible alternatives to treatment.

42. Scott, 606 P.2d at 557. Professor King has suggested that among the reasons supporting the
medical usage is to arrogate the decision on revelation to the physician alone. That
standard would "perpetuate medical paternalism by giving the profession sweeping
authority to decide unilaterally what is in the patient's best interests." Relying upon
Canterbury v. Spence, the court instead adopted a patient-oriented standard
measured by what patients would want to know, rather than by what physicians think
should be disclosed.

2. The Prima Facie Case and Affirmative Defenses

The structure of the Oklahoma cause of action based on lack of informed consent
is confusing at first glance. The court clearly states that the action is one based upon
negligence. However, the court sets out a prima facie case, together with separately
stated affirmative defenses upon which the defendant has the burden of proof. The
analytical structure more nearly resembles that of intentional tort liability.

The court states that the plaintiff's prima facie cause of action requires proof of
three elements: (1) a duty to inform; (2) causation; and (3) injury. The duty to
disclose includes, but may not be limited to, the procedures and risks connected with:
(1) the treatment proposed; (2) feasible alternative treatments; and (3) nontreatment
alternatives. The court then sets out a nonexclusive list of three exceptions to the
disclosure duty and clearly allocates the burden of proving these privileged non-
disclosure situations to the defendant. Informed consent disclosure is not required

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professional standard are: (1) the complexities of medical science entail that the issue of disclosure, even
if not viewed as a medical question, is still better left to the judgment of medical professionals; (2) the
professional standard gives professionals a fair way of learning what they must disclose; without its
protection they have no real way of knowing what the law prescribes; (3) the facts about what was
communicated depend upon what the parties remember about their conversation; a situation particularly
ripe for selective memory, self delusion and even fabrication; and (4) given the limitations often present
both as to teaching and learning about the medical situation, the time and effort it takes for real informed
consent is a misallocation of resources, in economic terms, and very often fails to achieve its objective
or is counterproductive. See Joseph H. King, Jr., The Law of Medical Malpractice (2d ed. Nutshell
Series 1986).

43. Scott, 606 P.2d at 557-58.
44. Id. at 557. Courts have set forth additional reasons for rejecting the professional standard. For
example, the Canterbury court stressed that the question about how much information a patient should
be given is not primarily a medical question. Canterbury v. Spence, 464 F.2d 772, 785 (D.C. Cir. 1972). There
is, thus, inadequate reason to have a special medical standard operating where the physician's activity
does not bring his medical knowledge and skills particularly into play. Additional reasons
included: (1) that the patient's right of self determination requires a standard set by law, not by
professional custom; (2) that often there is no medical standard regarding what disclosures a physician
ought to make; and (3) sometimes the expert witness's testimony might merely be expressing a personal
preference. Id.
45. 464 F.2d 772, 785 (D.C. Cir. 1972); see Scott, 606 P.2d at 558.
46. Scott, 606 P.2d at 558-59.
47. The affirmative defenses function as fixed rules about privileged nondisclosures, similar to those
fixed-rule affirmative defenses in intentional torts which are based on consent and privilege. In ordinary
negligence cases, such issues are subsumed under the breach of duty issue of whether the defendant has
acted as would a reasonable person in the same or similar circumstances.
49. Id. at 555 (Court's Syllabus No. 1).
when: (1) the risks in question either "ought to be known by everyone" or "are already known to the patient;" (2) full risk disclosure would be detrimental to the patient's total care and best interests; and (3) an emergency exists which incapacitates the patient from being able to decide himself. In an important footnote, the court states that these exceptions might not be "the sole defenses, as others may be presented in the future." Thus, defense attorneys can look to this concept of privileged nondisclosure of material information as a fertile source for arguments in favor of finding further exceptions needed to accommodate the tension between the competing medical ethical values of respect for patient autonomy and legitimate physician beneficence.

3. The Scope of Disclosure: Defining the Physician's Duty

The heart of the Oklahoma duty of disclosure is that a physician must give his patient enough information to make an intelligent decision about the treatment options by disclosing to him facts and other information that would likely be factors in the patient's decisionmaking process.

a) What Must the Physician Tell the Patient?

The Scott opinion suggests that the physician's basic obligation is to make a "reasonable disclosure," measured by "conduct which is reasonable under the circumstances." More specifically, the physician's duty includes disclosure of all "[m]aterial risks." What constitutes a material risk is to be a question of fact, with no bright line separating the material from the nonmaterial. The critical operative concept about what material risk means is its definition: "A risk is material if it would be likely to affect patient's decision."

The critical operative concept about the scope of what is material is the following holding: "We . . . hold the scope of a physician's communications must be measured by his patient's need to know enough to . . . make an intelligent choice."

Thus, when doctors ask their lawyers what Oklahoma negligence law requires them to tell their patients, the basic answer ought to be: information which is likely to be considered by his patient as a factor in deciding "yes" or "no" to the treatment proposed. Note that this is not the same as the lawyer advising his physician-clients as to what information disclosure is sufficient to protect them from liability for lack of informed consent. Information which might affect a patient's decision can be withheld if it would be a privileged nondisclosure under one of the affirmative defense exceptions. In addition, because of the causation element, the lawyer can assure the client that there is no exposure to liability, even as to information that ought to be

50. Id. at 558.
51. Id. at 559 n.16.
52. Id. at 557-58.
53. Id. at 558.
54. Id.
55. Id.
56. See discussion infra text at notes 80-102.
disclosed, if the patient would have opted against the treatment had he been informed as he should have been.

b) The Disclosure Standard — Is It Objective or Subjective?

The Scott opinion is nationally noteworthy because it so clearly and forcefully endorses a subjective standard on causation. However, a careful reading of the opinion supports the conclusion that the court also endorsed a subjective standard regarding the disclosure duty, thus rejecting the dominant view in other "material" information jurisdictions that the duty to disclose is likewise measured by an objective standard, viz., that the physician must disclose what a reasonable patient needs to know. Textually, the Scott opinion can be read as adopting a standard requiring disclosure of what a physician's patient subjectively would think was significant to his decision, not what a reasonable patient would deem significant. The opinion is less than crystal clear on this critical point, however. To be sure, the above holding regarding the scope of what is material says that it is measured by "his patient's need to know," and the definition of material risk speaks of risks likely to affect the "patient's decision." Reference to "his" patient's need suggests a subjective standard. In addition, the court at no point in the opinion makes reference to the concept of a reasonable patient in regard to the duty issue. On the other hand, the Scott court clearly intended to adopt the Canterbury standard of "reasonable disclosure" and its definition of material risks. However, the Scott court inexplicably, and without comment, omitted the language from the Canterbury court's definition of material risk where that court clearly adopts an objective standard of what a "reasonable person" would think was significant. In Canterbury, the court said that a risk was material when: "[A] reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk . . . in deciding whether to forego the proposed therapy." Moreover, the instruction given in Scott, endorsed by the Oklahoma Supreme Court as adequately encompassing its doctrine, used objective standard language like that in Canterbury. The interpretive question,

57. Id. Several commentators have advocated that the disclosure standard should be subjective so as to protect properly the patient's self determination interest. See, e.g., TOM L. BEAUSCHAMP & JAMES E. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 78 (2d ed. 1983); Capron, supra note 7.

58. See, e.g., Buzzell v. Libi, 340 N.W.2d 36, 41 n.3 (N.D. 1983) (citing Scott with approval, but noting that it did not reach the issue of whether the standard for disclosure was subjective or objective).

59. Scott, 605 P.2d at 558 (emphasis added).

60. Instead, the court speaks subjectively of a risk being material if it "would be likely to affect patient's decision." Id. at 558. By contrast it is at this point that the Canterbury opinion and the opinions of most courts speak of affecting a reasonable person's decision.

61. Canterbury v. Spence, 464 F.2d 772, 787 (D.C. Cir. 1972). Another textual difference between the Scott and Canterbury standards is that Oklahoma requires disclosure of information that is "likely to affect" a decision, whereas the Canterbury court speaks in terms of a risk to which the patient is "likely to attach significance in making a decision." However, it is not likely that this difference would itself be significant. Any risk to which a patient is likely to attach significance in making a decision is likely to be one which is "likely to affect" that decision.

62. See supra note 41. The language used by the trial court in Scott was taken from the Oklahoma case of Martin v. Stratton, 515 P.2d 1366, 1369, 1370 (Okla. 1973).
then, is whether the omission of the above passage from Canterbury by the Oklahoma Supreme Court was oversight or whether the court affirmatively meant to adopt a subjective standard, viz., disclosure of that to which his patient would attach significance, even if a reasonable patient would not. The court does not clarify this point in any subsequent decision.

Of course, from a practical standpoint, the question about whether the disclosure standard is subjective or objective is not that important because the situations where information will be credibly significant to plaintiff, but not to a reasonable patient, are likely to be few. However, the issue is more important in Oklahoma than it is in the vast number of other states whose causation standard is objective. It might make little "real world" difference that a doctor must reveal something which would be significant to his patient but not to a reasonable patient if liability will turn on whether a reasonable patient would refuse treatment if informed. In Oklahoma, however, liability will turn on whether one believes the plaintiff when he says that he would have followed his idiosyncracies. Under that subjective standard of causation, it is much more important to know whether he had to be told that information in the first place.

c) Scope of Disclosure Duty: Material Information

The literal scope of the physician's duty to inform his patient is very broad, perhaps as broad as that in any jurisdiction. This is mainly due to the important expansive language in the court's syllabus, as opposed to the terminology in the main body of the opinion itself. The main body of the Scott opinion speaks only of disclosing the risks of treatment, alternative treatments, and nontreatment. The syllabus by the court, however, sets forth more expansive language which speaks of material information and implies that the above specific items are a nonexclusive list:

[A] physician or surgeon has a duty to disclose to a patient all relevant material information his patient will need to make an informed decision on whether to consent to or reject physician's proposed treatment or surgery. This disclosure shall include alternatives to proposed treatment, and the risks of each course of action including those risks inherent in foregoing all treatment. 63

It is clear from the opinion as a whole that the physician's obligation is to communicate the required information in lay terms which his patient can understand; it is not so clear whether his obligation requires that he be assured that his patient does in fact understand. 64

63. Scott, 606 P.2d at 555 n.1 (emphasis added). Note that in addition to speaking more broadly about information, not just risks, the passage says "shall include," suggesting that the three categories of information addressed in the main body are required, but not necessarily the exclusive types of information which need to be disclosed.

64. There has been considerable debate and confusion as to whether the physician's informed consent duty is fulfilled if he discloses to his patient what the patient should know or whether it goes further and requires that he be assured that his patient understands the information so that his consent is in fact a knowledgeable consent. See Meisel, "Expansion," supra note 7, at 113-23; Meisel, "Exceptions," supra note 7, at 420. The Scott opinion refers to informed consent, "legally speaking" as
d) What Is "Material" Information? — Subsequent Oklahoma Cases

Masquat v. Maguire, the first Oklahoma informed consent case decided after Scott, created some doubt about whether the court would be as liberal in finding that a physician breached his disclosure duty as the Scott rationale had implied. However, those doubts were diminished by the 1984 case of Smith v. Karen Reisig, M.D., Inc. In Smith, the court found liability because defendant failed to disclose the existence of an alternative treatment, and such information was found to be material.

