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ARTICLES

DOCTOR, ARE YOU EXPERIENCED? THE RELEVANCE OF DISCLOSURE OF PHYSICIAN EXPERIENCE TO A VALID INFORMED CONSENT

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INTRODUCTION

The informed consent doctrine has been a topic of continuing debate and controversy since the seminal case of Salgo v. Leland Stanford Jr. University Board of Trustees first recognized the doctrine and used the

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term "informed consent." However, the seed for the doctrine was arguably sewn in *Schloendorff v. Society of the New York Hospital* where then Judge, and later Justice Benjamin Cardozo uttered his venerable statement that “every human being of adult years and sound mind has a right to determine what shall be done with his own body.” Since its original adoption, the doctrine, which requires a practitioner to inform a patient of all material risks, benefits, and alternatives attendant upon a proposed treatment option and to disclose to the patient the risks of a failure to go through with a recommended procedure has been expanded over the years.

This article argues that public policy militates in favor of requiring practitioners to disclose their levels of experience to inquiring patients in order to comply with the requirements of informed consent. Before arriving at this conclusion, this article examines the history of doctor-patient communication, judicial treatment of the informed consent doctrine since its adoption in *Salgo*, and then analyzes the relevance of physician experience in the informed consent inquiry.

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3. 105 N.E. 92 (N.Y. 1914). See also Lambert v. Park, 597 F.2d 236, 237, n. 1 (10th Cir. 1979) (asserting that the informed consent doctrine is traceable in part to judge, later, Justice Benjamin Cardozo’s statement in *Schloendorff*).
4. See *Schloendorff*, 105 N.E. at 93.
II. INFORMED CONSENT IN AMERICAN HISTORY: FROM CONSENT TO INFORMED CONSENT

Although a substantial majority of contemporary physicians agree, as do most patients, that the right of patients to informed consent is so paramount that it deserves legal protection, and although the informed consent doctrine is now well established in all the jurisdictions of the United States, the march towards the judicial adoption of the informed consent doctrine was painstakingly slow. This slow evolution may have been due to the traditional opposition and paternalism of the medical profession to any disclosure requirements. This paternalism dates back to the legendary Greek physician Hippocrates, whose oath many physicians take and are expected to abide by. Apparently Hippocrates was so mistrustful of patients, and disdainful of their inability to understand medically what needed to be done with their own bodies, that he believed it was imperative for physicians to hide most of the facts of

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6. See Louis Harris & Associates, Views of Informed Consent and Decisionmaking: Parallel Surveys of Physicians and the Public, in II President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, at App. B, Table 5-15, cited in Kurtz, The Law of Informed Consent, supra note 2, at 1254 (reporting that 89% of patients and 76% of physicians believe that the right to informed consent is so crucial that it deserves legal protection).

7. See Ketchup v. Howard, 543 S.E. 2d 371, 373 (Ga. Ct. App. 2000) (observing that up to the time this opinion was handed down, all of the states, with the exception of Georgia, recognized the informed consent doctrine). In Ketchup, the Georgia Court of Appeals overruled its prior decision in Young v. Yarn, 222 S.E.2d 113 (Ga. Ct. App. 1975) which had rejected the requirement of informed consent in Georgia. After an unreasonable delay in recognizing the right of patients to material information and alternatives to proposed medical procedures, Georgia finally became the last state to adopt the common law doctrine of informed consent.

8. See Joan H. Krause, Reconceptualizing Informed Consent in an Era of Health Care Cost Containment, 85 Iowa L. Rev. 261, 273 (1999) (observing that “physicians traditionally have not viewed patients as capable of making appropriate decisions about their own care.”). See also Ladonna L. Griffith, Informed Consent: Patient's Right to Comprehend, 27 How. L. J. 975, 975 (1984) (noting that “at one point in medical history, the cliché ‘Doctor Knows Best’ was simply accepted.”).

treatment and outcomes from them. Other early great thinkers such as Plato echoed Hippocrates. For example, Plato saw nothing wrong with a physician lying to the patient, provided the rationale behind the lie was to advance allegedly "good and noble purposes." Based on the positions of these ancient and venerable thinkers, it is no surprise that such esteemed pioneers of American medicine as Benjamin Rush embraced physician paternalism towards patients on the issue of consent with open arms. Dr. Rush argued passionately about the necessity of absolute physician authority over the patient, while divulging as little as possible to the patient regarding the patient's own condition. Significantly, Rush was viewed as highly enlightened in his day. Such views perhaps persuaded the American Medical Association ("AMA") to promulgate a code of ethics enjoining physicians from disclosing to the patient a gloomy prognosis of the patient's condition. The AMA code, which was adopted in 1847 provided in relevant part:

A physician should not be forward to make gloomy prognostications, because they savor of empiricism, by magnifying the importance of his services in the treatment or cure of the disease. But he should not fail, on proper occasions, to give to the friends of the patient timely notice of danger when it really occurs; and even to the patient himself, if absolute necessary ... For, the physician should be the minister of hope and comfort to the sick; that ... he may smooth the bed of death, revive expiring life, and counteract the depressing influence of those maladies which often disturb the tranquility of the most resigned in their last moments. The life of a sick person can be shortened not only by the acts, but also by the words or the manner of the physician. It is, therefore, a sacred

10. See id. at 1243 (noting that Hippocrates cautioned physicians to hide "most things from the patient while you are attending to him ... revealing nothing of the patient's future or present condition").

11. See JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984), cited in Kurtz, The Law of Informed Consent, supra note 2, at 1243 (noting that Plato viewed one of the vital roles of the physician as the employment of lies to persuade the patient to accept recommended treatment, and to use lies [deception] to achieve "good and noble purposes.").


13. See id.

14. See id.
duty to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits.\textsuperscript{15}

Not content with this level of paternalism, which was perhaps well-intentioned, and intent on fostering the absolute supremacy of the physician over the care of the patient, the same AMA code of ethics enjoined patients from questioning the opinions of their physicians no matter how unreasonable they may appear by proclaiming: "[t]he obedience of a patient to the prescriptions of his physicians should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them."\textsuperscript{16}

This paternalistic AMA code of ethics remained essentially unrevised until 1980. Unfortunately for patients, the judiciary was all too willing to put its imprimatur on physician paternalism. However, as early as 1889 at least one jurisdiction, Maryland, required physicians to consult with and obtain the consent of the patient prior to a surgical procedure.\textsuperscript{17} Through the middle part of the twentieth century, judicial attitudes in other jurisdictions changed slowly in requiring basic consent to surgical procedures.\textsuperscript{18} Although Justice Cardozo made his venerable statement in Schloendorff\textsuperscript{19} in 1914,\textsuperscript{19} and other jurisdictions had by this time recognized the right of a patient to consent prior to surgery, judicial approaches to the issue of consent prior to the Salgo decision were limited to the basic consent requirement in a battery analysis,\textsuperscript{20} and were generally saturated with paternalistic overtones. For example, consider the following case. In

