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INFORMED CONSENT IN OKLAHOMA: A SEARCH FOR REASONABLENESS AND PREDICTABILITY IN THE AFTERMATH OF SCOTT V. BRADFORD

ERIC S. FISHER*

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation on a patient without his patient's consent commits assault . . . .

— Judge Benjamin Cardozo
Schloendorff v. Society of New York Hospital

I. Introduction

Since 1914 American jurisprudence has followed Justice Cardozo's lead, developing the legal axiom that informed consent in the medical context consists of "[a] person's agreement to allow something to happen (such as surgery) that is based on a full disclosure of facts needed to make the decision intelligently." Nevertheless, physicians, lawyers, courts, and scholars have struggled for nearly eighty years trying to elucidate the standard for determining when a patient's consent is truly "informed." Indeed, numerous interpretations of the informed consent standard have developed, and it is not surprising that in the last thirty years

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1. 105 N.E. 92, 93 (N.Y. 1914).
3. Although courts have recognized the requirement of obtaining a patient's consent since close to the turn of the century, see, e.g., Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914), it was not until the late 1950s that courts began to require that the consent be "informed," see, e.g., Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 317 P.2d 170, 180 (Cal. Ct. App. 1957) (holding that disclosure and consent must be informed to be effective). See generally Alan Meisel, The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent, 56 Neb. L. REV. 51 (1977) (discussing the historical development of informed consent in the medical context).

informed consent has generated more scholarly articles, books, guidelines, debate, and confusion than any other medicolegal issue.\(^5\) Furthermore, informed consent has created much antagonism between physicians and patients' lawyers because the informed consent issue is frequently incorporated into medical negligence lawsuits.\(^6\)

Sixty-five years after Judge Cardozo authored the New York Court of Appeals' opinion in \textit{Schloendornf}, the Supreme Court of Oklahoma in \textit{Scott v. Bradford} created a standard for informed consent that has proved illogical in its reasoning and unworkable in its application. The \textit{Scott} court held that a physician must inform a patient of a treatment's risks to the extent that each individual, not necessarily a reasonable individual, would have needed to know before consenting.\(^7\) This extreme standard places an unreasonable burden on the doctor who, in order to avoid liability, must inform the patient of every possible risk of the proposed procedure.\(^8\)

In a recent edition of the \textit{Oklahoma Law Review}, Professor William J. McNichols presented an article entitled "Informed Consent Liability in a 'Material Information' Jurisdiction: What Does the Future Portend?" Professor McNichols provided a detailed historical review of the informed consent doctrine, examined the "Material Information" standard set forth in the \textit{Scott} decision, compared the Oklahoma standard to other national trends in informed consent, and discussed the complexities of informed consent litigation, especially lawsuits arising in "jurisdictions with a

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6. The author uses the term "physician" for simplicity, but most health care providers that perform medical treatments or surgical treatments are subject to providing their patients informed consent.

7. See Gary L. Bland, \textit{The Doctrine of Lack of Consent and Lack of Informed Consent in Medical Procedures in Louisiana}, 45 L.A. L. Rev. 1 (1985). This article discusses the role informed consent plays in most typical medical negligence cases and how plaintiff's lawyers are increasingly including informed consent claims as a matter of course when filing a medical negligence action. The author opines that: [a] patient who has suffered an undesired result of treatment and is unable to prove that his doctor was negligent can also seek relief on a different basis of liability — lack of informed consent. An allegation of a lack of informed consent will not only fortify a weak case of medical negligence, it will also guarantee the plaintiff that his case will reach the jury. As a result, it is hardly surprising that the percentage of malpractice suits alleging a lack of informed consent is increasing.

\textit{Id.} at 1-2 (footnotes omitted).


9. \textit{See id.} at 558. The Supreme Court of Oklahoma adopted the subjective standard by holding that:

\begin{quote}
[T]he scope of a physician's communications must be measured by his patient's need to know enough to enable him to make an intelligent choice. In other words, full disclosure of all material risks incident to treatment must be made. There is no bright line separating the material from the immaterial; it is a question of fact. A risk is material if it would be likely to affect the patient's decision. When non-disclosure of a particular risk is open to debate, the issue is for the finder of facts.
\end{quote}

\textit{Id.}

10. \textit{See id.}

liberal 'material information' disclosure standard." While Professor McNichols' article provides perhaps the most current and in depth resource for practitioners faced with informed consent issues, the article concludes by stressing the need for a "workable balance" between the "two competing values: (1) the ethical value of patient autonomy and (2) the medical ethic of beneficence," which are the natural byproducts of informed consent law. This article seeks to strike some balance between these concerns by suggesting a legislative response modeled after the statutory framework established by the Texas legislature.

The jurisprudential development of informed consent in Texas followed a more reasoned and moderate path than in Oklahoma when the Texas legislature in 1977 enacted the Medical Liability and Insurance Improvement Act establishing, inter alia, a Disclosure Panel responsible for placing all medical treatments and surgical procedures on two disclosure lists. The first list (List A) includes those procedures for which full disclosure is required, whereas the second list (List B) includes those procedures requiring no disclosure. More importantly, the Disclosure Panel "establish[es] the degree of disclosure required and the form in which the disclosure will be made." The Texas standard of informed consent eliminates the "guesswork among physicians while providing uniformity and predictability to the otherwise unpredictable nature of disclosure." The Oklahoma standard as defined by the Supreme Court of Oklahoma in Scott, on the other hand, relies on the patient's "hindsight and 20/20 vision" which might be clouded by self-interest. Responding to this concern about the lenient Oklahoma standard, Justice Doolin of the Supreme Court of Oklahoma gave a less than comforting response in Scott, stating that "[a]lthough it may be said this approach places a physician at the mercy of a patient's hindsight, a careful practitioner can always protect himself by insuring that he has adequately informed each patient he treats. If he does not breach this duty, a causation problem will not arise." Notwithstanding Justice Doolin's duty of care prescription, even the most careful physician faces an unreasonable burden of informing patients in Oklahoma.

12. Id. at 712.
13. Id. at 753.
15. See TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 6.03(c), 6.04(a) (West Supp. 1997).
16. See id. § 6.04(a), (b).
17. Id. § 6.04(b).
19. See id.; see, e.g., Reikes v. Martin, 471 So. 2d 385, 391 (Miss. 1985) (physician defendant placed at the mercy of a disgruntled patient's "bitterness and disillusionment").
This article proposes a practical approach to revising Oklahoma's medical informed consent standard, using the Texas Medical Liability and Insurance Improvement Act as a template upon which the Oklahoma legislature can pattern legislation to establish an Oklahoma standard that is equipped between the health care provider's duties and the patient's rights. This article suggests an approach to informed consent in Oklahoma that is achievable without compromising patients' rights or unfairly burdening physicians.

Part II of this article provides a historical perspective on the doctrine of informed consent in the medical context. Part III presents an overview of the development and current status of the Texas standard for informed consent. Part IV traces Oklahoma's treatment and mistreatment of informed consent from its inception to its current standard. Part V suggests a framework for informed consent legislation in Oklahoma based on modifying the Texas Medical Liability and Insurance Improvement Act. Finally, Part VI offers some observations regarding the future of informed consent.