The Masquat case gave physicians some hope that the materiality limitation might have significant content. The case is also a good example of the proper relationship between a battery and a negligence action concerning consent. In Masquat, the defendant-physician had performed a tubal ligation sterilization procedure on plaintiff during the course of a Caesarian section delivery of her child. Plaintiff apparently alleged, alternatively, that she had not consented to be sterilized, but that any consent she may have given was not adequately informed because defendant did not tell her that there were other sterilization methods available which had different chances of reversibility than the method he used on her. Plaintiff's informed consent theory apparently was that she was damaged because she was not allowed to choose a method which had a better chance for reversing her sterilization.

The court held that the trial court was correct in concluding that she was not entitled to an informed consent instruction on her evidence. It gave two reasons: (1) the difference in reversibility among the methods was "not so significant as to vitiate consent" and (2) there was no evidence of any causal linkage between "some unrevealed risk and the injuries complained" of. The first reason is suggestive of the materiality issue, but the court's "vitiate consent" terminology is the language of battery. It raises the question whether the court meant to say that the difference in reversibility was not so significant as to be "material information." Had the court

being the requirement that "consent to treatment, to be effective, should stem from an understanding decision based on adequate information . . . ." But it follows this by stating: "The doctrine imposes a duty . . . to inform a patient of his options and their attendant risks." Scott, 606 P.2d at 556-57 (emphasis added). It does not state that the duty is to inform the patient until the patient understands.

67. Id. at 288-89.
68. Masquat, 638 P.2d at 1105. The court's opinion is not clear whether plaintiff's complaint alleged informed consent facts or whether the theory was raised at trial.
69. Unfortunately, however, the court's opinion does not disclose what precise damages plaintiff sought, or what had happened to her. For example, the opinion does not state whether plaintiff suffered some untoward complication during the tubal ligation procedure and sought damages for those injuries or whether her damage was that she could not have her sterility reversed. In many tubal ligation informed consent cases, of course, the plaintiff subsequently gets pregnant and sues because she was not told of the chance that the sterilization operation might not be effective. See, e.g., Sard v. Hardy, 379 A.2d 1014 (Md. 1977).
70. Masquat, 638 P.2d at 1106.
71. Id. at 1107.
72. See discussion supra text at note 71. The court's second reason goes to the Scott "injury" element and raised questions about whether liability could in fact be available in an undisclosed...
been more precise in phrasing its rationale in terms of "material" information, the case might have been one of national significance. It would be noteworthy that the degree of reversibility of a sterilization operation was held to be "nonmaterial" as a matter of law under an arguably subjective disclosure standard.

On the other hand, the court says that when the plaintiff's evidence failed to show that she had consented to the tubal ligation, "she claimed that a battery occurred as her consent was not sufficiently informed." Perhaps the court meant to use battery language because it was merely holding on narrow grounds that the plaintiff had mistakenly tried to characterize her informed consent claim as one for battery. Thus, the court rejected her "battery" claim with language appropriate for battery. Then again, even if the holding is viewed as one about the reversibility information not being material, the court might have been merely indicating that a physician has discretion as to the methods he will choose in performing a procedure and that he need not bring the patient in on that decision. In context, that explanation is not very convincing. The gist of plaintiff's complaint was that she should have been able to choose a less permanent sterilization procedure. Surely, that should be treated as information likely to affect the patient's decision.

The Masquat case also points out a practical difference between what is arguably the Oklahoma subjective standard and the view of a majority of courts that the disclosure standard is objective. One might, perhaps, reasonably think that the reversibility of a sterilization would not be material to a "reasonable patient." However, the operation took place in a Catholic hospital where elective sterilization was prohibited. The opinion does not indicate plaintiff's religious preference. Suppose that she had been Catholic and was concerned that sterilization would be contrary to her faith. The degree of reversibility would certainly be material to "this patient," and her physician would seem to have an affirmative obligation to inquire into this matter if he were performing sterilizations in that particular hospital. Under a "material to a reasonable patient" standard, a physician can more easily defend his silence by saying that it was up to the patient to ask questions or ask for more information if she wanted it.

The antidote to the opaqueness of the Masquat opinion is the strength and clarity with which the court found liability based upon a physician's failure to disclose an alternative treatment in the subsequent case of Smith v. Karen Reisig, M.D., Inc. In the Smith case, the plaintiff suffered a complication during the course of a hysterectomy operation. Plaintiff claimed that the surgeon was negligent both because she had performed an unnecessary hysterectomy and because she had inadvertently, but

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73. *Masquat*, 638 P.2d at 1105 (emphasis added).
74. See infra text at notes 139-46 for the recent encounters which the court and the federal courts have had in Oklahoma in dealing with attorneys' understanding of the proper line between informed consent negligence and lack of consent battery.
76. 686 P.2d 285 (Okla. 1984). The Smith opinion also cleared up the uncertainties the *Masquat* case had created by its holding that there was no injury because no undisclosed risk materialized. See discussion infra text at notes 119-26.
negligently, cut her bladder. Alternatively, however, she claimed that the surgeon negligently failed to inform her: (1) of the inherent one-percent risk in a hysterectomy that her bladder might be inadvertently cut and (2) that hormone therapy would have been an available alternative to surgery. The trial court sustained a demurrer to plaintiff's evidence. The court first held that it need not decide whether the one-percent bladder risk was a "material risk" because there was insufficient evidence of causation as to that risk.77 However, the court ordered a new trial because it held that the evidence was sufficient to prove that the alternative availability of hormone therapy was material information. It noted that both defendant's testimony and plaintiff's medical records established that hormone treatment was a viable and possibly preferable alternative to surgery and that plaintiff had testified that she would have chosen the alternative therapy.78

While Oklahoma's informed consent doctrine is favorable toward patients, ultimate victory at trial is still a formidable hurdle, partly because of the difficulties in meeting the other requirements discussed in the following sections. In fact, the only appellate case decided under post-Scott Oklahoma law in which a patient has won a jury verdict is a Tenth Circuit case which involved the issue of materiality of the information not disclosed.79

4. The Defenses — Privileged Nondisclosures

The Scott opinion sets forth three affirmative defenses to the disclosure duty which it calls privileged nondisclosures, but indicates that there may be more in the future.80 Analytically, the defenses recognize that, in the particular situations covered by the

77. Smith, 686 P.2d at 289. See discussion supra text at note 71.
78. Id. at 288. A leading case from another material information state is useful to contrast with Masquat. Sard v. Hardy, 379 A.2d 1014 (Md. 1977), involved the difference in the failure rates of tubal ligation methods, as opposed to their difference in the rates of reversibility, which was at issue in Masquat. The patient became pregnant after a tubal ligation. She alleged that her physician failed to tell her about several other alternative methods of tubal ligation which had differing rates of failure. Applying the "reasonable patient" standard, the Maryland court held that a jury could reasonably conclude that the two-percent risk of failure inherent in the technique used was a material risk because a reasonable patient in plaintiff's position would have attached considerable significance to the failure rate, since plaintiff was concerned about the physical risks of future pregnancies and the financial burdens of having more children. Sard, 379 A.2d at 1025, 1026.
79. In Haley v. United States, 739 F.2d 1502 (10th Cir. 1984), the plaintiff recovered a $190,000 verdict which was affirmed on appeal. Haley brought suit against the doctors who examined her and the surgeon who removed her uterus during an operation to remove her rectal stump. Her informed consent claim was that the defendants failed to inform her about the risk of a wound infection, inherent in the operation, and of the risk that her uterus might possibly be removed. The court held that plaintiff's evidence was sufficient to show that the doctors had failed to inform her of the high risk of infection involved in operating on a person with her condition; had not been given clear information about the risk that her uterus might be removed; and had not disclosed that her doctors were not certain whether she had the Crohn's disease or ulcerative colitis for which she was undergoing surgery. Haley, 739 F.2d at 1505.
80. See supra notes 50-51 and accompanying text. The exceptions are that disclosure is unnecessary when: (1) the risks are known by everyone or by the patient; (2) disclosure would be detrimental to the patient's total care and best interests; or (3) an emergency exists that incapacitates the plaintiff.
exceptions, information which would be material from the patient's standpoint may be withheld in the particular case. Health care providers and their attorneys can take heart from the affirmative defenses portion of the Scott opinion. Having set out as patient-oriented a prima facie case as there is, the court then articulates affirmative defense rules which, if interpreted broadly, may undercut much of the patient self-determination protection which the court sought to achieve by its broad material information standard and its subjective causation rule. This danger is particularly acute if the court in future cases gives what it calls the "patient's total care and best interests" exception an expansive reading, or if it is open to significant expansion of the list of privileged nondisclosures. The risk is that the defenses may become the basis for legitimating through the back door a good deal of the medical paternalism of "doctor knows best" which the court's opinion elsewhere aimed to thwart. It would be unfortunate if the Scott defenses prove to "taketh" what the prima facie case rhetoric "giveth."

a) The Known Risk Exception

The known risk exception vitiates a physician's duty to disclose information which is: (1) known by everybody or (2) known to plaintiff.81 Note that the common knowledge rule, in effect, incorporates a portion of the protection given physicians in other states by the "reasonable patient" disclosure standard. Under a reasonable patient standard, the physician need not disclose commonly known risks because a reasonable person would know those risks, even if his patient does not.82 Neither Scott nor subsequent decisions address a critical interpretive question. Does the patient-oriented disclosure standard imply that the true Oklahoma common knowledge exception is this: the physician need not disclose a commonly known risk unless he has reason to believe that his patient does not know about it? In other words, does the exception stand on its own? (That is, unless his patient asks, a physician is safe in not disclosing risks which ordinary people know, no matter what he knows or should know about his patient's lack of knowledge.) Or does the exception apply unless the physician actually knows that his patient does not know of the risk? Or does the rule imply that the physician has an affirmative obligation to check that his patient is not ignorant of a clearly material but commonly known piece of information?83 The spirit of Scott,

81. Scott, 606 P.2d at 558. Wilkinson v. Vesey, 295 A.2d 676 (R.I. 1972), may be the source of the recognition of this exception. Among the cases turning on the known risk point are: Kinikin v. Heupel, 305 N.W.2d 589 (Minn. 1981) (jury could find experienced patient, even after nine or ten operations, did not know of risk of skin necrosis); Truman v. Thomas, 611 P.2d 902 (Cal. 1980) (potentially fatal risk of undetected cervical cancer from failing to undergo pap smear; issue was for jury); Stone v. Foster, 164 Cal. Rptr. 901, 910-11 (Cal. Ct. App. 1980) (risks of "tummy tuck" operation, patient's tummy had been tucked before); Crain v. Allison, 443 A.2d 558 (D.C. Ct. App. 1982) (patient and husband knew generally of risk of infection from cortisone shots for arthritis, but did not know extent of risk). See Prosser & Keeton, Torts, supra note 7, § 32, at 192 n.81.

82. Professor Meisel believes that the known risks situations are not really exceptions to the disclosure requirement because they are an integral part of the definition of the disclosure which is required. Meisel, "Exceptions," supra note 7, at 433 n.76. He is correct if the disclosure standard is measured by the reasonable person. When it is measured subjectively by the needs of the particular patient it can analytically be viewed as an exception, but this creates policy problems.

83. See Truman v. Thomas, 611 P.2d 902, 905 (Cal. 1980) ("[I]f the physician knows or should
if not the letter, suggests that the physician has an affirmative obligation to ask his patient about commonly known risks if he has or reasonably should have any doubts about what his patient knows.