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16. See id.
20. See also Bryan J. Warren, Comment: Pennsylvania Medical Informed Consent Law: A Call to Protect Patient Autonomy Rights by Abandoning the Battery Approach, 38 Duq. L. Rev. 917, 927-29 (2000) (observing that the early judicial approaches to consent were premised on battery, and limited to the requirement of bare consent); D. Scott Porch, IV, Note: Recent Developments in Tennessee's Doctrine of Informed Consent, 30 U. Mem. L. Rev. 593, 595 (2000).
\end{flushleft}
Barfield v. South Highlands Infirmary, et al, an Alabama case, the evidence revealed, and the defendant surgeon even admitted that the patient had vociferously objected to the amputation of her leg. Notwithstanding the patient's apparent lack of consent, the Alabama Supreme Court exonerated the surgeon on the dubious ground that there was allegedly a conversation where the patient's mother later indicated that her daughter had consented. Further, the Court rationalized that in light of the seriousness of the plaintiff's condition, "it was proper for defendant to consult with the mother – and not conceivably improper in any event – [and] to act upon her consent as the implied consent of plaintiff." Finally, demonstrating that its ruling was influenced more by paternalistic tendencies (though perhaps well-intentioned) and indicating an absence of any consideration for the plaintiff's right to decide what should be done with her own body, the Barfield court emphasized that, "considerations of custom, humanity, and reason," militated in favor of finding the defendant-surgeon not liable. Significantly, there was no indication from the opinion that the patient was either a minor or in a situation where she was objectively incapable of consent.

Consider also Hunt v. Bradshaw, a North Carolina case where the plaintiff alleged, among other things, that the surgeon failed to advise him of the seriousness of the contemplated surgery. The surgery resulted in severe injury to the patient. Although the court determined that the plaintiff's evidence established that the "damage to plaintiff's hand and arm resulted from the operation," this alone was not sufficient. The Court explained,

[It is understandable the surgeon wanted to reassure the patient so that he would not go to the operating room unduly apprehensive. Failure to explain the risks involved, therefore, may be considered a mistake on the part of the surgeon, but

22. See id. at 35 (noting that the patient declared "that she would rather die than have her leg cut off, it may be said, further, that there was no denial, but that plaintiff long persisted in her refusal to have the operation performed. Defendant himself testified to that." (emphasis added).
23. Id.
24. See id. at 35.
25. See id. at 36.
27. See id. at 523-24.
under the facts cannot be deemed such want of ordinary care as to import liability.\textsuperscript{28}

Completely absent from the court's consideration was a recognition of the patient's autonomy and right to bodily integrity. Nor did the court consider the necessity of providing the patient with the information necessary to decide whether or not to proceed with the surgery.

\textit{Bang v. Charles T. Miller Hospital}\textsuperscript{29} is a compelling example of brazen physician indifference to the right of the patient to determine what should be done with his own body. The evidence in \textit{Bang} revealed that the plaintiff began having urinary difficulties from 1951 to 1952. Seeking medical intervention, the plaintiff consulted with a local physician who referred him to a local hospital. Two physicians at the local hospital in the plaintiff's hometown of Austin, Minnesota apparently diagnosed his condition as an enlarged prostate and bladder soreness and recommended the defendant-hospital situated in St. Paul for tissue removal to correct the plaintiff's problems. Plaintiff, however, consulted with the defendant-physician in St. Paul who allegedly indicated to the patient that he was unsure of the exact nature of the plaintiff's problems, but advised admission to the defendant-hospital for a possible prostate surgery.

According to the defendant-physician's own admission, without informing the plaintiff-patient of the nature of prostate surgery, the defendant not only performed the surgery, but intentionally cut the patient's spermatic cords, rendering him sterile. Notwithstanding the admissions of the defendant, especially with regard to not informing the patient that he would sever his spermatic cords, the trial court dismissed the patient's action. On appeal, the Supreme Court of Minnesota appropriately held that "the question as to whether plaintiff consented to the severance of his spermatic cords was a fact question for the jury and that it was error for the trial court to dismiss the action."\textsuperscript{30} In addition, the court emphasized "that a reasonable rule is that, where a physician or surgeon can ascertain in advance of an operation alternative situations and no immediate emergency exists, a patient should be informed of the alternative possibilities and given a chance to decide before the doctor proceeds with the operation."\textsuperscript{31} Significantly, however, the court did not

\begin{itemize}
\item \textsuperscript{28} See \textit{id}.
\item \textsuperscript{29} 88 N.W.2d 186 (Minn. 1958).
\item \textsuperscript{30} \textit{Id.} at 189.
\item \textsuperscript{31} \textit{Id.} at 190.
\end{itemize}
explain whether the disclosure was to be based on the physician standard or the patient standard.

Notwithstanding the paternalistic approach of the many pre-Salgo cases, there were few exceptions to the paternalistic bandwagon. For example, in Hunter v. Burroughs, a Virginia case decided almost forty years prior to Salgo, the evidence revealed that following a bout of eczema, the plaintiff-patient consulted the defendant-physician for a treatment option. The defendant advised the plaintiff that the newly developed x-ray treatment was appropriate for his condition. However, the evidence further revealed that the defendant neither informed the patient of the risk of skin burns from the application of the x-ray to the patient's legs and ankles, nor applied the x-rays to the patient in accordance with the standard of care to which even he, the defendant, testified. The court agreed with the plaintiff-patient's contention "that it is the duty of a physician in the exercise of ordinary care to warn a patient of the danger of possible bad consequences of using a remedy." 

III. PHYSICIAN OR PATIENT STANDARD? THE BATTLE FOR THE STANDARD OF DISCLOSURE

After the judicial adoption of the informed consent doctrine in Salgo, the focus shifted to whether the standard of disclosure should be based on what a reasonable physician or reasonable patient would consider material to an informed decision. Although Salgo held in pertinent part 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," and emphasized that "the physician may not minimize the known dangers of a procedure in order to induce his patient's consent," it is not clear whether Salgo adopted the reasonable physician or patient standard of disclosure. Based on the ambiguity of Salgo with respect to the type of standard adopted, the struggle shifted to a determination of whether the

32. 96 S.E. 360 (Va. 1918).
33. Id. at 366.
34. Id. at 366-67, 369.
35. Id. at 366.
37. See id.
extent of disclosure should be left to the physicians, who had historically insisted on absolute supremacy over what should be done with the patient's own body, or be decided on the basis of what a reasonable patient would consider material in deciding whether or not to undergo a recommended treatment.

In the first major case on informed consent after Salgo, the Kansas Supreme Court decided that the physician was better equipped to determine what information should be disclosed to the patient. Three years after Salgo, in the seminal case of Natanson v. Kline, the court, while adopting the informed consent doctrine, made it clear that it was imposing the physician standard. Natanson is significant not only for being the first to adopt the physician standard, but for the exemplary display of paternalism by the defendant-physician. The facts revealed that following a radical left mastectomy as a result of breast cancer, the patient came under the care of radiologist, defendant Dr. John R. Kline, for the application of radiation therapy to the site of the mastectomy and the surrounding areas. The radiation therapy, involving application of radioactive cobalt, was fairly new in use. This therapy was so powerful when compared to ordinary x-ray treatments, which were then the traditional radiation treatment for cancer patients, that the cobalt machine was compared to "a three million volt X ray machine."


39. See id. at 1106 (emphasizing "In our opinion the proper rule of law to determine whether a patient has given an intelligent consent to a proposed form of treatment by a physician was stated and applied in Salgo v. Leland Stanford, Etc. Bd. Trustees [. This rule in effect compels disclosure by the physician in order to assure that an informed consent of the patient is obtained. The duty of the physician to disclose, however, is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances.") (emphasis added).