II. Historical Development of Informed Consent

A. The Battery Theory

The concept of informed consent originated in several cases at the beginning of this century with patients suing their physicians on a battery theory, claiming they never consented to the physical touching involved with a procedure. For example, in 1906 the Supreme Court of Illinois in the case of Pratt v. Davis heard Ms. Davis claiming that she "had placed herself under the care of appellant, and that he (Dr. Pratt), without her consent or the consent of anyone authorized to act for her . . . removed her uterus." In affirming the judgment in favor of Ms. Davis, the court held that:

Ordinarily, where the patient is in full possession of all his mental faculties and in such physical health as to be able to consult about his condition without the consultation itself being fraught with dangerous consequences to the patient's health, and when no emergency exists making it impracticable to confer with him, it is manifest that his consent should be a prerequisite to a surgical operation. [Otherwise, we must hold the] act to have been a trespass to the person.

Eight years after Pratt, then-Judge Benjamin Cardozo wrote the majority

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21. See, e.g., Mohr v. Williams, 104 N.W. 12, 16 (Minn. 1905) (holding that plaintiff was entitled to receive damages for procedure performed on her without her consent); Rolater v. Strain, 137 P. 96, 99 (Okla. 1913) (holding that physician's removal of a bone when patient expressly instructed against the procedure was a valid cause of action under the theory of battery).
22. 79 N.E. 362 (III. 1905).
23. Id. at 363.
24. Id. at 364.
25. Benjamin Nathan Cardozo served on the New York Court of Appeals from 1914 to 1932. He was confirmed as a United States Supreme Court Justice in 1932, but served as and was referred to as
opinion in the seminal case of Schloendorff v. Society of New York Hospital,²⁶ firmly establishing the standard which a majority of jurisdictions would follow in medical informed consent negligence cases for the next half century.²⁷ Judge Cardozo articulated the standard that every person is vested with a right to control what shall be done to his own body.²⁸ Therefore, unless extenuating circumstances exist, such as an emergency, or the patient is otherwise unable to provide consent to a procedure, the physician must refrain from treatment until the patient consents. Cardozo explained this premise:

In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained. The fact that the wrong complained of here is trespass, rather than negligence, distinguishes this case from most of the cases that have preceded it. Relatively to this transaction, the plaintiff was a stranger. She had never consented to become a patient for any purpose other than an examination under ether. She had never waived the right to recover damages for any wrong resulting from this operation, for she had forbidden the operation.²⁹

B. Development of "Informed" Consent

For nearly half a century, Schloendorff and its battery theory held true as the standard for failure to obtain a patient's consent before a procedure. However, in 1957, the California Court of Appeals recast the informed consent standard. In Salgo v. Leland Stanford, Jr. University Board of Trustees,³⁰ the California court addressed the issue of whether a physician must inform a patient of risks inherent to a procedure before the patient could truly consent to the treatment.

The plaintiff in Salgo entered a hospital complaining of leg cramps, and the defendant physicians recommended a translumbar aortography x-ray to localize the...
circulatory problem.\textsuperscript{31} Complications developed during the procedure, and the patient was permanently paralyzed.\textsuperscript{32} The \textit{Salgo} court held that the physician must not only obtain the patient's consent to the procedure, but the consent must be given after adequately informing the patient.\textsuperscript{33} Justice Bray, writing for the \textit{Salgo} majority, held that a physician must disclose in good faith all facts relevant to the patient's decision, stating that

a physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.

Likewise, the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent.\textsuperscript{34}

Over the next thirty-eight years, the California courts continued to mold the jurisprudential development of informed consent, focusing on the materiality of undisclosed information.

In \textit{Cobbs v. Grant},\textsuperscript{35} the defendant doctor diagnosed the plaintiff's peptic ulcer and ultimately performed surgery to relieve the gastric condition.\textsuperscript{36} Although the defendant physician discussed the general nature of the operation with the plaintiff, the physician failed to disclose certain inherent risks involved in the procedure.\textsuperscript{37} Following the initial surgery, complications developed which necessitated three additional surgeries and the removal of fifty percent of the plaintiff's stomach.\textsuperscript{38}

In holding that "this case constitute[d] a classic illustration of an action that sounds in negligence,"\textsuperscript{39} the Supreme Court of California moved away from the battery theory of informed consent to an action based in negligence.\textsuperscript{40} The \textit{Cobbs} court sought to distinguish between relief under the battery theory and the breach of duty to inform the patient under a negligence theory, by stating:

[The] battery theory should be reserved for those circumstances when a doctor performs an operation to which the plaintiff has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. \textit{However, when the patient consents to certain treatment and the doctor performs that treatment, but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather the doctor in obtaining consent may have failed to meet his due care duty}

\begin{thebibliography}{99}
\bibitem{31} See \textit{id.} at 173.
\bibitem{32} See \textit{id.} at 174-75.
\bibitem{33} See \textit{id.} at 181.
\bibitem{34} \textit{id.} (emphasis added).
\bibitem{35} 502 P.2d 1 (Cal. 1972).
\bibitem{36} See \textit{id.} at 4.
\bibitem{37} See \textit{id.}
\bibitem{38} See \textit{id.} at 4-5.
\bibitem{39} \textit{id.} at 8.
\bibitem{40} See \textit{id.}
\end{thebibliography}
to disclose pertinent information. In that situation the action should be pleaded in negligence.\(^{41}\)

Furthermore, even if there is a minimal inherent risk to the procedure, the Cobbs court held that the physician is nonetheless required to explain fully the risks to the patient.\(^{42}\) This disclosure requirement presents an even more difficult question, i.e., by what standard should informing the patient of these inherent risks be measured?

C. Standards of Disclosure

Once courts recognize that a physician has a duty to inform the patient of the inherent risks of a proposed medical procedure, the difficult question becomes what is sufficient disclosure and from whose viewpoint is the sufficiency measured. Two distinct theories exist: the professional standard and the materiality standard. Furthermore, the materiality standard is bifurcated into a subjective patient method and a reasonable patient method. The professional standard is based on what a reasonable physician would disclose under similar circumstances.\(^{43}\) Conversely, the materiality standard focuses on what information about the medical procedure a patient would deem necessary to provide or refuse consent.\(^{44}\)

1. The Professional Standard

The majority of jurisdictions use a professional standard as the basis for determining the extent of required disclosures for informed consent.\(^{45}\) There are generally two critical factors to the professional standard: a disclosure that a reasonable practitioner in a similar community would disclose\(^{46}\) and the burden of proof that the physician breached this standard.\(^{47}\) Recently, some courts have abandoned the locality rule and adopted a national standard which focuses on what reasonable practitioners in the country would disclose, rather than what a practitioner in a similar community would disclose.\(^{48}\)

The main policy consideration undergirding the professional standard is that physicians are best able to determine the risks and consequences that should be disclosed to a patient.\(^{49}\) Laymen are generally considered unable to determine what facts are material and necessary for a patient to know before giving an informed

\(^{41}\) Id. (emphasis added).