The "known to patient" aspect of the exception is not problematic, except as to the extent to which the court will require that the knowledge of the patient be shown to be an understanding knowledge, such that consent might be implied. Whatever might be the rule regarding whether the physician's duty is to disclose information or to obtain understanding consent from his patients when he does inform them of risk and alternatives, surely the rule should be that an understanding knowledge is needed before a physician may rely upon not informing his patient about a clearly material piece of information that he thinks his patient already knows.

The known to patient exception is the only defense that so far has been litigated at the appellate level in Oklahoma. *Goss v. Oklahoma Blood Institute* involved a patient who alleged that he was infected with the HIV virus by contaminated blood which had been supplied to him during a heart bypass operation. He sued both the blood institute which supplied the blood to the hospital and the hospital itself, alleging that he had not been informed of the contaminated blood risk. In ruling that summary judgment for the hospital was proper, the Oklahoma Court of Appeals held that the patient's physician, not the hospital, had the duty of obtaining informed consent.

However, the court held that, assuming arguendo that the hospital had an informed consent duty, defendant did not have to inform the patient in this case because the evidence was clear from the patient's deposition that he "knew of the risks of transmitted disease before he underwent surgery" and because there was no evidence that plaintiff would have foregone the transfusion if he had been "informed of the specific risk of contraction of AIDS from any necessary blood transfusion."

Similarly, in *Spencer v. Seikel*, the Oklahoma Supreme Court held that a pregnant woman who had requested an abortion during a prior pregnancy was adequately aware of abortion as an option when her physician advised her that her viable fetus would be born with severe birth defects.

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84. See discussion supra text at note 62, 64.
86. *Goss*, 856 P.2d at 1007.
87. Id. at 1006.
88. 742 P.2d 1126 (Okla. 1987).
89. *Spencer*, 742 P.2d at 1129. The court does not attend to the point that the plaintiff probably was maintaining that she was not aware of whether abortion of her fetus that late in her pregnancy was medically feasible and advisable. Simply knowing that one can abort when one is pregnant does mean that one knows enough to decide whether abortion is medically feasible when there are complications. The Tenth Circuit was much more sensitive to the point in *Haley v. United States*, 739 F.2d 1502 (10th Cir. 1984), where defendant had argued that plaintiff should have been aware of the potential for wound infection with surgery because she had undergone prior major surgery. The court rightly answered that "each type of surgery creates its own risks" and that her doctors did not tell her of the "abnormally high risk of infection that exists when people are operated on for her condition ([Chrons's disease])." *Haley*, 739 F.2d at 1505.
b) The Patient's Total Care and Best Interests Exception (the "Therapeutic Privilege")

The Oklahoma court's articulation of this exception had its source in Canterbury v. Spence. The Canterbury exception was a very limited one. Judge Robinson described it as available when:

risk disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or hinder the treatment, or perhaps even pose psychological damage to the patient.

Judge Robinson added:

The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself. Nor does the privilege contemplate operation save where the patient's reaction to risk information, as reasonably foreseen by the physician, is menacing. And even in a situation of that kind, disclosure to a close relative with a view to securing consent to the proposed treatment may be the only alterative open to the physician.

Unlike Judge Robinson's carefully crafted limitations of this privilege in Canterbury, the Scott opinion has no such language. Recognition of a broad privilege to withhold material information where full risk disclosure would be contrary to the patient's health care best interests would be an admission, as the Scott court put it, that "the primary duty of a physician is to do what is best for his patient." It is the informed consent doctrine's attempt to balance and accommodate the physician's competing ethical obligations of beneficence and respect for autonomy. In other states, the exception goes by the term "therapeutic privilege." That phrase captures its essence: disclosure of risks ought not occur where the decision-making role would present a serious health risk to the patient.

91. Canterbury, 464 F.2d at 789.
92. Id.
93. Scott, 606 P.2d at 558.
94. See ROZOVSKY, supra note 7, § 1.16.4, at 86.
Courts and commentators have strongly cautioned that the exception must be kept within very narrow limits, else it will swallow the "material information" doctrine under an avalanche of "doctor knows best" scenarios.\(^95\) However, the Scott opinion endorses an extraordinary example. It states, "for example, [disclosure may be withheld where it] would alarm or emotionally upset an apprehensive patient."\(^96\) Surely, the court is not to be taken literally, or perhaps even seriously, with this example. The example does not even say seriously upset! Almost any patient faced with any significantly risky therapeutic choice would be "apprehensive" and "alarmed" by the decision-making role in which she is placed. The case which Scott cites, however, is Nishi v. Hartwell,\(^97\) one of the more physician-protective of the "therapeutic privilege" cases. The exception would certainly swallow the patient-oriented rhetoric of the Oklahoma prima facie case and will amount to a back door acceptance of the "doctor knows best" tradition if courts subsequently interpret it, as the example in the Scott opinion suggests, to permit physicians to withhold material information which would cause a patient anxiety. One should note, however, that the Oklahoma Uniform Civil Jury Instructions have not taken Scott literally and have articulated the privilege in a way that limits the necessary emotional anxiety to situations where patients would not be able to weigh the risks rationally. The instructions state that the privilege exists when "disclosure would alarm an emotionally upset or apprehensive patient so that the patient would not be able to weigh rationally the risks of refusing to undergo the recommended treatment or operation."\(^98\) Hopefully, in the future, the court will articulate the true scope of this exception, perhaps by endorsing the privilege-narrowing language of the Canterbury opinion, which it failed to mention in Scott.

c) The Emergency Exception

The Scott court articulated the emergency privilege as one where "there is an emergency and the patient is in no condition to determine for himself whether treatment should be administered."\(^99\) This privilege is relatively self-explanatory. The practical issues of litigation will likely involve whether the patient was adequately incapacitated and whether there was a real emergency.\(^100\) One problem with the Scott formulation is that it conflates two analytically separate nondisclosure exceptions into

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95. See Applebaum, supra note 7, at 72-79; Meisel, "Exceptions," supra note 7, at 460-70.
96. Scott, 606 P.2d at 558.
97. 473 P.2d 116 (Haw. 1970). The Nishi court uses breathtakingly broad language in articulating the therapeutic privilege exception: A "doctor's primary duty is to do what is best for the patient. Any conflict between this duty and that of a frightening disclosure ordinarily should be resolved in favor of the primary duty." Id. at 119. Actually, very few cases have turned on the therapeutic privilege exception, and not many discuss it in detail. See generally Robert v. Wood, 206 F. Supp. 579 (S.D. Ala. 1962); Arato v. Avedon, 858 P.2d 598 (Cal. 1993); Watson v. Cluts, 136 S.E.2d 617 (N.C. 1964).
one. Incapacity should be viewed as a separate privilege because it covers more than emergency situations, and the privilege to forego full disclosure in emergency situations is not limited to cases where the patient lacks decisional capacity. The emergency, from a medical standpoint, may leave no time to discuss the risks and benefits of treatment with a patient who is fully in command of his senses and is otherwise capable of being a decision maker, except for the emergency circumstance.

5) Causation

Causation is the second element of the Oklahoma plaintiff's prima facie informed consent case. It has been a controversial problem. Oklahoma's rule, which is both logical and consistent with the implications of patient autonomy, is by far the minority view. Most states bow to expediency on this issue and to practical ideas of fairness to the medical profession by adopting an objective standard of causation, which is contrary to the logic of a doctrine based upon recognized patient autonomy.

a) The Standard — Objective vs. Subjective

All states require a plaintiff who relies on lack of informed consent to establish a minimal causal connection between the negligent nondisclosure and the damage for which he seeks relief. All require proof of some variation of the "but for" causation notion that the damage suffered would have been avoided because the medical intervention which caused the harm would not have occurred if the physician had fulfilled his disclosure obligation. Logic and the policy of vindicating self-determination suggests that this standard should be subjective: whether the individual patient himself would have refused treatment if told of the risks or other relevant material information. Nevertheless, the Canterbury case, and virtually all other courts, both in professional standard and material information states, have determined for practical and policy reasons that health care providers are entitled to the protection of an objective rule: a plaintiff can recover damages only if a reasonable patient would have refused treatment.

The Oklahoma court's opinion on this issue is a stirring vindication of both the logic and the policy of respecting self-determination. The "reasonable" person rule severely limits an injured patient's protection, said the court. Protecting physicians from the vagaries of subjective hindsight decision making is no excuse for backtracking on the law's protection of self-determination. Where the rule makes a difference (i.e., where a patient would have refused what a reasonable person would have chosen), choosing the reasonable person rule irrevocably "destroys the right of self determination." This

102. See id. at 434-38.
103. See PROSSER & KEETON, TORTS, supra note 7, § 32, at 191.
104. See Capron, supra note 7, at 408-09; see Arena v. Gingrich, 748 P.2d 547, 548 (Or. 1987) (opinion by Justice Linde states objective standard is "anomalous"; it was invented and defended for "purely pragmatic rather than logical reason.").
106. Scott, 606 P.2d at 559.
basic right to know and decide," said the court, is the reason for the broad disclosure rule the court adopts.\textsuperscript{107} The court was subsequently asked to reconsider its subjective causation standard in view of that rule's widespread academic and other criticism. However, the court strongly reaffirmed its position.\textsuperscript{108}

Although the Oklahoma subjective causation rule does subject health care practitioners to the uncertainties of patient hindsight, it is still a very significant barrier to patient compensation and the realistic bottom line on practitioner liability exposure from a practical standpoint. In \textit{Goss v. Oklahoma Blood Institute},\textsuperscript{109} for example, the court held that there was no evidence that a patient who became HIV positive because of a blood transfusion during heart surgery would have refused the transfusions if he had been told of that risk.

The impact of this causation element on settlement and its potential for success before a jury is a major reason why few cases are litigated where informed consent is the sole allegation of negligence. It is for this practical reason that the most significant growth concept for nondisclosure cases in the rest of the 1990s may be the breach of the fiduciary relationship theory recognized by California in \textit{Moore v. Regents of the University of California},\textsuperscript{110} rather than its informed consent theory of liability which was an alternate basis for liability in that case. If the breach of fiduciary relationship theory provides a way around the causation rule, it can realistically be as important, or more important, a factor in creating meaningful access to compensation by patients and exposure to liability of medical practitioners than is the rejection of the professional standard limitation on the disclosure duty.

Health care providers are not likely to miss the realistic legal advice that the tort law imposes a broad duty to inform patients determined by what patients would think is significant to their decisions, but that liability turns not on the question of what is likely to affect their decision, but what would have caused them to decide differently. Jurors may hear the court's instruction that the question is what the individual plaintiff, not what a reasonable patient, would have done, but their instincts of fairness may well lead them to award compensation to a plaintiff only if they think he reasonably refused his doctor's recommendation.

Thus, most plaintiffs will use the informed consent doctrine as a backup alternative to their attempts to show that the physician was negligent in some manner in regard to the procedure itself. The \textit{Scott} facts are thus typical: the patient alleges that her

\begin{itemize}
\item \textsuperscript{107} \textit{Scott}, 606 P.2d at 558.
\item \textsuperscript{109} 856 P.2d 998, 1004 (Okla. Ct. App. 1990).
\end{itemize}
doctor negligently cut her bladder, but if he did not, he negligently failed to tell her of the risk that he would nonnegligently cut her bladder.