40. See Porch, supra note 20, at 596 (observing that Natanson v. Kline represents the first adoption of the physician standard of disclosure).

41. See Natanson, 350 P. 2d at 1095.

42. See id. at 1101 (observing "The treatment of a cancer patient with radioactive cobalt is relatively new.").

43. See id.

44. See id. According to the opinion, the Atomic Energy Commission specified the construction of the room where the machine was housed, and required the filing of periodic reports of radiation outside the room. The room
addition, application of the cobalt radiation required a rotating beam, which necessitated the assistance of a specialist in physics. Despite these facts, the defendant, Dr. Kline, did not inform the patient that the treatment involved any danger of serious bodily injury. Rather, he admitted that he knew that he was "taking a chance" with the proposed treatment. Although the opinion did not explicitly indicate that Dr. Kline acted in complete disregard of the patient's right to determine what was to be done with her own body, there was no indication that the patient was advised of any alternative treatment options either. In the course of the application of the cobalt radiation, which plaintiff alleged was negligently done, plaintiff-patient's "entire chest, skin, cartilage, and bone were completely destroyed in those areas," and the "ribs of her left chest were so burned that they became necrotic, or dead."

Addressing the issue of "whether the physician... obtained the informed consent of the patient to render the treatment administered," the court emphasized "a patient cannot be expected to know the hazards or the danger of radiation from radioactive cobalt unless the patient is informed by a radiologist who knows the dangers of injury from cobalt irradiation." After observing that, "[a] doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception," the court cited Salgo with approval, and held

was located underground outside the hospital, and the walls were made of forty inches thick concrete. Even the ceiling was made of concrete so thick that it measured twenty-four inches. Adding to the sense of foreboding of the surroundings was the fact that "when the radiation treatment is administered to a patient, the operator in the outer room looks through a specially designed thick lead quartz glass which gives a telescopic view." *Id.*

45. See id. at 1096-97.
46. See id. at 1100.
47. See id. at 1100.
48. Id. at 1097.
49. Id. at 1098.
50. Id. at 1101.
51. Id.
52. Id. at 1106 (stressing "In our opinion the proper rule of law to determine whether a patient has given an intelligent consent to a proposed form of treatment by a physician was stated and applied in Salgo v. Leland Stanford, Etc. Bd. Trustees.").
upon all the facts and circumstances here presented Dr. Kline was obligated to make a reasonable disclosure to the appellant of the nature and probable consequences of the suggested or recommended cobalt irradiation treatment, and he was also obligated to make a reasonable disclosure of the dangers within his knowledge which were incident to, or possible in, the treatment he proposed to administer.\textsuperscript{53}

Perhaps more importantly on the applicable standard, the court emphasized, "[t]he duty of the physician to disclose, however, is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment."\textsuperscript{54}

Many of the cases following \textit{Natanson} went along with the "doctor knows best" notion by adopting either the physician standard,\textsuperscript{55} or remaining non-committal on the applicable standard,\textsuperscript{56} continuing the prevailing notion that professionals within the medical field were better equipped to determine the fate of patients.

Consider the 1966 case of \textit{Gray v. Grunnagle},\textsuperscript{57} which involved a plaintiff with leg problems who was admitted to a hospital under the services of an orthopedic surgeon named Dr. Blakeley. On the day he was admitted, the plaintiff-patient was made to sign a consent form for surgery,\textsuperscript{58} even though tests to determine whether his condition required surgery had in fact not yet been ordered, and the neurosurgeon, defendant Dr. Jerome Grunnagle who ended up performing surgery on him, had not yet been retained by Dr. Blakeley.\textsuperscript{59}

\textsuperscript{53} \textit{Id.} at 1106.
\textsuperscript{54} \textit{Id.}
\textsuperscript{56} \textit{See}, e.g., Gray v. Grunnagle, 223 A.2d 663 (Pa. 1966).
\textsuperscript{57} \textit{Id.}
\textsuperscript{58} \textit{Id.}
\textsuperscript{59} \textit{See id.} at 665 (noting that the defendant neurosurgeon, Dr. Grunnagle, who performed what the jury determined was surgery without informed consent, was brought into the matter and examined the plaintiff-patient on January 19,
Evidence at trial further revealed that although the medical procedure performed by Dr. Grunnagle, a laminectomy, was a major surgical procedure involving a substantial risk of paralysis, which risk materialized, rendering the plaintiff unable to walk, it was more probable than not that the defendant physician did not advise the patient of the attendant risks and alternatives to the procedure.

After consideration of the facts, the court held that

it is our opinion that a reasonable rule is that, where a physician or surgeon can ascertain in advance of an operation alternative situations and no immediate emergency exists, a patient should be informed of the alternative possibilities and given a chance to decide before the doctor proceeds with the operation.

Significantly, the court chose not to take advantage of the opportunity to specify whether the standard of disclosure should be the physician standard enunciated in Natanson v. Kline, or a patient standard yet to be determined.

1960, even though the patient was admitted and signed a consent to surgery a day earlier).

60. See id. at 673 (noting that testimony elicited from the defendant-neurosurgeon revealed that the laminectomy was a major surgical procedure carrying a 15 to 20 percent chance of paralysis, and that it was customary within the medical community to inform patients of this major risk. The laminectomy was described by Dr. Grunnagle as involving cutting several ligaments around the spinal cord). See id. at 665-66 for a detailed description of the extent of cutting which transpired during the laminectomy.

61. See id. at 665 for the text of the consent form. The consent form on which Dr. Grunnagle allegedly relied for his authority to perform the laminectomy neither contained risks inherent with the procedure, nor alternatives to the procedure. Id. In addition, the patient expressly testified that he was not advised of the nature of the surgery he was subjected to despite his nervous inquiry of a resident physician and nurses, and his testimony was deemed credible by the Court. Id. The court noted that “Mr. Gray's apprehension and continued questioning of nurses and a resident physician certainly is indicative that he was very uncertain of what surgical procedures were to be performed upon him. He could not have consented, certainly, with any knowledge or understanding of an impending operation on January 18, 1960, the date of his admission to the hospital, and at which time neither diagnostic tests had been performed, nor had surgery been discussed.” Id. at 674. Equally important was the testimony of the defendant physician that he could not recall advising the patient of the risks attendant to the surgery. Id. at 673.

62. Id. at 670.
The informed consent doctrine expanded by leaps and bounds after the pronouncement in *Salgo* to the extent that by 1972 the doctrine had permeated much of the United States. However, many jurisdictions continually favored the paternalistic oriented physician standard. Perhaps due to the expanding the judicial recognition of the physician conspiracy of silence, which made it very difficult or impossible for many patients to make out a prima facie case under the physician standard of disclosure, many important decisions advocating a disclosure standard based on the needs of a reasonable patient came down in the early 1970s. For example, in 1971 the Pennsylvania Superior Court decided *Cooper v. Roberts* and expressly adopted the reasonable patient standard of disclosure in informed consent cases as the common law of Pennsylvania. In adopting the reasonable patient standard, the *Cooper* court was greatly influenced by a "community of silence" within the medical profession. *Cooper* involved a physician who perforated a patient's stomach while performing a gastroscopic examination. The doctor had failed to inform...
his patient of the risks associated with using a fiberscope during such a medical procedure. The court recognized the difficulty of procuring physicians within the community who would be willing to testify against one of their colleagues on the information required to be disclosed prior to this procedure, and it was aware of the fact that Gray v. Grunnagle had not resolved the issue of which disclosure standard should be applied under Pennsylvania law. The Superior Court held that equitable considerations dictated the adoption of the reasonable patient standard under which the physician must disclose "all those facts, risks and alternatives that a reasonable man in the situation which the physician knew or should have known to be the plaintiff's would deem significant in making a decision to undergo the recommended treatment."