\(^{42}\) See id. at 11.

\(^{43}\) See, e.g., Aiken v. Clary, 396 S.W.2d 668, 675 (Mo. 1965) (holding that the professional standard applies in medical malpractice claims).

\(^{44}\) See, e.g., Sard v. Hardy, 379 A.2d 1014, 1022 (Md. 1977) (holding that the materiality standard applies in medical malpractice claims).

\(^{45}\) See Patterson, supra note 4, at 724.

\(^{46}\) See Allan H. McCoid, The Care Required of Medical Practitioners, 12 Vand. L. Rev. 549, 558, 569-75 (1959); see also Karp v. Colley, 493 F.2d 408, 420 (5th Cir. 1974) (holding that the community standard is appropriate for the professional standard in informed consent cases).

\(^{47}\) See McCoid, supra note 46, at 568.


\(^{49}\) See Patterson, supra note 4, at 729, for a detailed discussion of the theory that physicians know best.
2. The Materiality Standard

A majority of jurisdictions contend that the professional standard vests too much discretion in the medical profession, allowing the physician to determine what disclosure is necessary and circumvent patients' rights to choose what procedures can be performed on their bodies. On the other hand, the materiality standard focuses on what a patient would want to know about a procedure before consenting, rather than what a physician believes should be disclosed. Two divergent schools of thought regarding the materiality standard have evolved: first, the reasonable physician method and, second, the individual patient method.

a) The Reasonable Patient Method

The landmark case of Canterbury v. Spence abandoned the professional standard for informed consent and adopted the materiality standard. The Canterbury court held that it was "the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie." Nevertheless, the court's holding gave direction to courts in determining whether a "reasonable patient" in a similar circumstance would have declined treatment had he known the full extent of the risks associated with the proposed procedure. Accordingly, several commentators have criticized the Canterbury decision for adopting this objective or reasonable patient method because it essentially "backtracks" on the individual patient's right of self-determination. Nonetheless,

50. See id.
51. See McCoid, supra note 46, at 560-71 (discussing the compromising affect allowing laymen to testify might have a physician's ability to make decisions with the patient's best interest in mind, rather than what will play best before the jury). This issue has given rise to the therapeutic exception whereby physicians may withhold information from a patient if the physician believes the patient would suffer from the knowledge of such risks and consequences. See infra notes 59-60 and accompanying text for a detailed discussion of the "therapeutic privilege."
52. See, e.g., Scott v. Bradford, 606 P.2d 554 (Okla. 1979) (holding that a patient should be able to decide what is material to his/her decision to consent to a procedure); see also Patterson, supra note 4, at 726 (discussing the drawbacks of the professional standard). See infra notes 137-61 and accompanying text for a detailed discussion of the Scott case.
53. See Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation on a patient without his patient's consent commits an assault . . . ").
55. See id. at 780.
56. Id. at 781.
this method is used by the majority of jurisdictions which have adopted the materiality standard.\textsuperscript{58}

The \textit{Canterbury} court also recognized several exemptions to the requirement of disclosure. These exceptions include risks that the patient already knew of, hazards inherent to any surgical or medical procedure (e.g., infection), and emergencies where the doctor has no time to obtain the patient's consent and waiting for consent would further endanger the patient.\textsuperscript{59} The \textit{Canterbury} court also acknowledged a "therapeutic privilege" allowing a physician to withhold disclosure if a patient would become "so ill or emotionally distraught . . . as to . . . complicate or hinder the treatment, or perhaps even pose psychological damage to the patient."\textsuperscript{60}

\textit{b) The Individual Patient Method}

A minority of courts utilize the individual patient method which requires physicians to disclose all possible risks which could influence that particular patient's decision to consent to or refuse a specific procedure.\textsuperscript{61} The seminal case adopting this subjective or individual patient method is \textit{Scott v. Bradford},\textsuperscript{62} decided by the Supreme Court of Oklahoma in 1979. The individual patient method set out in \textit{Scott} provides that "the scope of a physician's communication must be measured by his patient's need to know enough to enable him to make an intelligent choice. In other words, full disclosure of all material risks incident to treatment must be made."\textsuperscript{63}

The \textit{Scott} court further adopted a subjective standard for determining whether a particular risk was material. Specifically, the court said that the materiality question is whether "that particular patient" would still have consented to the treatment if the specific risk had been disclosed, whether or not such choice would have been a reasonable choice.\textsuperscript{64} If the patient would not have consented to the treatment if the particular risk had been disclosed, such risk would be deemed to be material and must be disclosed.\textsuperscript{65}

Although this individual patient method recognizes a person's right to decide what should be done to his body, the Supreme Court of North Carolina in \textit{McPherson v. Ellis}\textsuperscript{66} recognized that a primary flaw with the individual patient method is that a plaintiff can always testify that a risk would have been material and would have precluded the plaintiff from consenting.\textsuperscript{67} The \textit{McPherson} court observed that "the

\begin{itemize}
\item \textsuperscript{58} See Wallach & Berry, supra note 18, at 842-44.
\item \textsuperscript{59} See \textit{Canterbury}, 464 F.2d at 788.
\item \textsuperscript{60} Id. at 789.
\item \textsuperscript{61} See Katz, supra note 57, at 163-64 (discussing the subjective or individual patient method used by a minority of courts).
\item \textsuperscript{62} 606 P.2d 554 (Okla. 1979). See infra notes 137-61 and accompanying text for a detailed discussion of the \textit{Scott} case.
\item \textsuperscript{63} Id. at 558 (emphasis omitted).
\item \textsuperscript{64} See id.
\item \textsuperscript{65} See id.
\item \textsuperscript{66} 287 S.E.2d 892 (N.C. 1982).
\item \textsuperscript{67} See id. at 896.
\end{itemize}
only evidence usually available is the plaintiff's bald assertion, tempered by hindsight, as to what he would have done had he known all the facts. 68 Despite its recognition of the subjective method's flaw, the McPherson court adopted the subjective or individual patient method. 69 Subsequently, however, the North Carolina legislature responded by enacting a statute imposing the objective or reasonable patient standard for all medical malpractice claims occurring one year after McPherson. 70 The North Carolina legislature is not the only state legislative body to seek resolution of informed consent difficulty through enactments to oppose a state's highest court's ruling. Three years before North Carolina enacted its remedial legislation, Texas enacted a sweeping medical malpractice reform package aimed at resolving problems with medicolegal litigation in its state, including the confused issue of informed consent. 71

III. Texas' Treatment of Informed Consent: Reasonable Legislative Intervention

A. Judicial Precedent

In 1967, the Supreme Court of Texas adopted the professional standard for determining when a patient has given an informed consent. 72 In Wilson, the court held that "the plaintiff had the burden to prove by expert medical evidence what a reasonable medical practitioner of the same school and same or similar community under the same or similar circumstances would have disclosed to his patient about the risks incident to a proposed diagnosis or treatment." 73 Subsequent informed consent cases in Texas strictly followed the Wilson professional standard, 74 and also promulgated a "therapeutic privilege" 75 and a consent exception for medical emergencies. 76 Nevertheless, the Wilson professional standard was destined for a short life in Texas.