Another way of looking at the impact of the causation limitation is that, in practical terms, it means that the informed consent cases likely to be litigated are those where there is a fair chance of showing that the defendant was negligent in some other way, as where the decision to perform the procedure was near the line of medical acceptability. As practical people, jurors are more likely to believe plaintiff would in fact have avoided a procedure where the evidence suggests the procedure might have been unnecessary or that one of the alternative treatment modalities was more appropriate, from a medical standpoint, for a person in the patient's situation.

A case factually similar to Scott, from another jurisdiction with a broad disclosure rule but an objective causation standard, illustrates the point. In LaCaze v. Collier, Scott, the patient alleged that she was not told of the risk of a urine leakage complication caused by a vesico vaginal fistula, which formed after her hysterectomy. The Supreme Court of Louisiana affirmed the dismissal of her case. She should have been told of the risk, even though it was small, said the court. The court added that she would have prevailed if the causation rule were subjective because she testified that she would have refused the hysterectomy if told about the risk. However, the court ruled she failed in her proof because a reasonable patient would have chosen the hysterectomy despite its risk of complications.

b) The Single Risk vs. Bundle of Risks Problem — What Must Have Changed Plaintiff's Decision?

Smith v. Karen Reisig, M.D., Inc. raised an interesting and practical question about the informed consent causation element. What is it that plaintiff must be able convincingly to establish would have caused her to have avoided the treatment her doctor recommended? Is it the whole bundle of information that he should have disclosed (i.e., that which the doctor did and that which he did not disclose); the whole bundle of risks that he should have, but did not disclose; or each individual risk that the plaintiff says he had a duty to disclose? One would think that it might be the first option, perhaps should be the second, but surely is not the third. Yet it is the third option that the court chose in Smith. As discussed above, the plaintiff alleged that defendant-surgeon inadvertently, but negligently, cut her bladder during a hysterectomy operation. Plaintiff alleged that defendant negligently failed to advise her of: (1) the risk that her bladder might be cut and (2) that there was a medically feasible medication alternative to surgery available (i.e., hormone therapy). The court held that plaintiff proved an informed consent case as to the alternative hormone treatment theory because she testified that she would have refused the hysterectomy if she had

111. 434 So. 2d 1039 (La. 1983).
112. Id. at 1049.
113. Id.
114. Id.
considered that information alone. However, the court also held that plaintiff failed to prove an informed consent case concerning the treatment given. This was because she could not say whether she would have refused the hysterectomy solely because of the risk that her bladder might be cut.

The court's choice of this option is ill-advised. It would seem that the appropriate solution is that the "but for" causation issue should be asked in regard to the totality of the information that the physician was duty bound to reveal. Suppose that the plaintiff in Smith could not say that knowing about either the hormone treatment alone or the bladder risk alone would have caused her to refuse the hysterectomy. Suppose, however, that she would have certainly refused if she knew about both. The logic of the court's reasoning is that plaintiff would have no remedy in the later situation. Surely, she should recover if the package of information she should have been given, but did not receive, would have prevented her harm. Defendant's breach of duty was in failing to deliver all of the information the patient needed. Recovery is justified when the entire body of required information would have resulted in refusal.

6. "Injury"

The precise meaning of the injury element of plaintiff's case in Oklahoma is somewhat problematic. In Scott, the court described this element as requiring both: (1) that plaintiff was injured as a result of submitting to the treatment and (2) that "the undisclosed risk" must actually materialize, in the sense that "the adverse consequences that were not made known did in fact occur."

a) Injury Caused By Treatment

The first "injury" requirement, namely that the treatment given injure the plaintiff, is relatively straightforward. In cases of nontreatment, of course, plaintiff needs to prove that the lack of treatment caused him an injury which treatment would have prevented. In Johnson v. Thompson, for example, the court held that no injury resulted from the physician's alleged breach of duty in failing to obtain a mother's informed consent before withholding aggressive care from her severely handicapped newborn and maintaining him only on supportive care. The court held that the child also had an anencephaly condition. It concluded that there was no proof of injury because he would have died even if the vigorous treatment had been provided.

b) The Risk Must Materialize Requirement

The "risk must materialize" element is more problematic. The first problem in regard to this element is that the Scott opinion seemed to have contemplated only the situation where plaintiff complains about nondisclosure of the risks inherent in the

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117. Id. at 289.
118. The distinguishable issue of whether the separate risks are a threshold or a limitation on the recoverable damages is discussed below. See infra text at note 118.
119. Scott, 606 P.2d at 559.
120. 971 F.2d 1487, 1499 (10th Cir. 1992) (applying Oklahoma law).
121. Johnson, 971 F.2d at 1499.
treatment given. There is no awareness by the court that the requirement makes little, if any, sense when plaintiff's claim is that he would not have consented to the treatment if he had been informed of the risks or benefits of alternative treatments or of nontreatment.

This problem was exacerbated and additional uncertainty was created when the court in *Masquat* relied on this "injury" element as an alternate rationale for denying plaintiff recovery. In the *Smith* case, however, the court clarified the situation. It stated that the rule that the undisclosed risk must materialize did not apply to treatment alternatives cases.

In *Smith*, the defendant claimed that there was no proof that any damage resulted from the treatment. In responding to this claim, the court discussed the nature of the proof required in nondisclosure of alternative treatment cases. It said that both: (1) the medical costs of the procedure (i.e., the hysterectomy) and (2) any damages caused by the complication (i.e., the bladder cut) could be recovered in a nondisclosure of alternatives case "without regard to whether the complication was a risk required to be disclosed." This is so," said the court, because there must be proof that the procedure would not have been performed "if the alternative had been disclosed." The court apparently meant that there is a sufficient "injury" in the sense of a causal connection between the breach of duty of nondisclosure and the damages suffered when the plaintiff shows that the unrevealed information (i.e., the alternative treatment) would have occurred and the harm suffered by the patient would not have happened. The court made no reference to the *Masquat* case, the holding of which is inconsistent with this statement.

c) Materialization of Risk — Threshold or Damage Limit?

A second problem concerning the "undisclosed risk must materialize" requirement of the injury element is whether the requirement is a threshold rule or whether it is a rule of limitation of damages. Suppose that two risks inherent in a procedure both occur. Suppose that one was disclosed to plaintiff and one was not. Will plaintiff be able to recover damages for both results or just the one that flowed from the breach of duty? One would think that plaintiff ought to recover for all the harm which the

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125. Id. at 289.
126. The alternate holding in *Masquat* was that plaintiff could not recover damages from her physician's failure to inform her of the reversibility differences among available alternative methods of sterilization because she did not prove that there was any "causal linkage between some unrevealed risk and the injuries complained of." *Masquat*, 638 P.2d at 1107. A purist might say that *Smith* does not overrule the alternate holding of *Masquat* because the above statement in *Smith* was only dictum. This is because the defendant in *Smith* was only arguing that plaintiff did not prove that her present injuries for which she sought damages were not caused by either the hysterectomy or the bladder cut. In regard to this problem, however, *Masquat* was clearly wrong and *Smith* clarifies the point. It is unfortunate and ironic, however, that neither opinion tells us precisely what was the injury for which each plaintiff sought recovery.
required disclosure would have prevented. However, the Smith opinion is not clear on this point. The court had stated in the Scott case that (1) the [undisclosed] "risk must actually materialize" and (2) "absent occurrence of the undisclosed risk, a physician's failure to reveal its possibility is not actionable." 127 Perhaps, the court means this rule is to operate like a "results within the risk" damages limitation rule of proximate cause. The questionable holding in Smith, viz., that plaintiff had no cause of action based upon this nondisclosure of the bladder risk because that risk alone would not have caused plaintiff to refuse treatment, might suggest that recovery is allowable only for the things that the patient should have been told about. However, the opposite and correct answer lies elsewhere in the Smith opinion itself. That case also holds that damages for the bladder complication and the costs of the hysterectomy were recoverable. Suppose that the hormone treatment was a less attractive option and the bladder risk was greater than it actually was. Suppose that the plaintiff could then say that only the bladder risk would cause her to forego the hysterectomy. It seems likely that the court would allow her to recover far more than the materialized risk for the costs of the hysterectomy, for the same reason it allowed that damage in the alternate treatment situation.

7. Waiver

One of the most disconcerting practical problems in litigating an informed consent case can be determining how far a physician may go in relying on the argument that he did not tell his patients more because the patient wanted his doctor only to decide on appropriate treatment, and the patient had waived his right to be informed. In one sense, the stronger a state's informed consent law is bottomed on patient autonomy, the more attractive this argument should be. 128 Neither Scott nor any subsequent Oklahoma case touches on this fundamental point. This is true despite Scott's broad language vindicating patient autonomy. This may not be surprising because there is very little law on the implications of a waiver argument in any American jurisdiction. However, the language of some courts recognizes patient waiver as a defense, 129 and several commentators have endorsed broad recognition of the concept. 130


128. See Meisel, "Exceptions," supra note 7, at 458-60; Applebaum, supra note 7, at 69-72.


130. Few if any informed consent cases turn explicitly on a patient waiver rationale, although several courts recognize the strength of this argument and its importance as a fundamental aspect of patient autonomy (i.e., the autonomous right to refuse to exercise one's autonomy). See Arato v. Avedon, 858 P.2d 598, 609 (Cal. 1993) (strong waiver facts, but opinion not grounded on waiver theory because the information provided to patient covered all necessary aspects of material information); Armando A. Arambian, Informed Consent: From the Ambivalence of Arato to the Thunder of Thor, 10 ISSUES L. & MED. 261, 279 (1994) ("The context of Arato did not permit the court to directly address the waiver issue . . . . Nevertheless, . . . the court acknowledged that 'a patient may validly waive the right to be informed.'" (quoting Arato, 858 P.2d at 609)); see also Cobb v. Grant, 502 P.2d 1, 12 (Cal. 1972) (recognizing validity of express waiver of decision-making role); Palmer v. Biloxi Regional Med. Ctr., 564 So. 2d 1346 (Miss. 1990) (recognizing patient waiver of right to information as affirmative defense to informed consent cause of action).
There are, of course, moral and legal limits to an individual's claim to be an autonomous sovereign of his body. Neither permit him to make a contract to enslave himself. But, if strongly patient autonomy means anything, should it not mean that a patient is free to decide not to decide? On the other hand, one of the most difficult arguments to sustain in any context is a waiver of legal rights. Waiver of rights requires strong proof of a knowing and understanding relinquishment of rights. However, if informed consent is to imply a right to an "informed refusal" of treatment, ought it not also imply a right to an "informed refusal" of the decision-making role? There is surprisingly little law directly on this point. It can arise, of course, if a consent form has a specific provision on the point. Suppose that a consent form said:

In the exercise of my sovereign rights I have decided to let my doctor alone decide whether the risks of his recommended treatment outweigh its benefits and those of my other alternatives. So I hereby knowingly waive my right to be a decision-maker in that respect and also waive my right to be more fully informed on those matters than I am now.

The facts in Arato v. Avadon illustrate this tension quite starkly. In Arato, a cancer patient had indicated to his oncologist that he wanted to be truthfully informed about his condition and treatment by checking a box on a consent form. However, suppose that the cancer patient in Arato had answered the oncologist's consent form the other way, i.e., by saying that he did not want to be told the truth about his cancer prognosis. The crucial issue in that scenario, an issue on which there is inadequate legal precedent to give a confident answer, is whether the patient's answer is sufficient to shield the physician from liability.