For whatever reason, Cooper v. Roberts did not inspire jurisdictions to adopt the reasonable patient standard of disclosure. However, the celebrated case of Canterbury v. Spence, which some commentators erroneously credit with first announcing the patient standard, may have been the lightning rod for the adoption of the reasonable patient standard of disclosure by many jurisdictions. The pertinent facts in Canterbury, in

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68. See id. (noting "[t]here was no dispute among the parties that the cause of the perforation was in fact the gastroscopic examination.").


70. Cooper, 286 A.2d at 650. The Court emphasized "[a]s the patient must bear the expense, pain and suffering of any injury from medical treatment, his right to know all material facts pertaining to the proposed treatment cannot be dependent upon the self-imposed standards of the medical profession." Id.

71. 464 F.2d 772 (D.C. Cir. 1972). See Krause, supra note 8, at 271 (highlighting Canterbury as "perhaps the most well-known of all American informed consent cases").


the words of the Court of Appeals, were depressing. Equally depressing, and profoundly illustrative of the paternalism of some within the judiciary, were the trial court’s directed verdicts in favor of all the defendants in the case.

The facts of Canterbury show that in December 1958, nineteen year-old Jerry Canterbury, a clerk-typist for the Federal Bureau of Investigation, began to experience severe pain between his shoulder blades. He consulted with defendant-neurosurgeon, Dr. William Spence, after prior consultations with two general practitioners and prescription medications failed to relieve his pain. Dr. Spence’s extensive physical examination and a subsequent x-ray failed to pin-point the cause of the patient’s severe pain, prompting Dr. Spence to order a diagnostic medical procedure known as a myelogram. The myelogram revealed a filling defect within the region of the fourth thoracic vertebra. Dr. Spence recommended a surgical procedure known as a laminectomy to determine the cause of the aberration.

Prior to the surgery on February 11, 1959, almost two years after the decision in Salgo, Dr. Spence failed to advise either the patient or the

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74. See Canterbury, 464 F.2d at 776 (noting “[T]he record we review tells a depressing tale.”).
75. At the conclusion of the plaintiff’s case-in-chief, the trial court granted both defendants’ motions for a directed verdict. See id. at 778-79. A directed verdict is similar to a non-suit, and is normally granted when the party with the burden of proof, usually the plaintiff, fails to prove the elements of his or her cause of action. See, e.g., Emmanuel O. Ihekwumere, Application of the Corporate Negligence Doctrine to Managed Care Organizations: Sound Public Policy or Judicial Overkill?, 17 J. CONTEMP. HEALTH L. & POL’Y 585, n.159 (2001) [hereinafter Ihekwumere, Corporate Negligence Doctrine] (referencing Pa. R. Civ. P. 230 and 230.1, and Fed. R. Civ. P. 41).
76. See Canterbury, 464 F.2d at 776.
77. See id.
78. See id. According to the opinion, a myelogram is “a procedure in which dye is injected into the spinal column and traced to find evidence of disease or other disorder.” Id.
79. See id.
patient's mother of the one percent risk of paralysis from the surgery.\textsuperscript{81} Approximately one day after the laminectomy surgery the patient fell out of bed while attempting to relieve himself while completely left unattended and unassisted by hospital personnel.\textsuperscript{82} Several hours after the fall the patient suffered complete paralysis from the waist down. Later that evening, Canterbury underwent surgery to restore some control over the muscles below the waist. Despite the surgery, Canterbury was unable to void properly and required constant care from a urologist. Nine years later, Canterbury continued to suffer from urinal incontinence and paralysis of the bowels. As a result, Canterbury needed the assistance of crutches to walk and had to wear a penile clamp.\textsuperscript{83}

Mr. Canterbury brought suit against Dr. Spence and the Washington Hospital alleging, among other causes of action, negligent performance of the laminectomy, negligent post-operative care, and Dr. Spence's violation of the informed consent doctrine by his failure to warn of the one percent risk of paralysis from the laminectomy.\textsuperscript{84} For some inexplicable reasons, save an inability to secure any expert witness willing to bridge the community of silence to testify against one of their own,\textsuperscript{85} plaintiff-patient "introduced no evidence to show medical and hospital practices, if any, customarily pursued in regard to the critical aspects, and only Dr. Spence, called as an adverse witness, testified on the issue of causality."\textsuperscript{86}

However, Dr. Spence conceded that he did not inform the patient of the one percent risk of paralysis because "communication of that risk to the patient is not good medical practice because it might deter patients from undergoing needed surgery and might produce adverse

\textsuperscript{81} See Canterbury, 464 F.2d at 794, n.138.
\textsuperscript{82} See id. at 777 (noting that the patient indicated a need to void, and was given a receptacle by the hospital nurse, who then left without assisting the patient, even though by the patient's apparently uncontradicted testimony, the hospital bed had no side rail to prevent a fall). According to the opinion, "[T]he one fact clearly emerging from the otherwise murky portrayal by the record, however, is that the appellant did fall while attempting to void and while completely unattended." Id. n.4.
\textsuperscript{83} See id. at 777-78.
\textsuperscript{84} See id. at 778.
\textsuperscript{85} See id. n.124 (observing "[w]e the chief obstacles facing plaintiffs in malpractice cases has been the difficulty, \textit{and all too frequently the apparent impossibility}, of securing testimony from the medical profession") (emphasis added, internal citations omitted).
\textsuperscript{86} Canterbury, 464 F.2d at 778.
psychological reactions which could preclude the success of the operation. Significantly, Dr. Spence testified that the paralysis could have been due to both the surgery and trauma. Despite Dr. Spence’s admissions and the immediate onset of the paralysis after the patient’s fall from his hospital bed while completely unattended, the trial judge granted both Dr. Spence’s and the hospital’s motions for a directed verdict. Citing the plaintiff’s alleged failure to introduce medical evidence of negligence in the performance of the laminectomy, and the plaintiff’s failure to introduce medical testimony on the relationship between the patient’s fall and his subsequent paralysis, the trial judge granted the motions. The issue of consent was not addressed in the trial court’s ruling.

The Court of Appeals for the District of Columbia reversed and remanded for a new trial on all counts. Addressing the issue of consent, the Court of Appeals held “[t]he testimony of appellant and his mother that Dr. Spence did not reveal the risk of paralysis from the laminectomy made out a prima facie case of violation of the physician’s duty to disclose which Dr. Spence’s explanation did not negate as a matter of law.”

Responding to Dr. Spence’s contention that the one percent risk of paralysis was immaterial, thus foreclosing disclosure, the court countered, stating that “[a] very small chance of death or serious disablement may well be significant; a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady may summons discussion with the patient.” The court then examined the history of consent in American jurisprudence, and observed: “To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the

87. Id.
88. Id.
89. Id.
90. See id. at 779 (observing “The [trial] judge did not allude specifically to the alleged breach of duty by Dr. Spence to divulge the possible consequences of the laminectomy.”).
91. Canterbury, 464 F.2d 772.
92. Id.
93. According to the opinion, Dr. Spence termed the risk of paralysis from the laminectomy “a very slight possibility.” Canterbury, 464 F.2d at 778 (emphasis in the original).
94. Id.
direction in which his interests seem to lie."