68. Id.
69. See id.
70. See N.C. Gen. Stat. § 90-21.13(a)(3) (1995). This statute provides that there shall be no recovery for lack of informed consent where "[a] reasonable person, under all the surrounding circumstances, would have undergone such treatment or procedure had he been advised by the health care provider in accordance with the provisions of . . . this subsection." Id.
73. Id. at 302.
75. See Marsh v. Arnold, 446 S.W.2d 949, 951-53 (Tex. Civ. App. 1969, writ ref'd n.r.e.) (holding that when a physician believes benefit of nondisclosure outweighed risks of disclosure, an explanation of the specific risks is unnecessary).
76. See Gravis v. Physicians & Surgeons Hosp., 427 S.W.2d 310, 311 (Tex. 1968) (holding that consent is implied in emergency situations).
B. Trouble in Texas: The Legislature's Response to a Perceived Insurance Crisis

Shortly after Wilson, Texas physicians, hospitals, and insurance company lobbyists began to pressure the legislature for relief from the escalating cost of medical malpractice insurance.77 At this time in the early 1970s, insurance rates had increased at alarming rates and reached levels where many physicians and hospitals were unable to afford coverage.78 The inability to purchase insurance coverage forced some physicians and hospitals in Texas to reduce the types of procedures they performed, thus precluding many Texas citizens from receiving necessary care.79

Prior to 1975, no special legislation existed in Texas limiting a patient's right to bring medical malpractice actions.80 However, the Texas legislature in 1975 enacted the Professional Liability Insurance for Physicians, Podiatrists and Hospitals Act81 in response to lobbying efforts from the healthcare industry.82 The Act abolished the "discovery rule" which tolls the statute of limitations until the patient discovers or reasonably should have discovered an injury and established a two-year statute of limitations period for medical malpractice actions.83 The Act, however, was but a temporary solution. The legislature intended to replace it with a more comprehensive tort reform package.84 and consequently, one year later, the Texas legislature appointed the Texas Medical Professional Liability Study Commission to study the medical liability insurance situation and offer suggestions to avert a crisis.85 The Commission, chaired by W. Page Keeton, former dean of the University of Texas Law School,86 presented its findings in the Keeton Report in 1977 which the Texas legislature adopted as the basis for the Medical Liability and Insurance Improvement Act (MLIIA).87

C. The Texas MLIIA: A Reasonable Treatment of Informed Consent

The MLIIA, enacted in 1977, curtailed the frequency and severity of medical malpractice claims against healthcare providers and ensured the availability and affordability of liability insurance.88 However, some commentators suggest that the

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77. See Sherman & Pate, supra note 14, at 345.
78. See TEX. REV. CIV. STAT. ANN. art. 4590a, § 1.02(a)(4) (West Supp. 1997).
79. See id. § 1.02(a)(6).
81. TEX. INS. CODE ANN. art. 5.82, § 4 (West 1976) (repealed 1977).
82. See Witherspoon, supra note 80, at 421.
83. See TEX. INS. CODE ANN. art. 5.82, § 4 (West 1976) (repealed 1977).
84. See Witherspoon, supra at note 80, at 421.
85. See Final Report, Texas Medical Professional Liability Study Committee 11-12 (1976).
86. W. Page Keeton was also the Dean of the University of Oklahoma College of Law in the 1940s.
88. See TEX. REV. CIV. STAT. ANN. art. 4590a, § 1.02(a)(13) (West Supp. 1997). The Texas Medical Professional Liability Study Commission's findings were adopted in subsection (13) of section 1.02(a) which now provides: "These facts have been verified by the Medical Professional Liability Study
Texas legislature misconstrued the Keeton Report in an effort to distort the magnitude of the insurance crisis.\textsuperscript{89} Despite criticisms of the MLIIA, two recent Supreme Court of Texas cases deciding medical informed consent issues failed to question the MLIIA's legitimacy, thus suggesting that the high court of Texas agreed with the Act's purpose and its legislative history.\textsuperscript{90}

The informed consent sections of the MLIIA\textsuperscript{91} depart drastically from Texas' pre-1975 treatment of medical informed consent and represent a novel means of determining the adequacy and sufficiency of informed consent. The Texas Medical Disclosure Panel\textsuperscript{92} (the Disclosure Panel) established by the MLIIA "determin[es] which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients and to establish the general form and substance of such disclosure."\textsuperscript{93} Six physicians and three lawyers appointed by the Texas Commissioner of Health comprise the Disclosure Panel.\textsuperscript{94}

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Commission, which was created by the 64th Legislature. For further amplification of these facts the legislature adopts the findings of the report of the commission." \textit{Id.} Section 1.02(b) further provides:

(b) Because of the conditions stated in Subsection (a) of this section, it is the purpose of this Act to improve and modify the system by which health care liability claims are determined in order to:

1. reduce excessive frequency and severity of health care liability claims through reasonable improvements and modifications in the Texas insurance, tort, and medical practice systems;

2. decrease the cost of those claims and assure that awards are rationally related to actual damages;

3. do so in a manner that will not unduly restrict a claimant's rights any more than necessary to deal with the crisis;

4. make available to physicians, hospitals, and other health care providers protection against potential liability through the insurance mechanism at reasonably affordable rates;

5. make affordable medical and health care more accessible and available to the citizens of Texas;

6. make certain modifications in the medical, insurance, and legal systems in order to determine whether or not there will be an effect on rates charged by insurers for medical professional liability insurance; and

7. make certain modifications to the liability laws as they relate to health care liability claims only and with an intention of the legislature to not extend or apply such modifications of liability laws to any other area of the Texas legal system or tort law.

\textit{Id.} § 1.02(b).

\textsuperscript{89} See Darrell L. Keith, \textit{The Texas Medical Liability and Insurance Act — A Survey and Analysis of Its History, Construction and Constitutionality}, 36 BAYLOR L. REV. 265, 268 (1984) (suggesting that Healthcare lobbyists distorted the Keeton Report findings to enable health care providers to pay less insurance premiums); Witherspoon, \textit{supra} note 80, at 422-24 (implying that the Keeton Act was distorted to make informed consent claims more difficult to bring against healthcare providers).

\textsuperscript{90} See, e.g., Barclay v. Campbell, 704 S.W.2d 8 (Tex. 1986); Peterson v. Shields, 652 S.W.2d 929 (Tex. 1983). These cases are discussed in more detail infra at notes 112-31 and accompanying text.

\textsuperscript{91} TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 6.01-6.07 (West Supp. 1997).

\textsuperscript{92} See id. § 6.03.

\textsuperscript{93} Id. § 6.03(a).