B. Other Aspects of the Oklahoma Doctrine

1. A Hospital's Duty to Obtain Informed Consent

The general rule is that the patient's physician, not the hospital, has the duty to obtain the patient's informed consent. The concern is that to hold otherwise would unconstitutionally interfere with the doctor-patient relationship. Thus, a hospital is usually not exposed to tort liability based upon a theory of lack of informed consent.

An exception, of course, is when the physician who has the informed consent responsibility is an employee of the hospital, or someone for whose negligence the hospital is otherwise vicariously liable. This should also be true where the hospital would be liable for the physician's conduct under the Oklahoma doctrine of apparent authority.

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131. 858 P.2d 598 (Cal. 1993). See infra notes 159-69 and accompanying text for a comprehensive discussion of Arato.


The distinction may become important as a practical matter if the patient is unable to bring suit against his physician. The latest Oklahoma informed consent case illustrates this problem. In Trousdale v. City of Faith Hospital, the patient did not obtain service of process on the physician who operated on him at City of Faith Hospital. Instead, he sued the hospital and the clinic, City of Faith Medical and Research Center, where he was treated before the operation. He alleged that both were liable for failing to advise him of the possible complications involved in his surgery. The Oklahoma Court of Appeals sustained the summary judgment granted to the hospital but reversed that obtained by the clinic. The court reasoned that a hospital has no duty to obtain a patient's informed consent under Oklahoma law.

A recent Oklahoma case suggests that Oklahoma has now entered the arena of expanded hospital liability under the so called "corporate negligence" theory. Although the Oklahoma court took pains to limit its endorsement of the "corporate negligence" theory, its recognition of the doctrine presents an interesting possibility. Suppose that a hospital has clear notice that one of its nonemployee staff physicians has a longstanding and well-known habit of failing to obtain adequate informed consent from his patients. Here there may be a clear risk that the hospital may be exposed to potential liability under the corporate negligence doctrine because it failed to intervene and assumed that adequate consent was being obtained from his patients. Would this be a "pattern of incompetence" under the Strubhart decision? Certainly a physician who was competent in his ability to perform medical procedures could properly be called professionally incompetent if he habitually refused or failed to follow his professional obligation to obtain adequate informed consent. In jurisdictions which have liberal corporate negligence doctrines, a hospital's failure to intervene when its staff physicians negligently fail to obtain informed consent might be even more likely to be held to informed consent corporate liability than in a state like Oklahoma, where the physician's conduct must amount to a "pattern of incompetence."

2. Negligence v. Battery

Two recent cases point out the practical need for attorneys to be clear about the boundary line between a cause of action, the gist of which is information nondisclosure where express or implied consent to the medical intervention is present, and a cause of action where no legally effective consent to the procedure exists. In addition to the other differences from informed consent which battery has because it is an intentional tort, there are two that may potentially make an outcome-determinative difference for a litigant: (1) time limitations and (2) immunity under the Federal Tort Claims Act. Both issues were litigated recently under Oklahoma law.

135. Trousdale, 892 P.2d at 680.
136. See Strubhart v. Perry Memorial Hosp. Trust Auth., 903 P.2d 263 (Okla. 1995) (adoption of corporate negligence doctrine). In Strubhart, the doctrine was limited to situations where the hospital knows or should have known of a "pattern of incompetence" of its staff physicians. Id. at 276.
In other states, convincing a court that one's case is properly negligent informed consent, rather than battery, can be very important because the battery statute of limitations may be shorter. However, a 1994 Oklahoma Court of Appeals case ruling did away with that difference in Oklahoma, making the distinction insignificant for statute of limitation purposes.

In Rosson v. Coburn,139 defendant allegedly unnecessarily ligated plaintiff's right fallopian tube without her consent during an exploratory procedure for treatment of an ectopic pregnancy. Plaintiff alleged two causes of action: (1) battery and (2) negligent medical malpractice. The trial court dismissed plaintiff's battery claim because it was barred by the one year statute of limitations140 and ruled that no other negligent malpractice was involved. The court of appeals held: (1) an unconsented to operation is a battery, but the statute that controls is Oklahoma's special medical malpractice two-year statute141 not the general battery statute and (2) the trial court was wrong to dismiss the negligent malpractice claim because a plaintiff may "waive" a technical battery claim and sue for a wrongful and unskilful breach of duty by a physician.142

The Rosson court reasoned that the claim which alleged that defendant operated without consent was clearly a battery under Oklahoma law. Hence, it came within the language of both statutes. The two-year malpractice provision, the court held, was the proper limitation because, as between a general statute and a special statute which clearly includes the matter in controversy, the special statute applies.143

Thus, if the court of appeals is correct, a two-year limitation period applies to both true battery and negligent informed consent cases, so the line marking the boundary between the two is not important in Oklahoma for that purpose. The Rosson court's "waive the battery and sue in negligence" concept is superfluous for that problem. However, the idea, by analogy, would be critical to plaintiff's recovery in the context of another problem which was the subject of recent litigation. That problem is the scope of the federal government's immunity from being sued under the Federal Tort Claims Act when an action for malpractice arises in a Veteran's Administration Hospital or other federal facility.

In Franklin v. United States,144 the question was whether an action for battery based on medical treatment provided without consent was available to a patient or whether it was barred by the Federal Tort Claims Act which permits suits against the

140. 12 OKLA. STAT. § 95(4) (1991) (stating that statute of limitations applying to civil actions other than for recovery of real property has one-year period expressly applying to battery).
141. Rosson, 876 P.2d at 734; see 76 OKLA. STAT. § 18 (1991) (providing by separate statutory provision a two-year period of limitations for damages actions "in tort" or otherwise against "any physician . . . arising out of patient care").
143. Rosson, 876 P.2d at 734. Interestingly, the court also allowed plaintiff to proceed on its second count, which alleged negligent malpractice. A patient may waive a battery claim and proceed on a theory of breach of the professional duty to obtain consent and informed consent, the court reasoned. Id. at 735.
144. 992 F.2d 1492 (10th Cir. 1993).
United States for negligence but not for intentional torts. The Tenth Circuit held that battery actions were barred but allowed the action in the particular case because of a specific immunity statute dealing with medical tort claims against the Veterans Administration. The case was remanded for trial. At trial, the court found that plaintiff had in fact consented to the operation and was competent to do so. On a second appeal, the plaintiff attempted to argue that he had preserved an alternate cause of action based upon negligent informed consent. In an unpublished opinion, the court held that the issue was clearly whether he consented or not.

Thus, the boundary line will be important for purposes of the Federal Tort Claims Act in the Tenth Circuit. Only true negligent informed consent facts are actionable, and true batteries are barred.

3. When Will Expert Testimony Be Relevant or Required in a Material Information State Like Oklahoma?

The lay-oriented standard has a very limited purpose and scope. It applies to the issue of what information is material. Expert testimony, for example, will usually be required to prove what the risks were, or the medical feasibility of alternatives, or the risks and the medical advantages of nontreatment. The rationale is that issues such as identifying the risks connected with a particular procedure or feasibility of alternate medical treatments are properly considered to be medical questions. However, the issue about what treatment risks or other similar information should be disclosed to a patient is essentially not a medical question. Hence, it ought not be controlled exclusively by medical judgment. In addition, expert medical testimony will usually be required to prove the causation and "injury" elements of plaintiff's case. Whether plaintiff's injury resulted from the materialization of a nondisclosed risk or whether the treatment procedure caused plaintiff harm rather some disease process, for example, are medical questions for which expert evidence is required. Indeed, expert testimony may be needed to establish that the defendant physician should have known about the information in question. At least one court has so held.

4. The Oklahoma Uniform Jury Instructions — Are There Problems?

The Oklahoma Uniform Civil Jury Instructions (OUJI-CIV) for informed consent appear to capture the essence of the Scott doctrine because they tell the jury that the physician must disclose to "his/her patient all relevant information." There

145. Id. at 1501.
147. See, e.g., Jozsa v. Hottenstein, 528 A.2d 606 (Pa. Super. Ct. 1987) (expert testimony is needed to establish the nature of the risk, but it is up to the trier of fact to determine whether a risk is material and whether plaintiff would have refused treatment if informed), appeal denied, 541 A.2d 746 (Pa. 1988). See ROZOVSKY, supra note 7, § 1.18, at 91.
148. See Reinhardt v. Colton, 337 N.W.2d 88, 96 (Minn. 1983) (expert testimony required to show that "it is accepted medical practice to know" of the risks).
149. The relevant informed consent instructions are Instructions 14.10-14.16. See OKLAHOMA JURY INSTRUCTIONS, supra note 98.
150. Instruction 14.14 states:
are a few significant language problems, however. The main one is that nowhere in Instruction 14.14 is there any reference to the key operative word "material." As noted above, the Scott opinion speaks of "material risks;" the court's syllabus speaks of "all relevant material information."

The comments to Instruction 14.14 raise the interesting point that "consent may not be required under the Good Samaritan Act." The Good Samaritan Act is indeed ambiguous on the point. It is helpful that the comments note this.

The instruction dealing with the exception to the disclosure duty is noteworthy,


151. Scott, 606 P.2d at 555 (emphasis added). On the other hand, it would help to assure that juries do not give an unduly narrow reading to the scope of the disclosure if the instruction had used the phrase "includes but is not limited to," instead of simply "includes" as the Scott opinion does when it states that the duty "shall include alternatives." Id. This is because the instruction has a specific reference to "shall include known risks of death or serious bodily harm." Under Scott, "material information" can be broader than information about the risks of death or serious bodily harm. It would help to be more specific that information which the jurors can consider to be material is not limited to information about serious bodily harm.


153. The instruction's comment provides specific reference to the relevant subsection of the Act. Perhaps the comment drafters had in mind that section 5(a)(3), which applies to operations or other forms of surgery, provides that there is immunity, except for gross negligence and wilful and wanton conduct, when civil actions are brought because of nonconsent. However, that same subsection excepts from the immunity it grants those situations where the "victim is an adult who is conscious and capable of giving or on refusing her consent" or if authorized persons can be reached in the case of a minor. Perhaps they mean to interpret the subsection as excepting from immunity only those (battery type) facts situations where no consent at all is obtained, by contrast to the negligence informed consent where consent to the treatment is obtained but material information is not disclosed. Thus, as so interpreted, a battery action is available against a Good Samaritan physician, but an informed consent negligence action is not available. On the other hand, the more inclusive section 5(a)(1) which provides immunity for all "emergency care" rendered in "good faith," "wherever required," makes no exception for lack of consent situations. Both that section and the surgery section make an exception for injuries resulting from "gross negligence or wilful or wanton wrongs," in "rendering the emergency care." One reading of this could be that physicians could be liable if they were grossly negligent in not obtaining such informed consent, from adults with capacity, as would be allowed by the time constraints of the emergency. Perhaps, however, the comment drafters read the gross negligence exceptions as referring to the treatment given, as opposed to the disclosure duty. Under that reading a Good Samaritan could be liable for gross negligence in the manner of treatment, etc., but was immune from liability for failure to obtain informed consent.