Emphasizing that the scope of the physician’s disclosure to the patient must be measured by the amount of information that a patient needs to make an intelligent choice, the court observed that “a risk is thus 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 or cluster of risks in deciding whether or not to forego the proposed therapy.” The court then held that where an issue of informed consent arises, the physician must communicate to the patient “the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated.”

Justifying its emphasis on the informational needs of the patient, and not on what the physician only feels is necessary to disclose, the Canterbury court appropriately noted the difficulty of patients in overcoming the community of silence among physicians, as did Cooper v. Roberts. Both courts correctly emphasized that respect for the patient’s right of control over his or her own body strongly militated in favor of a judicially imposed standard rather than one arbitrarily set by the members of the medical community, particularly since in attempts to exonerate one of their own from liability, physician silence may be mistaken for a non-existent custom in any particular case. Further, Canterbury correctly noted the inherent paternalism in allowing physicians to determine what is adequate information for an informed decision. Following in the footsteps of Canterbury, many jurisdictions soon adopted the patient

95. Id. at 781.
96. Id. at 787 (citing Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw. U.L. Rev. 628, 640 (1970)).
97. Id. at 787-88.
98. See Cooper, 286 A.2d at 650; see generally Canterbury, 464 F.2d at 772.
99. See Canterbury, 464 F.2d at 783-84 (regarding the dangers inherent in making disclosure dependent on medical custom, the court warned “We sense the danger that what in fact is no custom at all may be taken as an affirmative custom to maintain silence.”).
100. Id. at 786 (observing that “[a]ny definition of scope [of disclosure] in terms purely of a professional standard is at odds with the patient’s prerogative to decide on projected therapy himself. That prerogative, we have said, is at the very foundation of the duty to disclose, and both the patient’s right to know and the physician’s correlative obligation to tell him are diluted to the extent that its compass is dictated by the medical profession.”).
standard of disclosure.\textsuperscript{101}

However, despite \textit{Canterbury}'s celebrated status and the force of its criticism against the physician standard of disclosure, and a nationwide trend towards the patient standard,\textsuperscript{102} the physician standard has retained its resiliency and remains the majority view.\textsuperscript{103} This is particularly true in those jurisdictions where the informed consent doctrine has been adopted by statute.\textsuperscript{104} Notwithstanding the constant battles for supremacy between the physician and patient standards, one of the major developments in the informed consent jurisprudence since \textit{Canterbury} has been the focus on the type of information which is material, warranting disclosure by the physician. The court in \textit{Canterbury} found a one percent risk of paralysis from a laminectomy material, warranting disclosure.\textsuperscript{105}

IV. MATERIALITY AND THE EVOLUTION OF DISCLOSABLE INFORMATION

Recognizing the necessity of a balance between the informational needs of the patient and the placement of a limit on the disclosure obligation of the physician, the \textit{Canterbury} court wisely formulated the rule of disclosure in terms of materiality, instead of unduly burdening the physician with the obligation of disclosing all risks, no matter how trivial,

\begin{itemize}
  \item \textsuperscript{101} See \textit{Logan v. Greenwich Hosp. Ass'n}, 465 A.2d 294, 300 (Conn. 1983) (noting the adoption of the patient standard by many jurisdictions soon after \textit{Canterbury}).
  \item \textsuperscript{103} See \textit{Porch}, \textit{supra} note 20, at 596 (observing that the patient standard remains the minority view among the states). \textit{See also} \textit{Ketchup v. Howard}, 543 S.E.2d 371, 378 (Ga. Ct. App. 2000) (noting that the majority of states retain the physician standard, although emphasizing that “almost as many states adhere to the lay [patient] standard.”).
  \item \textsuperscript{104} See \textit{Kurtz}, \textit{supra} note 2, at 1252.
  \item \textsuperscript{105} See \textit{Canterbury}, 464 F.2d at 779 (holding that the plaintiff’s and his mother’s testimony that Dr. Spence did not disclose a one percent risk of paralysis from a laminectomy, made out a prima facie case of violation of the informed consent doctrine, requiring a new trial).
\end{itemize}
attendant upon a recommended procedure.\textsuperscript{106} Canterbury's materiality formulation has quickly gained support in other jurisdictions, and appears to be the benchmark on disclosable information.

Subsequent to Canterbury many important informed consent decisions came down addressing the materiality of information in divergent ways, which included, among other factors, the percentage of the risk occurring and the severity of the harm should the risk materialize. Consider the case of Wilkinson v. Vesey,\textsuperscript{107} decided the same year as Canterbury, where the Rhode Island Supreme Court first addressed and adopted the informed consent doctrine.\textsuperscript{108} The facts and trial court rulings in Vesey epitomized medical and judicial indifference to the plight of the suffering patient. In 1951, 33-year-old patient, Mrs. Winifred Wilkinson, described in the opinion as then in very good health, began experiencing radiating pains in her hands, arms, and legs. Upon consulting her family physician, she was advised to enter the Roger Williams General Hospital and was

\textsuperscript{106} See id. at 787. Although Canterbury framed the requirement of disclosure in terms of information which a reasonable patient (objective standard) would find material to whether or not to proceed with a medical procedure, at least one court has expressly rejected the reasonable person approach, deeming it an encroachment on the patient's right of self-determination. See Scott v. Bradford, 606 P.2d 554, 559 (Okla. 1979) (observing that the reasonable person approach of Canterbury "certainly severely limits the protection granted an injured patient," and holding "[a]ccordingly, we decline to jeopardize this right by the imposition of the 'reasonable man' standard."). In addition, some commentators have highlighted the reasonable patient standard as too restrictive to the extent it impacts on the patient's right of self-determination. See, e.g., Seidelson, Medical Malpractice: Informed Consent Cases in "Full Disclosure" Jurisdictions, 14 DuQ. L. Rev. 309 (1976); Katz, Informed Consent - A Fairy Tale? Law's Vision, 39 U. Pitt. L. Rev. 137 (1977). Although the Scott court and these commentators certainly make a good point that the requirement of "reasonable patient" impacts on the patient's right of self-determination, I believe that the Canterbury approach is eminently justified as a means of balancing the interest of the patient while recognizing the dilemma of physicians who must deal with patients with varying informational needs and idiosyncrasies. A subjective approach leaves the physician too much at the mercy of a disgruntled patient with an ax to grind and the benefit of hindsight.

\textsuperscript{107} 295 A.2d 676, 687 (R.I. 1972).

\textsuperscript{108} Id. at 690 (observing that "this is the first time that we have considered the doctrine of informed consent.").