\textsuperscript{94} See id. § 6.03(c), (d).
Subchapter F of the MLIIA defines the standard for informed consent in the medical context. Thus, informed consent actions in Texas became by legislative fiat, as defined in section 6.02, actionable negligence claims:

In a suit against a physician or health care provider involving a health care liability claim that is based on the failure of the physician or health care provider to disclose or adequately to disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider, the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent. 95

This statutory definition resembles the reasonable patient method adopted by a majority of jurisdictions utilizing a materiality standard for informed consent. 96 This section, in part, mandates the specific risks and hazards which must be disclosed. 97 The actual disclosure requirements in effect codify the professional standard, because the Disclosure Panel articulates the risks and hazards that must be disclosed by all physicians and health care providers.

The Disclosure Panel segregates medical procedures into two disclosure lists. List A consists of procedures that require some form of disclosure, and the Disclosure Panel determines the exact form of disclosure required for each procedure on this A list. 98 List B includes the remaining procedures which may be administered with no specifically defined disclosure of any risks or hazards. 99 A written explanation of the procedures on both lists is published annually in the Texas Register (See Appendix for an excerpt from the Disclosure Lists). 100

Section 6.05 of the MLIIA defines the precise disclosure of the risks and hazards involved in the List A procedures, 101 and the manner in which physicians and health care providers must disclose this information is governed by section 6.06 of the MLIIA, 102 i.e., "disclosure shall be considered effective . . . if it is given in writing, signed by the patient or a person authorized to give the consent and by a competent witness, and if the written consent specifically states the risks and hazards that are involved in the medical care or surgical procedure . . . ." 103 Although no Texas cases have challenged the validity of written consent forms, many commentators criticize their readability and argue that patients often lack the capacity to understand the consequences of signing these forms. 104 Nevertheless,
written consent as mandated by the MLIIA and guided by the Disclosure Lists published in the Texas Register remains the standard for informed consent disclosure in Texas.

The apparent legislative intent of the MLIIA was guidance for physicians and health care providers to prepare patients for medical procedures and to assist courts in determining if a patient's consent was truly informed. Disclosure of List A risks and hazards as provided in section 6.07, as well as nondisclosure of List B procedures made according to sections 6.05 and 6.06, are "admissible in evidence and shall create a rebuttable presumption" that the physician or health care provider did satisfy the disclosure requirements of the MLIIA.105 At first, compliance with section 6.06 created an irrebuttable presumption that the physician or health care provider had satisfied the duty of disclosure.106 However, the Attorney General of Texas concluded that an irrebuttable presumption created by section 6.06 violated a patient's right to a jury trial.107 Consequently, the Texas legislature made compliance merely a rebuttable presumption of informed consent.108

Finally, section 6.07(b) addresses the disclosure requirements for procedures which the Disclosure Panel has yet to examine and place on either list.109 This catch-all provision offers little guidance to the health care provider, stating simply that "[i]f medical care or surgical procedure is rendered with respect to which the panel has made no determination either way regarding a duty of disclosure, the physician or health care provider is under the duty otherwise imposed by law."110 This "otherwise imposed" phrasing, critics contend, will likely lead to unnecessary litigation required to determine the correct statutory interpretation of this unartful drafting.111

\[\text{for Research in Veterans Administration Medical Centers, 250 JAMA 2646 (1983); Richard Sherlock, Ph.D., Competency to Consent to Medical Care: Toward a General View, 6 GEN. HOSP. PSYCHIATRY 71 (1984); William M. Altman, J.D., M.A., et al., Autonomy, Competence, and Informed Consent in Long Term Care: Legal and Psychological Perspectives, 37 VILL. L. REV. 1671 (1992); Kenneth Dedeker, M.D., Informed Consent vs. Consent Forms, 66 MINN. MED. 575 (1983).}\]


106. See Elliot, supra note 89, at 384.

107. See Tex. Att'y Gen. LA-135 (1977). In an advisory letter, the Texas Attorney General concluded that:

- Since the utilization of the signed form would constitute consent as a 'matter of law, the jury would be unable to inquire into the actual validity of the consent. Presumably the form could be signed by a person who could read or by an individual who was not competent to understand the document. Yet the statute would make such consent effective without further inquiry. What has been a fact issue would be taken from the jury's consideration and would be transformed into an irrebuttable presumption. Where the statute makes signature on the form conclusive on the issue of consent, it would be a denial of the constitutional right to have the issue determined by a jury.

Id. (citations omitted).


109. See id. § 6.07(b).

110. Id. (emphasis added).

111. See Frank W. Elliott, The Impact of the Texas Medical Liability and Insurance Improvement Act on Informed Consent Recovery in Medical Malpractice Litigation, 10 TEX. TECH L. REV. 381, 388-
D. The Supreme Court of Texas: Ignoring Legislative Intent?

In 1983, the Supreme Court of Texas did not disappoint the critics of the MLIIA when it decided Peterson v. Shields, a medical malpractice action brought by a woman who claimed that her physician failed to inform her of the risks inherent to a lymph node biopsy. Because the Disclosure Panel "had not evaluated and published [its] determination of the type of disclosure required in lymph node biopsies" at the time of this woman's surgery, the physician/defendant argued that the disclosure standard was what a physician in the same community would have disclosed under the same circumstance, or the duty otherwise imposed by the law at that time.

The trial court directed the verdict for the physician/defendant because the patient/plaintiff was unable to offer expert opinion that the physician breached the local standards of disclosure. The trial court, citing Wilson v. Scott, upheld the "locality rule" by stating that:

The plaintiff had the burden to prove by expert medical evidence what a reasonable medical practitioner of the same school and same or similar community under the same or similar circumstances would have disclosed to his patient about the risks incident to a proposed diagnosis or treatment . . . .

When the Supreme Court of Texas heard the plaintiff's appeal, it focused on section 6.07(b) of the MLIIA in determining that the disclosure standard for procedures not included on Lists A or B is the reasonable patient method. Section 6.07(b) reads, "If medical care or surgical procedure is rendered with respect to which the panel has made no determination either way regarding a duty of disclosure, the physician or health care provider is under the duty otherwise imposed by law." The Peterson court relied on section 6.02 to decide what the legislature intended by the language "duty otherwise imposed by law." Because section 6.02 contained the phrase "failing to disclose the risks or hazards that could have influenced a reasonable person," the court adopted the reasonable patient

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89 (1979) (discussing poor drafting that leads to difficulty in construing the statute); Alan Meisel & Lisa D. Kabnick, Informed Consent to Medical Treatment: An Analysis of Recent Legislation, 41 U. Pitt. L. Rev. 407, 536-41 (1980) (discussing how poor drafting hampers the proper construction of statutes); Susan Kessler Rachlin, Comment, The Effect of the Texas Medical Liability and Insurance Improvement Act on the Texas Standard for Medical Disclosure, 17 Hous. L. Rev. 615, 625-27 (1980) (discussing that the drafting of the statute is difficult to construe).