154. Instruction 14.15 states:

1. A physician has no duty to disclosure rights that are already known to the patient, or which are commonly understood by the average person to be involved in the proposed treatment or operation.
as mentioned above, because it interprets the text of Scott to make it consistent with the Canterbury limitations and disregards the example which the Scott court offered.

The instruction on causation combines what the Scott opinion set out as the separate elements of causation and injury. It concisely sets out the requirements of the subjective standard. In regard to the injury element, the instruction fails to incorporate the holding of Scott that the "risk must materialize" rule does not apply in a non-disclosure of alternatives to treatment situation.

As a whole, the instructions do an adequate job of communicating to the jury the main contours of the Scott doctrine. The omissions can easily be supplied by the trial courts.

IV. Recent Developments in Modern Informed Consent Doctrine: Expansions and Limitations on the Duty to Disclose

The Smith case is probably the most recent important fundamental development of Oklahoma's informed consent doctrine. The decisions of the last few years have tended to be at the fringes of the doctrine. Important cases in other jurisdictions, however, have significant implications for Oklahoma.

A. Restrictions on the Scope of Material Information

Arato v. Avedon, a 1993 California Supreme Court decision which cuts back on the scope of the information required to be disclosed in typical types of informed consent situations, is certain to become a landmark opinion. It has important

2. A physician has no duty of disclosure when [he/she] relies upon facts which would demonstrate that full disclosure would be detrimental to a patient's total care and best interest, or where such disclosure would alarm an emotionally upset or apprehensive patient so that the patient would not be able to weigh rationally the risks of refusing to undergo the recommended treatment or operation.

3. A physician has no duty to inform a patient of the risks of a medical procedure when an emergency exists and the patient is unconscious or otherwise incapable of determining for [himself/herself] whether treatment should be administered.

Oklahoma Jury Instructions, supra note 98, Instruction 14.15.

155. See supra text at note 98.

156. The instruction recognizes two types of privileged situations disclosures which (1) are detrimental to a patient's total care and best interest, or (2) would so emotionally upset him that he could not decide rationally. Only the second has the rationality limits. The borderline heart attack situation could be covered by the first category. The severely anxious patient is covered by the second.

157. Instruction 14.6 states:

Before a physician may be held liable for a breach of [his/her] duty to disclose, the patient must establish that [he/she] would have chosen no treatment or surgery or a different course of treatment or surgery had the alternatives and material risks of each been made known to [him/her]. In addition, the patient must have been injured by the undisclosed risk as a result of submitting to the treatment or surgery.

Oklahoma Jury Instructions, supra note 98, Instruction 14.6.

158. See supra text at note 124.

159. 858 P.2d 598 (Cal. 1993).
implications for material information states like Oklahoma, even though it was decided under California's hybrid disclosure standard.  

The important recent precedents which expand the scope of disclosure, such as the Moore case from the same California Supreme Court, deal with situations at the fringe of clinical practice, which occur infrequently. By contrast, the Arato case deals not only with a typical "tragic choice" scenario and the nuts and bolts of everyday clinical practice, but also with a series of problems which lie at the very heart of the value conflict between respect for autonomy and beneficence and the negligence law's attempt to accommodate that tension through the informed consent doctrine. It could prove to be an influential opinion in Oklahoma, because it deals with several key issues as to which there are as yet no Oklahoma precedents.

In Arato, the widow and children of Miklos Arato, a patient who died of pancreatic cancer, alleged that Arato's treating physicians failed to provide him material information necessary for his informed consent to undergo a proposed combination course of chemotherapy and radiation (FAM). They alleged that his doctors failed to inform him of his statistical life expectancy, even though he had indicated he wanted to be told the truth about his disease. More specific information about his chances for survival would have been material to him, they argued, both to help him decide whether to undergo the recommended cancer treatment and to assist him in getting his financial affairs in order. They claimed that the doctors had failed to adequately disclose the shortcomings of the proposed treatment and, thus, failed to obtain his informed consent.

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160. Cobbs v. Grant, 502 P.2d 1, 11 (Cal. 1972). Although the opinion in Arato takes the position that the type of information in issue should be tested by the professional standard under California's hybrid approach, most of Justice Arabian's opinion reasons as if the issue was whether the information should be treated as material without reference to what was the medical standard of disclosure. In other words, much of the opinion reads as if it were being decided under Oklahoma's broad subjective standard of what would be material information to the patient.

161. See generally Guido Calabresi & Peter Bobbit, Tragic Choices 17-28 (paper ed. 1978) (maintaining that many of the thorny issues of medical practice, such as life and death decisions like cancer patients deciding on whether to undergo chemotherapy, represent dilemmas created by insolvable conflicting values. Thus, they represent "tragic choices").

162. Arato's pancreatic cancer was discovered when doctors detected a tumor on the distal portion of his pancreas in the course of an operation to remove his failing kidney. He was referred to defendants where he checked the "tell me the truth" box on their routine questionnaire. It asked whether he "wanted to be told the truth about his condition," or whether he wanted his physician to "bear the burden" for him.

The oncologists recommended the FAM course of chemo/radiation therapy because it had shown promise in experimental trials with pancreatic cancer patients. The FAM treatment would, however, be long, difficult, and painful. Their justifications for recommending the treatment were that then recent studies had shown that FAM showed promise of extending pancreatic cancer patients' lives by several months and that the high statistical rate of mortality with pancreatic cancer was partly because it usually spreads throughout the body before it is discovered and is often inoperable. Arato's cancer, however, was discovered by chance during his kidney surgery, so it was operable "cleanly," and was in the "tail" section of the pancreas, where the mortality rate was lower than for cancers in the main body of that organ.
The Supreme Court of California reversed the court of appeals and affirmed a jury verdict for defendants which had found that the defendant-physicians "had disclosed to Mr. Arato all relevant information which would have enabled him to make an informed decision regarding the proposed treatment," even though they had not told him specific information about the statistical mortality of pancreatic cancer. The court held that the California uniform jury instructions, which directed the jury in general terms to determine whether "all relevant information" had been disclosed, adequately met the requirements of California law, without referring to specific disclosures such as statistical life expectancy.

The California Supreme Court rejected the idea that jury instructions should mandate specific disclosures such as statistical percentages of life expectancy which the court of appeals seemed to require. This was because an abstract formulation (in terms of "all material risks") allowed juries the flexibility to consider the overall medical context in which medical disclosures are made and the "common practicalities" of medical treatment.

Although the court reaffirmed the Cobbs requirement that all material information should be disclosed, it was impressed by the defendant's justification that the statistics would have had little predictive value in the plaintiff's individual case and that the physicians had told him as much about his condition and prognosis as he wanted to know. The court, thus, affirmed because the evidence was sufficient to support the jury's conclusion that the physicians had "reasonably disclosed . . . information material to" plaintiff's decision about treatment.

163. *Arato*, 858 P.2d at 603. *But see* Johnson v. Kokemoor, 545 N.W.2d 495 (Wis. 1995) (holding that, on the facts of the particular case, the trial court had properly admitted evidence of the statistical mortality and morbidity rate of a surgical procedure as material information to a reasonable person in making an intelligent and informed decision). *See* discussion *infra* text at notes 192-207.


165. *Arato*, 858 P.2d at 606. The oncologists told Arato about the side effects of their proposed therapy, that it was unproven and that he had the option of foregoing treatment. They told him that most cancer patients die, that he was at great risk for his cancer to recur if he chose the therapy, and that he would die if it did recur. Arato's treating physicians and the operating surgeon all admitted that they did not tell Arato or his wife that pancreatic cancer has a high mortality rate; only 5-10 percent live five years. *Id.* at 602. Arato chose the therapy; the results looked good at first, but his cancer recurred. His doctors then stopped that treatment and he died within a few months.

The doctors justified not telling him the statistical information by arguing that they had told him sufficient information to allow him to make an informed decision about having therapy, and that they told him as much about his condition and prognosis as he actually wanted to know. They emphasized that all statistics have little predictive value in individual cases; that his case looked more hopeful that the norm although they could not predict how long he had to live; and that it would have been medically inappropriate to disclose specific rates to him because he exhibited great anxiety, and they wanted not to deprive him of any hope of cure as disclosure of high mortality rates does to many cancer patients. They testified that although Arato had indicated that he wanted the truth when he signed their form, he in fact gave many signs that he did not want to know his life expectancy.

166. *Arato*, 858 P.2d at 606. The court also held that the trial court properly rejected plaintiff's suggested instructions and that expert evidence about the medical standard of care regarding disclosure was admitted on the issue of whether the statistical data was material information. *Id.* at 609-10.

167. *Id.* at 607. For an interesting and helpful discussion of the implications of *Arato* by Justice Arabian, author of the California Supreme Court's majority opinion, see Arabian, *supra* note 130.
The court rejected out of hand, however, the plaintiff's argument that the doctors had a duty to disclose the information so that plaintiff could have attended to his will and financial affairs and have avoided the adverse impact on his business that his death caused. The physician's fiduciary duty, as reflected in informed consent law, said the court, is to disclose information to enable the patient to make treatment decisions. It is not a duty to communicate information material to nonmedical interests. The doctrine of informed consent has a therapeutic focus and an inherent therapeutic limitation. The court did not attempt to distinguish its Moore decision, which held that information about a physician's potential conflict of interest could be material information under the doctrine of informed consent. Rather, it quoted from Moore: "a physician is not the patient's financial adviser."169

B. Expansion of the Informed Consent Doctrine: Portents for the Future in Material Information Jurisdictions?

A well known California Supreme Court case and three decisions in other states are important to the question of what the growth potential of the Oklahoma informed consent doctrine may be.

1. Collateral Information Disclosure About Physician's Capacity or Conduct Which Magnifies the Risk

Until very recently, the informed consent cases to which the courts extended the doctrine all involved information about the medical aspects of the treatment options available to the patient or the medical consequences of foregoing medical treatment. A problem arises when the broad language of a doctrine like Oklahoma's speaks of a doctor's obligation to disclose information that would be likely to affect a patient's treatment decisions. Does this mean that the doctrine extends to information that is not about the medical aspects of treatment interventions?170 Four recent cases answer affirmatively. All have in common that they impose liability on the physician for failing to tell his patient information that affects the physician's capacity to carry out his fiduciary responsibilities or professional duties.171

168. Arato, 858 P.2d at 608.

169. Id. (quoting Moore v. Regents of the Univ. of Cal., 793 P.2d 479 (Cal. 1990), cert. denied, 499 U.S. 936 (1991)).

170. See Daar, Informed Consent, supra note 7, at 187 (suggesting that a few recent informed cases dealing with disclosure of information "unrelated to the patient's medical care" may "signal a new era in informed consent"). For an excellent analysis of the relationship between regulatory measures and informed consent liability as control mechanisms for dealing with physician-specific conflict of interest and capacity concerns, see Bobinski, Autonomy, supra note 7. Professor Bobinski favors expansion of informed consent liability for information about health care providers, arguing that required disclosure of personal information about capacity may unduly infringe a provider's legitimate privacy rights. Id. at 284.