\textsuperscript{109} Id. at 680.
later referred to the defendants, radiologists Drs. Vesey and Hunt. The defendants' radiographic studies of Mrs. Wilkinson were inconclusive regarding a suspicion of cancer. Neither doctor ordered a biopsy, which was necessary to determine the presence or absence of a malignancy and to confirm the need for deep radiational therapy. The defendants not only initiated deep radiational therapy but also failed to inform the patient of the risks attendant. In addition, the defendants failed to employ the necessary anatomical diagram helpful to insuring the absence of an overlap in the radiational exposure, which the defendants admitted during trial, was essential. The result of these breaches, which the defendants' own trial testimonies established, was that by the time of trial Mrs. Wilkinson had suffered eight operations, the removal of her clavicle, sternum and seven ribs, and endured the surgical movement of her heart and its cushioning by muscles taken from her left arm. These were the alleged consequences of deep radiation therapy for a suspected malignant tumor, which never existed, and was not ruled out by an available

110. *Id.*

111. See *id.* at 681.

112. See *id.* at 683 (observing that defendant, Dr. Hunt, conceded that at the time of the procedure at issue, a biopsy "was a recognized diagnostic procedure." The patient's plastic surgeon and pathologist "made it quite clear that a biopsy supplies conclusive proof of whether or not a tumor is or is not malignant.").

113. *Wilkinson*, 295 A.2d at 682 (noting that "[b]oth defendants testified that they would not recommend the x-ray therapy given Winifred unless they were 'convinced' that she had cancer." (emphasis on convinced in the original).

114. See *id.* at 684.

The defendants explained that in order to insure no [radiational] overlap, it was essential that the filter [radiation beams] be centered exactly in the middle of the field of exposure every time the treatment was given. Doctor Hunt explained that they employed no anatomical diagram to mark the areas of the body that were to be exposed to the radiation. *Id.*

Even more alarming, and clearly indicative of the radiologists lack of concern for precision, which was apparently absolutely essential to the treatment, was the fact that neither one made a mark on the patient's body to note where the beam had been lowered in order to avoid re-exposure to the same site, and to warn the other. *See id.*

115. *Id.* at 681.
diagnostic procedure.\textsuperscript{116}

Notwithstanding the overwhelming evidence of negligence and the physician's failure to advise Mrs. Wilkinson of the risks attendant upon the deep radiation therapy, the trial judge granted the defendant's motion for a directed verdict apparently on all the claims.\textsuperscript{117} The court cited the plaintiff's failure to adduce expert testimony to prove her case, despite the then existing adverse witness statute of Rhode Island that allowed a party to prove his or her case through the expert testimony of the adverse party.\textsuperscript{118}

Addressing the informed consent claim on appeal, the Rhode Island Supreme Court adopted the materiality requirement of \textit{Canterbury}\textsuperscript{119} and noted the difficulty patients faced in securing experts who would testify against one of their own.\textsuperscript{120} Further, the court made one of the most compelling statements in informed consent jurisprudence, i.e., that "[t]he keystone of this doctrine is every competent adult's right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession, or even the community."\textsuperscript{121} The \textit{Vesey} court also emphasized that "the greater the risk, the greater the duty to inform."\textsuperscript{122}

\textsuperscript{116} See \textit{id.} at 681, 683-84 (noting that a biopsy of all the tissues and bones removed from the patient subsequent to the deep radiation therapy showed no evidence of cancer).

\textsuperscript{117} See \textit{id.} at 680 (observing that "[a] jury trial was held in the Superior Court [trial court]. At the end of eight days of testimony, the plaintiffs concluded their case. At that juncture, the trial justice first refused them permission to amend their complaints and then granted the defendants' motion for a directed verdict."). For an explanation of a directed verdict see \textit{supra} note 75 and accompanying text.

\textsuperscript{118} See Wilkinson, 295 A.2d at 682 (noting that "the trial justice overlooked the fact that plaintiff called both defendants as adverse witnesses," each of whom was an expert in his specialty, in violation of R.I. GEN. LAWS § 9-17-14 (1969), which allowed a party to establish the applicable standard of care through the testimony of an adverse witness).

\textsuperscript{119} \textit{Id.} at 688 (emphasizing "the patient is entitled to receive material information upon which he can base an informed consent.").

\textsuperscript{120} See \textit{id.} at 687.

\textsuperscript{121} \textit{Id.}

\textsuperscript{122} See \textit{id.} at 690, \textit{quoting} MORRIS AND MORITZ, DOCTOR AND PATIENT AND THE LAW (5th ed. 1971).
Other cases decided after Canterbury such as Cobbs v. Grant, Logan v. Greenwich Hospital Association, and Hartke v. Mckelway, added their weight and authority to the materiality requirement of Canterbury. Hartke, for instance not only sanctioned the materiality standard, but epitomized the Vesey admonition that the greater the risk, the greater the duty to inform. In Hartke, the plaintiff-patient was prone to numerous and traumatic gynecological and pregnancy related medical problems. She became pregnant after undergoing a sterilization procedure known as a laparoscopic cauterization, which she had been told would foreclose any more pregnancies. The patient sued, contending, among other things, that her physician breached the informed consent doctrine by failing to inform her of a .1%-3% risk of pregnancy after the laparoscopic cauterization. The jury agreed and awarded judgment to the plaintiff. On appeal, the defendant-physician argued “that he had no duty to disclose the risks of pregnancy in this case since no ‘reasonable person in what the physician [knew] or should [have known] to be the patient’s position would be likely to attach significance to the risks in deciding whether to accept or forego the proposed treatment.’

The court – the same court which decided Canterbury eleven years earlier – observed that the risk of pregnancy in this case would be

123. 502 P.2d 1 (1972). In Cobbs the Supreme Court of California held that a physician was obligated to advise the patient of not only the risks inherent upon a recommended procedure, but also of the risks of foregoing a recommended procedure. Id. at 10.

124. 465 A.2d 294 (Conn. 1983). In Logan the Connecticut Supreme Court for the first time addressed the doctrine of informed consent “as a basis for malpractice liability of a physician,” and echoed the Canterbury reasoning that the patient, not the medical profession, is better suited to determine what should be done with his or her body, and sharply criticized the physician standard of disclosure as impinging on the right of self-determination of the patient. Significantly, in this case the court held that a physician was obligated to disclose to the patient an alternative procedure which was arguably more hazardous than the one performed. Id.

125. 707 F.2d 1544 (D.C. Cir. 1983).

126. Id. at 1548.

127. Id.

128. Id. at 1549.

129. See id. at 1546.

130. Id. at 1548 (quotation in the original) (internal citation omitted).
considered very small by most people, but rejected the physician’s argument on appeal on the grounds that he knew or should have known that any risk of pregnancy subsequent to the procedure was of great concern to the patient. The court focused on the materiality of any risk of pregnancy whatsoever to this special patient who appeared to have considered the risk of pregnancy a matter of life and death.

In the 1990s, perhaps as a result of the invariability of death from the Acquired Immunodeficiency Syndrome (“AIDS”), its association originally with traditionally disfavored groups and the intolerable social stigma which infection with AIDS invited, courts began to address the materiality of risks of factors external to, and not inherent in, medical procedures such as the potential Human Immunodeficiency Virus (“HIV”) infection of patients from their doctors. The three cases analyzed herein show the split among the courts on the materiality of potential infection from practitioner to patient.