112. 652 S.W.2d 929 (Tex. 1983).
113. See id. at 930.
114. Id. at 931.
115. See id. at 930.
116. See id.
117. 412 S.W.2d 299 (Tex. 1967).
118. Peterson, 652 S.W.2d at 930 (quoting Wilson v. Scott, 412 S.W.2d 299, 302 (Tex. 1967)).
119. See id. at 931.
120. TEX. REV. CIV. STAT. ANN. art. 4590i, § 6.07(b) (West Supp. 1997).
121. See Peterson, 652 S.W.2d at 931.
method for situations in which the Disclosure Panel had not sorted a procedure into either List A or List B.\textsuperscript{122}

This interpretation is inconsistent with other language in the MLIIA\textsuperscript{123} and arguably ignores the legislature's intent in passing the MLIIA to curb the frequency and severity of medical malpractice actions. In requiring the Disclosure Panel, partially comprised of physicians, to determine the scope and form of disclosure required for all medical procedures in Texas, the legislature impliedly adopted the professional standard. Furthermore, the reasonableness language in section 6.02 seems to serve more as guidance for the Disclosure Panel in its process of deciding the scope and form of disclosure, rather than an explanation of what the "duty otherwise imposed by law" language in section 6.02 of the MLIIA was intended to convey. Because the Supreme Court of Texas adopted the professional standard in Wilson v. Scott,\textsuperscript{124} it seems logical that the legislature would have explicitly overruled this standard in the MLIIA's section on procedures not included on Lists A or B. Therefore, the Peterson court clearly stepped outside of the MLIIA in reaching its holding.

The Supreme Court of Texas continued to carve away the effectiveness of the MLIIA in Barclay v. Campbell.\textsuperscript{125} The Barclay decision ignored well-settled precedent from the vast majority of jurisdictions and terminated the therapeutic privilege for cases involving procedures not included on Lists A or B. The Barclay plaintiff brought a medical malpractice action, claiming, inter alia, that his physician failed to disclose the risks and hazards inherent to prescribing neuroleptic drugs for treating mental illnesses.\textsuperscript{126}

The patient/plaintiff argued that the probability of contracting tardive dyskinesia, an adverse reaction to neuroleptic drugs, was significant enough to influence a reasonable person in deciding whether or not to take the drugs.\textsuperscript{127} The court of appeals agreed that if this risk was material enough to influence a reasonable person, disclosure would then be proper.\textsuperscript{128} Nevertheless, the court of appeals excused the physician/defendant's failure to disclose because the patient/plaintiff was suffering from schizophrenia and perforce was not a reasonable person. The court of appeals concluded "that it was the legislature's intent to excuse a defendant who is negligent in failing to disclose a risk if it was not medically feasible to make the disclosure."\textsuperscript{129} Essentially, the court of appeals held that the physician/defendant had a therapeutic privilege to refuse disclosure if it might harm the patient.

The Supreme Court of Texas in Barclay disagreed with the court of appeals and held that "it was not the legislature's intent to take away an individual's right to make such decisions for himself just because his doctor does not believe his patient

\textsuperscript{122} See id.
\textsuperscript{124} 412 S.W.2d 299 (Tex. 1967).
\textsuperscript{125} 704 S.W.2d 8 (Tex. 1986).
\textsuperscript{126} See id. at 9.
\textsuperscript{127} See id.
\textsuperscript{128} See id.
\textsuperscript{129} Id. at 10.

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is reasonable." The Barclay court strictly followed the Peterson reasoning and concluded that if a reasonable person could have been influenced by the disclosure, then Barclay (the schizophrenic plaintiff) was also entitled to be warned by the disclosure.\(^{131}\)

In giving no deference to a physician's judgment, the Barclay court's stringent adherence to the reasonable patient method seems almost doctrinaire. Because the Barclay court rejected the therapeutic privilege for unclassified procedures, it effectively created by judicial fiat two informed consent disclosure standards. For List A procedures, section 6.07(a)(2) retains the therapeutic privilege, and thus nondisclosure is only actionable under a negligence theory. However, for unlisted procedures (i.e., procedures on neither List A nor List B), the lack of the therapeutic privilege virtually gives rise to strict liability for nondisclosure. The remaining exception to nondisclosure for unlisted procedures is the emergency exemption which allows physicians to waive patient consent if the delay in obtaining the same would endanger the life of the patient, but the Supreme Court of Texas has yet to rule on this exigent aspect for informed consent.

**E. The Teachings of Peterson and Barclay**

Despite the opinions from the Supreme Court of Texas in Peterson and Barclay which are inconsistent with the MLIIA, the Texas legislature seems content not to revise the MLIIA to clarify the specific areas discussed in these two cases. Until the legislature does revise these areas of the MLIIA, physicians practicing in Texas must proceed with medical, as well as legal, caution when performing procedures which are on neither Disclosure Panel lists. More importantly, other legislatures might well heed the unintentional warning from the Supreme Court of Texas and ensure that their legislative initiatives regarding informed consent are drafted with precision and clarity so that the controversial aspects of the Disclosure Lists are avoided.

**IV. Informed Consent in Oklahoma: Texas' Needy Neighbor**

Informed consent in Oklahoma is a relatively new, court-imposed legal doctrine. The current subjective or individual patient standard contradicts previous dicta by the Supreme Court of Oklahoma describing how informed consent should be treated by Oklahoma's courts.\(^{132}\) The Supreme Court of Oklahoma in 1973 first encountered the doctrine of informed consent in *Martin v. Stratton.*\(^{133}\) Although the Martin court never expressly adopted the doctrine of informed consent, the court explained what the standard should be in Oklahoma.\(^{134}\) Justice Berry opined:

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130. *Id.*
131. See *id.* at 10-11.
134. See *id.* at 1369-70.
We conclude that if the theory of liability referred to as "informed consent" is ever adopted by this Court the plaintiff will have the burden to either introduce evidence from which the jury could reasonably infer that the defendant failed to disclose to plaintiff 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 that material risks were inherent in the proposed medical procedure in terms of seriousness, probability of occurrence and feasibility of alternatives, and defendant failed to disclose these risks to plaintiff.135

Despite Justice Berry's prediction of how Oklahoma ought to deal with informed consent, six years later the Supreme Court of Oklahoma shocked many legal and medical professionals by adopting a substantially different standard for informed consent.136 The Supreme Court of Oklahoma in Scott v. Bradford137 held that "the scope of a physician's communications must be measured by his patient's need to know enough to enable him to make an intelligent choice. In other words, full disclosure of all material risks incident to treatment must be made."138 The subjective or individual patient method adopted by the Supreme Court of Oklahoma in Scott makes informed consent, in even the best of circumstances, an impossible burden for the health care provider by requiring that each patient be informed of all possible risks that he or she might find relevant in consenting to treatment.