171. Expansion of informed consent disclosure requirement may be encouraged by the recent movement toward the development of provider-specific information, such as surgical success rates. Bobinski, Autonomy, supra note 7, at 295. See Douglas Sharratt, Note, Provider-Specific Quality-of-Care Data: A Proposal for Limited Mandatory Disclosure, 58 BROOK. L. REV. 85, 95-104 (1992); Twerski & Cohen, New Era, supra note 7, at 6-13.
a) Conflict of Interest Information

The first significant expansion of the informed consent doctrine to information not related to the medical aspects of treatment options came in the landmark case of Moore v. Regents of the University of California. The Supreme Court of California decision is most noted for its rejection of the claim that a medical research subject has a property interest in his body tissues which can thereby become the subject of a conversion claim. Also significant, however, is the court's sweeping language regarding informed consent. Specifically, one of the court's justifications for rejecting the Moore plaintiff's "property in his body" arguments was its willingness to expand California informed consent law. The court held that the plaintiff would have a cause of action under either: (1) the doctrine of informed consent or (2) breach of a fiduciary duty of disclosure arising from the doctor-patient relationship.

John Moore was diagnosed with hairy-cell leukemia. Shortly thereafter, he began undergoing treatment for his disease at the UCLA Medical Center under the care of Dr. David Golde. Initially, Dr. Golde tested a number of Moore's body tissues to confirm the diagnosis of hairy-cell leukemia. Soon after these tests were run, Moore alleged, Golde discovered that his patient's blood and blood products were sufficiently unusual to be commercially valuable in connection with Golde's scientific research. During the course of his treatment of Moore, Golde convinced Moore that his spleen needed to be surgically removed in order to slow the progression of his life-threatening disease. On this basis, Moore consented to the surgery.

Moore further alleged that before performing his splenectomy, Golde and a codefendant researcher had made arrangements to conduct research on his spleen following its removal. He was never told of these plans.

Following the surgery, Moore sporadically traveled from his home in Seattle, Washington to the UCLA Medical Center for scheduled appointments with Golde. He was told these visits were necessary to his continued treatment. However, Moore alleged that Golde continued to take samples of Moore's bodily tissues for the purpose of conducting research on his cells.

About three years after first seeing Moore, Golde's scientific research efforts bore fruit. He derived a cell line from Moore's tissues and ultimately obtained a patent on that cell line. As an employee of the UCLA Medical Center, he was contractually bound to assign his patent rights to the Regents of the University of California. However, he was entitled to share in the profits and royalties arising from those patent rights. Golde ultimately negotiated agreements for the commercial development of his patented cell lines in exchange for financial compensation. When Moore discovered these facts, he filed a lawsuit against Golde, the regents, and other defendants, alleging...
fourteen causes of action which included conversion, lack of informed consent, and breach of fiduciary duty.\textsuperscript{176}

The Moore court emphatically rejected the plaintiff's conversion theory, noting that such a claim "implicates policy concerns far removed from the traditional two-party ownership disputes in which the law of conversion arose."\textsuperscript{177} However, the court embraced the informed consent theory with strikingly broad language.

[A] physician who treats a patient in whom he also has a research interest has potentially conflicting loyalties. This is because medical treatment decisions are made on the basis of proportionality — weighing the benefits to the patient against the risks to the patient. . . . A physician who adds his own research interests to this balance may be tempted to order a scientifically useful procedure or test that offers marginal, or no, benefits to the patient. The possibility that an interest extraneous to the patient's health has affected the physician's judgment is something that a reasonable patient would want to know in deciding whether to consent to a proposed course of treatment. It is material to the patient's decision and, thus, a prerequisite to informed consent.\textsuperscript{178}

Thus, the opinion invites expansion of the informed consent doctrine to include other types of information which impair a physician's ability to perform his professional responsibilities.

One practical problem with the Moore decision is determining what measure of damages would be appropriate to vindicate the plaintiff's harm. The majority opinion nowhere definitively outlines what the plaintiff's damages should be if he were to succeed on his informed consent or breach of fiduciary duty theories. The Moore case never was retried, but reportedly was settled for a "token amount," based on Moore's not having been adequately informed.\textsuperscript{179}

We do not, therefore, know what damages a plaintiff can recover under a Moore type collateral information informed consent case. The plaintiff in Moore unquestionably wanted to proceed on his original conversion theory in order to share in the commercial profits to be derived from the cell line created from his unique genes. It is highly likely that Moore would not have succeeded in that desire on retrial under either the informed consent or the breach of fiduciary obligation theory. Had the case been retried, perhaps the court would have tailored Moore's informed consent theory damages by reconceptualizing his "injury" as damage to his right to be an informed decision maker. Moore's damages, thus, would be measured by the value of losing his right to make a decision in partnership with a physician unencumbered by the temptations of self-interest. The court could then tailor damages to compensate for the

\textsuperscript{176} Moore, 793 P.2d at 483 n.4.
\textsuperscript{177} Id. at 487.
\textsuperscript{178} Id. at 484 (emphasis added); see Bobinski, Autonomy, supra note 7, at 302 n.37 (stressing that the scope of disclosure under Moore is nevertheless limited) ("[The] court imposes disclosure requirements where economic interests could affect professional judgment, implying that not all economic interests would do so.").
\textsuperscript{179} Daar, Informed Consent, supra note 7, at 198 n.31.
doctor's interference with those rights, which would be far removed from participating in the potential profits and much less than is normal when the informed consent theory is used as the key to recovery for the significant iatrogenic physical harm caused by nonnegligently performed medical intervention, as in the ordinary informed consent case. One does not know what the "token" amount of the Moore settlement was, but Moore's awardable damages, when measured by this lost decision-making right concept would certainly be a mere token of what he had originally in mind under his property right theory.\textsuperscript{180}

\textit{b) Capacity-Related Information — The HIV Positive Physician}

One of the boundary issues in informed consent law is fraught with important and conflicting social and political policies: the AIDS crisis and its impact on health care professionals. If any hypothetical is likely to strike a disorienting note in people's minds and emotions, it is this question: Would the fact that your surgeon is HIV seropositive be material information with respect to your decision to undergo invasive surgery? Should such information be material for informed consent liability purposes?

A 1993 decision from the highest court in Maryland, a state with a broad material information standard like Oklahoma's, ruled that information about a surgeon's HIV status could be "material" information for informed consent purposes. In \textit{Faya v. Almaraz},\textsuperscript{181} patients of an HIV positive surgeon who did not disclose his seropositivity before operating on them sought recovery for their fear of contracting the AIDS virus under an informed consent theory. The patients tested negative for the virus but, nonetheless, claimed a host of psychological ills after discovering their doctor was HIV positive.

The \textit{Faya} court ruled that the plaintiffs' allegations that the surgeon had a duty to disclose his HIV status could survive a motion to dismiss.\textsuperscript{182} Specifically, the court agreed that such information would be material, not because the mere performance of surgery by an HIV-infected doctor posed a real threat of transmission, but because such a surgeon could accidently puncture his protective garments, thereby inadvertent-

\textsuperscript{180} Moore's compensable "injury" under this analysis is his loss of his right to decide about treatment. Analyzing the remedy this way in situations where the nondisclosure is information unrelated to the treatment or nontreatment risks is analogous to the way some states, but not Oklahoma, analyze recovery for damages in so called "lost chance" cases where the patient has difficulty in proving that a physician's negligent conduct, such as misdiagnosis, was a proximate cause of his patient's death. See, \textit{e.g.}, Herskovitz v. Group Health Coop., 664 P.2d 474, 486 (Wash. 1983) (Pearson, J., concurring) (the injury being compensated is the reduced chance of survival) (citing Joseph H. King, \textit{Causation Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences}, 90 \textit{Yale L.J.} 1353, 1363-64 (1981)).

\textsuperscript{181} 620 A.2d 327 (Md. 1993).

\textsuperscript{182} \textit{Id.} at 334. \textit{But see K.A.C. v. Benson, 527 N.W.2d 553, 559, 561 (Minn. 1995)} (physician examined patient without revealing he was HIV positive; court did not reach informed consent allegation because the court held that fear of AIDS was not compensable damage; physician conduct was not a battery). See generally \textit{Daar, Informed Consent, supra} note 7, at 201-08; Phillip L. McIntosh, \textit{When the Surgeon Has HIV: What to Tell Patients About the Risk of Exposure and the Risk of Transmission}, 44 \textit{U. Kan. L. Rev.} 315 (1996).
ly commingling his blood with the patient's blood. However, the court noted that the plaintiffs' damages might be limited at trial given the fact that they had tested negative more than one year after the procedures took place. Damages might properly be limited to the anxiety the plaintiffs suffered between the time they learned of the doctor's HIV status and the time they received their own test results.

An intermediate appellate court in New Jersey has indirectly indicated that it might be receptive to informed consent cases brought by plaintiffs against HIV-infected physicians. In *Estate of Behringer v. Medical Center*, a doctor who contracted AIDS sued a hospital for, among other things, conditioning his privileges to practice at the hospital on the disclosure of his HIV positive status to patients. The court found the hospital's actions in this regard were proper, but more importantly, it buttressed this holding by referencing the informed consent doctrine and indicated in dicta that patients would have a right to be informed of their physician's HIV-positive status. It is, nonetheless, a significant extension to move from the holding that a hospital may require its surgeons to disclose their seropositivity to a holding that the informed consent law of a state requires such disclosure.

c) Capacity Related Information — The Substance Impaired Physician

A third significant extension came in 1991 from an intermediate court of appeals in Louisiana in the case of *Hidding v. Williams*. Paul Hidding, a patient of Dr. Williams, an orthopedic surgeon, brought suit against him based on lack of informed consent after he lost bowel and bladder control following a laminectomy. The patient claimed that Dr. Hidding failed to disclose: (1) the known risk of nerve damage connected with the operation and (2) that he was suffering from alcohol abuse at the time of surgery. The court held that the patient proved an informed consent case as to both risks. It approved the trial court's finding that Dr. Williams' prolonged alcohol abuse was a "material risk" to the patient of "the increased potential for injury during surgery" and that, had that risk been disclosed, Hidding would have chosen "another course of treatment." Arguably, the court meant that Hidding would have chosen another surgeon, not that he would have chosen to forego the operation to repair his spinal problem.

d) Capacity Related Information — The Risks of a Physician's Inexperience

A fourth significant extension came in 1995, when the Supreme Court of Wisconsin interpreted that state's statutory informed consent requirement to extend to information

184. The court took judicial notice of the fact that the vast majority of HIV-infected people will test positive for the virus within six months of exposure. *Id.* at 337.
185. *Id.*
188. *Id.* at 1278-79.
190. *Id.* at 1195-96.
191. *Id.* at 1198.
about the risks created by a defendant's inexperience in performing the type of operation he recommended. In *Johnson v. Kokemoor*, the plaintiff suffered "incomplete paraplegia" as result of an operation to "clip" a basal aneurysm. She did not allege that the defendant was negligent in performing the operation, but claimed her consent was uninformed because the defendant failed to tell her about the risks of his lack of experience in operating on her particular type of aneurysm and failed to advise her that an operation by more experienced surgeons was one of her alternatives. Both parties appealed from a judgment for the plaintiff. The court stated that it was a question of first impression whether physician specific evidence, as opposed to medical treatment information, may form the basis of an informed consent action. In an opinion which treated as a question of first impression the issue of whether physician specific evidence, as opposed to medical treatment information, may form the basis of an informed consent action, the Supreme Court reversed the intermediate appeals court and remanded the case. It held that, on the facts of that particular case, the trial court had properly admitted evidence of (1) the defendant's limited experience in operating on the plaintiff's type of aneurysm, (2) statistical information about the mortality and morbidity rates of that type of operation when performed by inexperienced surgeons, like the defendant, and (3) the existence of the alternative that she could be operated upon by more experienced surgeons with better facilities.