ESTATE OF BEHRINGER v. THE MEDICAL CENTER AT PRINCETON

In early June 1987, plaintiff, Dr. Behringer, an attending surgeon at the

131. Id. at 1549.
132. See id. at 1548-49 (emphasizing that defendant Dr. McKelway had conclusive evidence of the significant risk of subsequent pregnancy to the patient based on these factors: (1) defendant knew that the patient had a history of frequent and traumatic gynecological, and pregnancy related problems; (2) he knew that she contracted a severe infection known as peritonitis after her first delivery by Caesarean section, suffered an ectopic pregnancy, and had been hospitalized numerous times for minor gynecological procedures; and (3) he had been informed by the patient, apparently before the procedure that several physicians had opined that she would not likely survive another pregnancy. Significantly, the patient’s boyfriend had indicated to Dr. McKelway his willingness to undergo a vasectomy if there was a chance that the patient’s sterilization would be unsuccessful).
133. See id.
134. See generally Iheukwumere, supra note 5 (discussing the inevitability of death from AIDS infection, the stigma of infection and arguing that HIV infected physicians involved in invasive procedures have both a legal and ethical obligation to disclose their infection status to patients despite indications that the risk of physician to patient infection is very small).
135. HIV is the virus that causes AIDS. See id. at 715-16.
defendant Medical Center ("Center"), became ill and was admitted to the Emergency Room ("ER"). His treating physician examined him upon admission, and determined that he needed to undergo a diagnostic procedure known as a bronchoscopy. Results of the bronchoscopy revealed that Dr. Behringer was infected with AIDS. Somehow news of Dr. Behringer's AIDS diagnosis reached the president of the Center, who promptly canceled Dr. Behringer's pending surgical cases. Subsequent to the Center president's action, the Center's board of trustees voted to require HIV positive surgeons to disclose their infection status to their patients prior to surgery. At the conclusion of several months of intense consultations between the medical and dental staff, hospital administration, and the board of trustees, the Center adopted a measure prohibiting any HIV positive practitioner from performing any "procedures that pose any risk of HIV transmission to the patient." Based on this measure Dr. Behringer's surgical privileges were suspended.

Dr. Behringer filed suit against the Center, alleging, among other claims, that "1) the risk of transmission of HIV from surgeon to patient is too remote to require informed consent, and 2) the law of informed consent does not require disclosure of the condition of the surgeon." In addressing Dr. Behringer's allegations the Court emphasized:

It is this court's view that the risk of transmission is not the sole risk involved. The risk of a surgical accident, i.e., a needle stick or scalpel cut, during surgery performed by an HIV-positive surgeon, may subject a previously uninfected patient to months or even years of continual HIV testing. Both of these risks are sufficient to meet the Jansen standard of "probability of harm."

137. A bronchoscopy is a medical diagnostic procedure involving bronchial washings to establish the presence or absence of Pneumocystis Carinii Pneumonia ("PCP"). A positive indication of PCP conclusively establishes the presence of AIDS. See Iheukwumere, supra note 5, n.69, citing Estate of Behringer, 592 A.2d at 1255.

138. See Estate of Behringer, 592 A.2d at 1258.

139. Id. at 1259-1260.

140. Id.

141. Id. at 1279. In addition, Dr. Behringer alleged that the measure which requires HIV positive surgeons to disclose their status to their patients prior to surgery violated the New Jersey statutory prohibition against discrimination. Id.

and the Largey\textsuperscript{143} standard requiring disclosure.\textsuperscript{144}

The court observed that an "infected surgeon, even if the virus drastically shortens his surgical career, can be expected to perform numerous operations. Assuming that the surgical patient's risk is exceedingly low (1/130,000), the risk that one of his patients will contract HIV becomes more realistic the more operations he performs."\textsuperscript{145} The court then held that "[i]n assessing the materiality of risk, this court concludes that the risk of accident and implications thereof would be a legitimate concern to the surgical patient, warranting disclosure of this risk in the informed consent setting."\textsuperscript{146} In addition, the court stressed that "[a] reasonably prudent patient would find information that his physician is infected with HIV material to his decision to consent to a seriously invasive procedure because the potential harm is severe and the risk, while low, is not negligible."\textsuperscript{147}

FAYA V. ALMARAZ\textsuperscript{148}

Two years after Estate of Behringer, the issue of the materiality of a physician infected with AIDS came before the Maryland Court of Appeals. The facts in Faya v. Almaraz reveal that one year after being diagnosed with AIDS, defendant Dr. Rudolf Almaraz, an oncological surgeon with operating privileges at Johns Hopkins Hospital ("Hospital") in Baltimore performed invasive surgeries on the plaintiffs Sonya Faya and Perry Mahoney Rossi respectively, at the Hospital.\textsuperscript{149}

Dr. Almaraz failed to advise the plaintiffs of his AIDS status.\textsuperscript{150} However, three weeks after Dr. Almaraz died from AIDS'-related complications the plaintiffs learned of his AIDS infection from a local newspaper.\textsuperscript{151} The plaintiffs then initiated a suit against Dr. Almaraz's


\textsuperscript{144} See Estate of Behringer, 592 A.2d at 1279.

\textsuperscript{145} Id. at 1280.

\textsuperscript{146} Id. (emphasis added).

\textsuperscript{147} Id. at 1283.

\textsuperscript{148} 620 A.2d 327 (Md. 1993).

\textsuperscript{149} Id. at 329.

\textsuperscript{150} Id. at 333.

\textsuperscript{151} Id. at 329.
estate, his practice group, and the Hospital for compensatory and punitive damages. Plaintiffs alleged, among others, that Dr. Almaraz breached his duty under the informed consent doctrine by failing to advise them of his AIDS infection prior to the surgeries.\footnote{152}

The trial court dismissed the plaintiffs' action for failure to state a claim upon which relief could be granted, on the grounds that the plaintiffs failed to sufficiently allege actual exposure to the AIDS virus, and perhaps, more importantly, tested negative for the virus.\footnote{153} On appeal, the Court of Appeals held: "we cannot say as a matter of law that no duty was imposed upon Dr. Almaraz to warn the appellants of his infected condition or refrain from operating upon them."\footnote{154}

Justifying its holding, the court noted that an important premise underlying the duty to inform is the foreseeability of a potential harm.\footnote{155} The court then stressed "[u]nder the allegations of the appellants' complaints, taken as true, it was foreseeable that Dr. Almaraz might transmit the AIDS virus to his patients during invasive surgery."\footnote{156} Addressing the defense's argument that the risk of physician to patient transmission is a remote risk, the court observed that "legal scholars have long agreed that the seriousness of potential harm, as well as its probability, contributes to a duty to prevent it."\footnote{157}

KERINS V. HARTLEY\footnote{158}

In Kerins v. Hartley, the California Court of Appeals for the Second District, in reversing the trial court's grant of summary judgment to the defendant obstetrical surgeon, held that a legally cognizable battery action existed where a patient-plaintiff testified that the defendant performed an invasive procedure on her despite his HIV seropositivity, combined with the fact that her consent was predicated on the defendant's good health.\footnote{159} On remand from the California Supreme Court, the court held that recovery was not possible as a matter of law when a plaintiff's

\footnotesize{152. Id. at 330.}
\footnotesize{153. Faya v. Almaraz, 620 A.2d. 327, 330-331 (Md. 1993).}
\footnotesize{154. Id. at 334.}
\footnotesize{155. Id. at 327.}
\footnotesize{156. Id. at 333.}
\footnotesize{157. Id. at 333. (emphasis added).}
\footnotesize{158. 33 Cal. Rptr. 2d 172 (Cal. App. 1994).}
\footnotesize{159. Id. at 174 (citing Faya v. Amaraz, 620 A.2d. 327 (Md. 1993)).}
fear of contracting AIDS during a lengthy surgical procedure under a seropositive physician was not "corroborated by reliable medical or scientific opinion, that her risk of developing AIDS has significantly increased and has resulted in an actual risk of AIDS that is significant.""160