The plaintiff in Scott brought a surgical malpractice action after she experienced incontinence problems caused by a vesico-vaginal fistula, a complication resulting from a hysterectomy.139 She never claimed that the physician/defendant was negligent in performing the surgery, but rather she argued that if the physician/defendant had advised her of the risks of developing a vesico-vaginal fistula, she would have refused the operation.140 Essentially, she argued that her consent was not "informed," and therefore the physician/defendant was liable for the injuries even though he was not negligent.141

At the trial court, the jury entered a verdict in favor of the physician/defendant. Although the Supreme Court of Oklahoma found that the trial court gave sufficiently broad jury instructions regarding a physician's duty to disclose, the Scott court formally recognized the doctrine of informed consent.142 The court also established the foundational elements that a patient/plaintiff must prove in order to maintain an action against a physician/defendant for failure to obtain an informed

135. Id. at 1370 (emphasis added).
137. 606 P.2d 554 (Okla. 1979).
138. Id. at 558.
139. See id. at 556.
140. See id.
141. See id.
142. See id. at 558.
Informed Consent in Oklahoma

CONSENT BEFORE A MEDICAL PROCEDURE. The Scott court held that a patient/plaintiff suing under an informed consent theory must allege and prove:

1) defendant physician failed to inform him adequately of a material risk before securing his consent to the proposed treatment;
2) if he had been informed of the risks he would not have consented to the treatment;
3) the adverse consequences that were not made known did in fact occur and he was injured as a result of submitting to the treatment.

The Scott standard for informed consent significantly deviates from the Martin court's suggested standard. The subjective or individual patient method adopted in Scott infinitely enlarges the category of risks which a physician must inform the patient about before consent can be truly informed. Under the Martin professional standard, it would have been sufficient for a physician to warn the patient of risks customarily disclosed by other physicians under similar circumstances. By requiring a physician to disclose all material risks that might affect a particular patient's decision regarding a procedure, the Scott court places an unreasonable, if not unbearable, burden on the physician to know what risks and hazards are important to each individual patient. This standard makes the patient the final arbiter of disclosure because the patient, by this egregious standard, is the only one who knows what information would actually impact her decision to consent to a procedure.

From the physician's viewpoint, the Scott decision renders informed consent practically impossible. More importantly, the Scott standard is susceptible to abuse because of the essential importance given to the patient/plaintiff's testimony. For example, when patients/plaintiffs contemplate medical malpractice actions, hindsight can become perfectly clear. Therefore, if a particular risk materializes in the form of an injury, patients/plaintiffs could understandably be tempted to conclude post facto that informing of such a risk would have influenced their decisions to accept treatment.

The Supreme Court of Oklahoma recognized the practical shortcomings of the Scott standard but offered little guidance for Oklahoma physicians, noting that "[a]lthough it might be said this approach places a physician at the mercy of a patient's hindsight, a careful practitioner can always protect himself by insuring that he has adequately informed each patient he treats." Many medical procedures involve myriad risks and hazards, varying in likelihood and seriousness, and the Scott court's impractical guideline provides no meaningful assistance to physicians. As a practical matter, physicians can hardly inform each patient of every conceivable risk. Consequently, physicians must exercise their judgment in the disclosure process. After Scott, however, should an undisclosed risk of treatment

143. See id. at 559.
144. Id.
146. Scott, 606 P.2d at 559.
manifest into an injury, the physician may well face a patient's self-serving testimony in an informed consent medical malpractice action that is largely based on clear hindsight.

Three other jurisdictions have faced the decision of whether to adopt the subjective method of determining informed consent\(^\text{147}\) since the Supreme Court of Oklahoma issued the *Scott* opinion, and each found *Scott* unpersuasive. In 1984, the Court of Appeals of South Carolina in *Hook v. Rothstein*\(^\text{148}\) declined to follow *Scott* and adopted a reasonable practitioner standard for informed consent.\(^\text{149}\) One year later, the Supreme Court of Mississippi in *Reikes v. Martin*\(^\text{150}\) rejected the "subjective test" of *Scott*.\(^\text{151}\) The *Reikes* court reasoned:

The problem with the subjective test [is] . . . "[s]ince at the time of trial the uncommunicated hazard has materialized, it would be surprising if the patient-plaintiff did not claim that had he been informed of the dangers he would have declined treatment. Subjectively he may believe so with the 20-20 vision of hindsight, but we doubt that justice will be served by placing the physician in jeopardy of the patient's bitterness and disillusionment."\(^\text{152}\)

Finally, in *Arena v. Gingrich*,\(^\text{153}\) the Court of Appeals of Oregon held that a fact finder could discern whether the particular patient/plaintiff had given an informed consent, using the objective or reasonable patient method.\(^\text{154}\) In rejecting *Scott* and the subjective method, the *Arena* court concluded:

The real question is whether this plaintiff would have consented if she had been properly informed. Although the subjective question is the ultimate one, we do not agree with plaintiff's and the *Scott* court's view that only evidence about the particular plaintiff's subjective reactions and decision can be relevant to that question. Evidence and arguments about whether other patients — hypothetical or real — would have consented under similar circumstances can assist the factfinder in evaluating the plaintiff's credibility and in exercising its common sense.\(^\text{155}\)

Recognizing that medical malpractice actions based on lack of consent can well be bootstrapped by plaintiffs' testimony, the Oklahoma State Medical Association and the Physician's Liability Insurance Company (an Oklahoma physician-owned liability insurance carrier) urge physicians to utilize consent forms with all


\(^{149}\) See *id.* at 698.

\(^{150}\) 471 So. 2d 385 (Miss. 1985).

\(^{151}\) See *id.* at 392-93.

\(^{152}\) Id. (quoting *Cobbs v. Grant*, 502 P.2d 1, 11-12 (Cal. 1972)).


\(^{154}\) See *id.* at 78-79.

\(^{155}\) *Id.* at 79.
procedures.\textsuperscript{156} Although the Supreme Court of Oklahoma and the lower courts in Oklahoma have yet to address a medical malpractice case based on the use of consent forms, the mere specter of an informed consent case may lead to better communications between patients and physicians. Nonetheless, consent forms cannot be the only disclosure to the patient, rather the forms are intended to supplement more specific discussion about risks and hazards between the physician and the patient. However, until case law is available in Oklahoma clarifying the role of consent forms, many commentators will remain suspect about the legal protection offered by consent forms.\textsuperscript{157}

\textbf{V. The Lone Star Solution: A Legislative Proposal for Oklahoma}

The subjective informed consent standard of \textit{Scott} would appear to subject Oklahoma physicians to the clarity of patients/plaintiffs' hindsight vision and recall of events, sometimes clouded by bitterness and disillusionment. It has become clear that the Supreme Court of Oklahoma does not want to reconsider the precedent of its \textit{Scott} holding, as indicated by the number of years the decision has remained the standard. Indeed, the \textit{Scott} standard has been followed in at least four published Oklahoma opinions.\textsuperscript{158} The time has come for the Oklahoma legislature, as it did for the Texas legislature in 1977, to balance patients/plaintiffs' interest of informed consent against the interests of physicians needing a workable and reasonable standard by which to inform all patients. The example of the MLIIA which has governed the determination of informed consent in Texas for nearly two decades may offer a framework for the Oklahoma legislature.

The Oklahoma legislature could well begin a reform of informed consent law by establishing its own Medical Disclosure Panel in the fashion of the Texas Disclosure Panel. However, unlike the Texas Panel, which is comprised of six physicians and three lawyers, the Oklahoma Panel could expand the Panel representation to include disinterested laypersons from outside the medical and legal professions, and in so doing, broaden its patients' rights advocacy. Certainly the Oklahoma Panel must include lawyers and doctors, but the inclusion of laypersons might temper the panel's deliberations with a dispassionate layman's perspective, perhaps more akin to a patient's advocate.