In a unanimous opinion by Justice Shirley Abrahamson, the court's rationale opened the door for a wide range of information about a health care provider's capacity to be

192. Wis. Stat. § 448.30 (1988) (requiring information about "all elements, viable medical modes of treatment and about the benefits and risks attending these treatments").
193. 545 N.W.2d 495, 501 (Wis. 1995).
194. As a result of the operation, plaintiff was unable to walk or to control her bowel and bladder and had impaired vision, speech and upper body coordination. Id. at 498-99.
195. Id. at 499-500.
196. Id. at 498.
197. Id. The intermediate court of appeals had remanded the case for new trial, holding that the trial court had erroneously admitted evidence about the defendant's failure to refer the plaintiff to more experienced surgeons because that failure was irrelevant to the informed consent claim and because such evidence would allow a jury to conclude that defendant was negligent simply because he was less negligent than other physicians when his negligence, other than in regard to informed consent, was not in issue. Id. at 498.
198. In fact, the defendant had relatively limited experience with aneurism surgery. He had performed thirty aneurysm surgeries during residency, but all involved anterior circulation aneurysms, which are significantly less complex than posterior circulation aneurysms like the plaintiff's. After residency he had performed only six aneurysm surgeries, none of which were large basilar bifurcation aneurysms like the plaintiff's. Id. at 499.
199. The plaintiff's evidence was that defendant told her that her surgery carried a two percent risk of death or serious harm, was less risky than the angiogram needed to prepare for it, and compared its risks to those of tonsillectomies, appendectomies and gall bladders. The plaintiff presented evidence that the morbidity and mortality rate for basilar bifurcation aneurysms, as reported in the literature, was 15%, but was 10.7% when performed by very experienced surgeons and, when performed by those with little experience like the plaintiff, would be between 20%-30%. Id. at 506.
200. The court reasoned that evidence about the defendant's failure to refer the patient elsewhere was relevant to the issue of available alternate treatment. Id. at 508.
considered as material information, even though the court took pains to restrict its holding to the facts of the case and even though one of the factors that the court relied upon was that the defendant had responded in an evasive manner to the plaintiff's specific questions about his experience, suggesting misrepresentation as an alternate theory of liability.

The court stated that the standard for disclosure in Wisconsin was the objective one of "what a reasonable person in the patient's position would want to know." The disclosure obligation extends to "such information" that a "reasonable person in plaintiff's position . . . would have considered material in making an intelligent and informed decision about surgery." Defendant urged the court to adopt a "bright line" rule restricting the informed consent doctrine to disclosures about the medical aspects of treatment alternatives. For example, defendant had argued that admission of evidence about his surgical experience unfairly prejudiced him because it diverted the jury's attention from deciding the appropriate issue of about how much information about the patient's treatment alternatives needed to be disclosed to the improper question of who should perform the treatment. Judge Abrahamson responded that a "bright line" approach which limited the scope of disclosure, as a matter of law, to "risks associated with particular 'treatments' rather than risks associated with particular physicians" would be inconsistent with Wisconsin's prudent patient standard. The scope of the informed consent doctrine should be "fact driven and context specific, best resolved on a case by case basis" and flexible enough to extend on a limited basis to physician specific information. Thus, Judge Abrahamson reasoned, on the facts of this case, information about defendant's relative lack of experience and risk ratio was material information because, with it, the reasonable person in plaintiff's position "would have been better able to make an informed and intelligent decision" about surgery.

e) Collateral Information Disclosure: Other Potential "Growth Areas"

The foregoing expansions of the informed consent doctrine raise interesting questions regarding what physicians may be forced to disclose in the future. If the potential impact of alcoholism on a physician's ability to practice medicine without negligence, or if the risks of negligence that flow from a physician's inexperience, is

201. Id. at 498, 506-08. "We conclude that all three items of evidence were material to the issue of informed consent in this case." Id. at 498. For example, the court said, "We caution . . . that our decision will not always require physicians to give patients comparative risk evidence in statistical terms to obtain informed consent. Rather, we hold that evidence of the morbidity and mortality outcomes of different physicians was admissible under the circumstances of this case." Id. at 507.

202. The plaintiff introduced evidence that the defendant overstated the urgency of her need for surgery as well as his experience with the particular aneurysm involved. She testified that when plaintiff inquired about defendant's experience with the surgery, she was facing, he replied, "several times," and when pressed to what he meant, he said "dozens" and "lots of time." Id. at 499.

203. Id. at 505.
204. Id.
205. Id. at 504.
206. Id. at 508.
207. Id. at 505, 506-08.
to be considered material to a patient's decision whether or not to accept treatment, is not a history of negligent malpractice the next logical extension, whatever may be the policy implication of that extension? For example, might a court deem it to be material information whether a doctor has ever been sued for malpractice? Would the requirement be limited to disclosing only those lawsuits which resulted in plaintiffs' verdicts or only the cases of successful malpractice claims involving the procedure or other type of medical intervention which the doctor intends to perform on his current patient?

Another source for fruitful speculation about "growth areas" for informed consent, once Moore has opened the lid to Pandora's box, might be the impact which the new era of managed care is to have on the doctor/patient relationship. For example, much has been written about the potential impact of DRGs on physician behavior. Still another may be the area of "death and dying" law, where the expansion of a patient's legal right to forego life-sustaining medical treatment may lead to claims.

The horizons of current informed consent doctrine appear to provide a sufficient analytical basis to make these questions more real than fanciful. If courts continue to expand the scope of information relevant to the disclosure obligations of health practitioners, some lines inevitably must be drawn. However, it is clear that the outer boundaries of the informed consent doctrine have yet to be reached.

2. Collateral Information Disclosure — Is It in Oklahoma's Future?

Obviously, the logic of the language in the Oklahoma precedents makes Oklahoma a prime candidate for the foregoing expansions of liability under the informed consent doctrine. However, the court has shown no indication that it is willing, or even thinking, of straying from the accepted informed consent boundary of medical information dealing with treatment options. Moreover, there is an implicit indication

208. DRG is an acronym for "diagnosis related groups." Here, the term is used to refer to the prospective payment method utilized by the Medicare system. BARRY R. FURROW ET AL., HEALTH LAW § 13-10, at 574-76 (West Hornbook Series student ed., 1995).

209. See, e.g., Wendy K. Mariner, Prospective Payment for Hospital Services: Social Responsibility and the Limit of Legal Standards, 17 CUMB. L. REV. 379, 399 (1987) ("It is possible, indeed likely, that there will be at least some lawsuits brought alleging injury as a result of improper care resulting from the limits of DRG payments. Such cases could involve . . . failure to obtain informed consent by failing to disclose alternatives and risks of low cost therapy."); Francis H. Miller, Denial of Health Care and Informed Consent in English and American Law, 18 AM. J.L. & MED. 37 (1992) ("The Article contends that as rationing becomes more explicit, the doctrine of informed consent will come under increased pressure. The Article suggests that courts and legislatures consider imposing a legal obligation on physicians to inform their patients when potentially effective treatment is to be withheld for economic or non-clinical reasons."); Marshall B. Kapp, Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups, LAW MED. & HEALTH CARE, Dec. 1984, at 15. For example, would the cost implications of a physician's recommendation of surgery as opposed to a medical alternative ever be sufficiently "material" to be "material" under Oklahoma's informed consent doctrine?

to the contrary in an interesting Oklahoma case in which the Oklahoma Supreme Court, in effect, said that it would not require doctors to act as if they were lawyers.

In *Spencer v. Seikel*, 211 Paula Spencer sought prenatal care from Dr. Seikel during her third pregnancy. When her fetus was twenty-three to twenty-four weeks old, Dr. Seikel discovered and told plaintiff that the fetus was suffering from hydrocephalus, a condition that usually produces severe brain retardation. She subsequently gave birth to a son who was born with virtually no brain and was blind, deaf, and in a permanent vegetative state. The mother and child brought actions against Dr. Seikel. These were essentially wrongful birth and wrongful life claims with an unusual twist. Plaintiff claimed that Dr. Seikel failed to disclose material information to her, namely that abortion was a medical treatment alternative to continued pregnancy, which she would have chosen if adequately informed. Dr. Seikel’s defense was that the fetus was viable at the relevant time, and, thus, he had no duty to inform her of an illegal alternative, since abortion was not legally available under Oklahoma law which prohibited abortion of a viable fetus unless the mother’s life or health was threatened. Plaintiff argued that Dr. Seikel should, nevertheless, have advised her that abortion would have been legally available in other states at the time. The court of appeals affirmed a jury verdict for defendant 212 The Oklahoma Supreme Court agreed on two grounds: (1) the abortion option was known to plaintiff and (2) a physician has no duty to disclose that an alternative, not legally available in the state where he practices, was legally available elsewhere 213

It remains for the future to reveal whether the Oklahoma Supreme Court will follow the logic of its language and embrace an expansive informed consent duty to disclose collateral information in the style of the Wisconsin court in *Kokemoor* or will be more inclined to follow the California lead in *Arato* to keep the doctrine within more traditional and manageable bounds. It will be interesting to observe which turn it takes. Given the strength of Oklahoma’s strong autonomy-centered rationale, the court ought to recognize that, at least in some cases, withholding of information which is collateral to the medical aspects of a proposed treatment regimen ought properly be considered adequate to sustain a damages action for negligent failure to obtain informed consent. The court ought to be circumspect in taking that path, however. Like the *Kokemoor* court, it ought to reject a "bright line" rule of total exclusion, but ought to be even more careful than simple acceptance of case-by-case jury decision making about what is material information in those cases that lie beyond the boundary line of the medical aspects of treatment options. Perhaps a "bright line" approach which draws lines of inclusion, rather than of total exclusion, is the proper solution. That could be accomplished by treating questions about the scope of disclosure responsibility in collateral information situations as being an issue of duty for the courts rather than as questions of fact for the jury. There ought to be room within the Oklahoma doctrine for conflict of interest cases like *Moore* and for situations involving significant physical impairments such as substance abuse. On the other

211. 742 P.2d 1126 (Okla 1987).
212. Id. at 1128.
213. Id. at 1129.

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hand, information about the level of one's experience, where there are no facts suggesting misrepresentation concerns as there were in the facts of *Kokemoor*, are more difficult to justify, even if one grants the point that a reasonable patient would want to know such information in making his decision. Drawing the lines among such cases remains the problem, but total rejection of significantly material collateral information is not the solution.

V. Conclusion

The protection and vindication of patients' rights of autonomy lie at the heart of the informed consent doctrine. An individual requiring medical intervention does not thereby lose her right to direct and control what shall be done to her, even though it is likely that she lacks the skill and training of a medical professional. However, the doctrine creates tension between two competing values: (1) the ethical value of patient autonomy and (2) the medical ethic of beneficence. The struggle to balance these competing interests is at the essence of informed consent law. Oklahoma's doctrine is instructive in this regard. Oklahoma's broad protection of autonomy is evidenced by subjective standards with respect to both disclosure and causation. Yet, its description of informed consent defenses threatens to engulf that protection.

Hopefully, a workable balance of the competing values will emerge as the Oklahoma courts continue to deal with the scope of material information and the affirmative defenses in the future.