No special interest group should have an undue influence on the scope and form of the disclosure standards established by this Panel. The representatives must be insulated from any pressures from the medical community, the plaintiff's bar, the defense bar, or other influential sources possibly interested in affecting informed consent disclosure requirements. From wherever these representatives are drawn, the primary consideration must be their impartial independent judgments about risks.


\textsuperscript{157} See various articles \textit{supra} note 104 and accompanying text for a discussion of consent forms.

to be disclosed in establishing an informed consent standard for Oklahoma's health care providers.

A major problem with the Texas MLIIA was that the Disclosure Lists remained incomplete at the Act's effective date, thus creating a third unspecified list of procedures for which the standard of disclosure was yet to be defined.\(^{159}\) Several Texas lawsuits arose in which plaintiffs claimed nondisclosure of risks inherent to a procedure that was not included on either List A or List B.\(^{160}\) If the Oklahoma legislature should follow the lead of the Texas legislature, much of Oklahoma's standards could be patterned after the work already completed by the Texas Panel. Instead of examining every medical procedure de novo, the Oklahoma Panel could adopt the Texas Panel's standards. In those specific procedures where the Oklahoma representatives felt the disclosure requirements were overinclusive or underinclusive, the disclosure requirements' language could be fine-tuned to conform to the Oklahoma Panel's perspective. In this way, perhaps the incomplete listing that plagued the early Texas experience would be avoided in Oklahoma.

Although the Oklahoma Disclosure Panel might adopt the Texas Disclosure Lists and examine and classify most procedures before this proposed reform legislation takes effect, certain procedures could remain unlisted, for example, either new treatments or procedures the Panel overlooked. Oklahoma's legislation should explicitly provide a disclosure standard for these unlisted procedures. The shortcomings inherent in the \textit{Scott} subjective standard for informed consent would likely persuade the Oklahoma legislature to adopt another standard. Because the Disclosure Panel's requirements of disclosure for List A procedures are premised, in part, on what reasonable doctors would disclose to their patients, a consistent standard of disclosure for unclassified procedures seems a logical progression of legislative intent. A reasonable practitioner standard was the standard for informed consent that the Supreme Court of Oklahoma suggested in \textit{Martin}, six years before it decided \textit{Scott}. The Oklahoma legislature could well serve the state by resurrecting this informed consent standard as a "reasonable" compromise to satisfy the competing interests involved in this controversial area.

Although the Texas MLIIA adopted a therapeutic privilege and an emergency exception for disclosure of its List A procedures, the Texas legislature failed to address whether these exemptions from disclosure applied to all unlisted procedures. Subsequently, the Supreme Court of Texas in \textit{Barclay} eliminated the therapeutic privilege for unclassified procedures.\(^{161}\) The Supreme Court of Texas, however, has yet to decide a controversy dealing with the emergency exception for informed consent disclosure of unlisted procedures. In order to avoid these same statutory problems, the Oklahoma legislature should address these exemption issues in its reform legislation. Because the therapeutic privilege and the emergency exception

\begin{itemize}
  \item \textit{160}. See id. at 403.
  \item \textit{161}. See Barclay v. Campbell, 704 S.W.2d 8 (Tex. 1986). See also supra notes 125-31 for a discussion of the \textit{Barclay} case.
\end{itemize}

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are included in the Texas MLIIA for List A procedures, it would seem inconsistent if both exemptions did not apply to unlisted procedures. If the Oklahoma legislature can enact legislation modeled after the MLIIA including these reform modifications, certainly a problematic proposition, it could well achieve a reasonable and predictable standard for informed consent, eliminating the inherent inequities in the Scott court's subjective method that is the judicial standard in Oklahoma today.

VI. An Uncertain Future

Therapeutic miracles and lifesaving treatments which enable Oklahomans to live longer and more fulfilling lives have given the citizens of our state a world class health care delivery system. However, unrelenting exposure to medicolegal liability may well force many of the physicians and other health care providers responsible for this state's health care to reduce the scope of their practices, and in some cases to cease providing services. Medical malpractice cases brought under a lack of informed consent theory using Oklahoma's Scott subjective standard, as currently applied by Oklahoma's courts, enhance the medicolegal liability exposure for doctors and other health care providers.

The MLIIA has successfully provided guidance in the form of disclosure requirements for medical procedures in Texas, achieving a legislatively created and balanced approach to informing patients and obtaining their consent for medical or surgical procedures. The Oklahoma legislature could benefit the state by enacting similar guidelines for health care providers to provide a uniform, predictable solution to the informed consent dilemma created by the Scott opinion. Unless the legislature acts, Oklahoma health care providers will face the future, uncertain about their liability exposure, remaining vulnerable to the patients they seek to help.
APPENDIX

20 TEXAS REGISTER 2594
25 TEXAS ADMINISTRATIVE CODE 601.1-601.6

TITLE 25. HEALTH SERVICES
PART VII. TEXAS MEDICAL DISCLOSURE PANEL
CHAPTER 601. INFORMED CONSENT MEDICAL TREATMENTS
AND SURGICAL PROCEDURE ESTABLISHED BY THE TEXAS
MEDICAL DISCLOSURE PANEL

601.1. General.
(a) The purpose of this chapter is to implement the requirements of the Medical
Liability and Insurance Improvement Act of Texas, Texas Civil Statutes, Article
4590i; Subchapter I, relating to informed consent.
(b) The treatments and procedures requiring full disclosure by a physician or
health care provider to a patient or person authorized to consent for the patient are
found in 601.2 of this title (relating to Procedures Requiring Full Disclosure-List A).
(c) The treatments and procedures requiring no disclosure by a physician or
health care provider to a patient or person authorized to consent for the patient are
found in 601.3 of this title (relating to Procedures Requiring No Disclosure-List B).

601.2. Procedures Requiring Full Disclosure-List A.

* * *

Thyroideectomy
(A) Injury to nerves resulting in hoarseness or impairment of speech.
(B) Injury to parathyroid glands resulting in low blood calcium levels that require
extensive medication to avoid serious degenerative conditions, such as cataracts,
brittle bones, muscle weakness and muscle irritability.
(C) Lifelong requirement of thyroid medication.

* * *

Corneal surgery, such as corneal transplant, refractive surgery and pterygium.
(A) Complications requiring additional treatment and/or surgery.
(B) Possible pain.
(C) Need for glasses or contact lenses.
(D) Partial or total loss of vision.

Glaucoma surgery by any method.
(A) Complications requiring additional treatment and/or surgery.
(B) Worsening of the glaucoma.
(C) Pain.
(D) Partial or total loss of vision.

Removal of the eye or its contents (enucleation or evisceration).
(A) Complications requiring additional treatment and/or surgery.
(B) Worsening or unsatisfactory appearance.
(C) Recurrence or spread of disease.

Surgery for penetrating ocular injury, including intraocular foreign body.

(A) Complications requiring additional treatment and/or surgery, including removal of the eye.
(B) Chronic pain.
(C) Partial or total loss of vision.