The court's about-face after the remand from the Supreme Court appears justified by the facts of the case. The pertinent facts revealed that approximately five days after performing an invasive procedure on the plaintiff to remove a tumor, the defendant received the results of a test showing that he was HIV positive.161 Approximately a year and half later, the defendant-physician filed a discrimination lawsuit against his partners when they refused to allow him to return to his surgical practice.162 He announced on television that he had AIDS.163 Shortly after viewing the news conference the plaintiff underwent testing for HIV. The result came back negative for the virus.164

Despite the negative result, and the fact that the defendant received test results five days after the plaintiff's surgery showing that the defendant had tested positive for HIV, the plaintiff sued the defendant, alleging, among others, that her consent to the surgery had been vitiated by the defendant's failure to inform her of his seropositive HIV status.165 The trial court granted the defendant's motion for summary judgment, holding as a matter of law that the defendant had not committed a battery upon the plaintiff.166 On appeal, the Court of Appeals, citing the rationale of Faya v. Almaraz,167 held that the plaintiff had set forth a legally cognizable cause of action with her assertion of the fear of contracting AIDS.168 However, on remand from the California Supreme Court, the intermediate appellate court held that the plaintiff's fear of developing AIDS was unreasonable as a matter of law, and that she could not recover on her battery claim.169

160. Id. at 181. (emphasis added).
161. Id. at 174.
162. Id.
163. Id.
164. Id. at 175.
165. Id. at 180.
166. Kerins, 33 Cal. Rptr. 2d at 180.
167. 620 A.2d 327 (Md. 1993).
168. See Kerins, 33 Cal. Rptr. 2d at 174.
169. Id. at 181.
V. THE RELEVANCE OF PHYSICIAN EXPERIENCE TO A VALID INFORMED CONSENT: SELECTED CASES

In the 1990s, while the potential for physician to patient transmission of AIDS infection was receiving judicial and scholarly attention, the materiality of physician experience in the context of informed consent began to percolate. In *Kaskie v. Wright*, the Pennsylvania Superior Court confronted the issue of whether or not the defendant surgeon breached the informed consent requirement by failing to advise the parents of his minor patient prior to surgery of his alcoholism, and lack of a Pennsylvania medical license. Addressing this issue, the Superior Court agreed with the trial court that the physician’s alcoholism was not a material issue requiring disclosure, and affirmed the trial court’s grant of summary judgment to the defendants.

*Kaskie* held that to expand the informed consent doctrine to include disclosure of matters personal to the treating physician such as alcoholism would take the doctrine “into realms well beyond its original boundaries.” The informed consent issue, however, may not have been the main reason, which influenced the court to affirm the trial court. Rather, the *Kaskie* court may have been persuaded that the plaintiffs’ action was filed after the running of the applicable statute of limitations, and refused to accept the plaintiffs’ fraudulent concealment argument.

171. See *id.* at 214 (“[a]ppellants... claimed that informed consent was lacking, as they had not been told prior to permitting the operation on their son that Dr. Stewart was an alcoholic and unlicensed to practice medicine in Pennsylvania.”).
172. *Id.* at 213.
173. *Id.* at 217.
174. See *id.* at 215 (“[t]here is no dispute here that the action was commenced beyond the two year limitations period set by 42 Pa. [C.S.A.]5524(2).”). See also *id.* at 216 (“the patient, or in this case his representatives, does not need to know the precise extent of the alleged injuries before the statute of limitation on informed consent will run. Here appellants knew the child died. At that time medical negligence would have been apparent and/or could have been discovered.”).
175. See *id.* at 215.

Appellants contend... that appellees are estopped from advancing the statute [of limitations] as a defense, arguing that the statute is tolled by the appellees’ failure to provide them...
To the extent Kaskie implied that matters personal to a physician are irrelevant to the requirements of the informed consent doctrine, such implication is not only misplaced, but is contradicted by the same Pennsylvania Superior Court's opinion in *Cooper v. Roberts*[^176] which held that prior to a surgical procedure the physician must disclose "all those facts, risks and alternatives that a reasonable man in the situation which the physician knew or should have known to be the plaintiff's would deem significant in making a decision to undergo the recommended treatment."[^177] Certainly, the fact of a physician's alcoholism would be of significant concern to a reasonable patient, since an alcohol impaired physician, or one likely to be impaired during an invasive procedure would impact on the likelihood of a mistake during the procedure.

In 1996, the Wisconsin Supreme Court raised the ante on the materiality of risks of factors external, not inherent, to medical-surgical procedures with its audacious and well-reasoned ruling in *Johnson v. Kokemoor.*[^178] The relevant facts were set forth by the court as follows: following bouts of headaches, the plaintiff underwent a CT scan diagnostic test. Apparently aided by the results of the CT scan, the defendant doctor diagnosed "an enlarging aneurysm at the rear of the plaintiff's brain and recommended surgery to clip the aneurysm."[^179] However, prior to the recommended surgery, involving clipping the aneurysm classified as a basilar bifurcation aneurysm,[^180] reputed as one of the most difficult surgical undertakings in all of neurosurgery,[^181] the plaintiff allegedly asked the defendant how many times the defendant had performed the contemplated surgery.[^182] The defendant indicated that he

[^177]: Id. at 650.
[^178]: 545 N.W. 2d 495 (Wisc. 1996).
[^179]: See id. at 498.
[^180]: See id. at 499 n.10.
[^181]: See id. at 505 (noting that "The plaintiff also introduced evidence that surgery on basilar bifurcation aneurysms is more difficult than any other type of aneurysm surgery and among the most difficult in all of neurosurgery.").
[^182]: Id. at 499.
had performed the surgery dozens of times. The fact, according to the opinion, however, was that:

The defendant had relatively limited experience with aneurysm surgery. He had performed thirty aneurysm surgeries during residency, but all of them involved anterior circulation aneurysms. According to the plaintiff’s experts, operations performed to clip anterior circulation aneurysms are significantly less complex than those necessary to clip posterior circulation aneurysms such as the plaintiff’s. Following residency, the defendant had performed aneurysm surgery on six patients with a total of nine aneurysms. He had operated on basilar bifurcation aneurysms only twice and had never operated on a large basilar bifurcation aneurysm such as the plaintiff’s.

In addition to overstating his experience with the surgery, evidence revealed that the defendant reviewed medical literature prior to the surgery and was aware of the substantial morbidity and mortality risks attending the procedure. Even so, he failed to inform the patient of the levels of risk of death or serious impairment for this particularly difficult surgery. Evidence showed that when this procedure was performed by a physician with the defendant’s level of experience, the risks were actually closer to thirty percent, instead of the two percent represented by the defendant. Further, evidence showed that the defendant failed to advise the plaintiff that a tertiary care center was the appropriate setting for her difficult surgical procedure, since such a center had the necessary experienced neurosurgeons and facility.

183. *Id.*
184. *Id.* (emphasis added) (footnotes omitted).
185. *Id.* at 506. The defendant also admitted at trial that he had not shared with the plaintiff information from articles he reviewed prior to surgery. These articles established that even the most accomplished posterior circulation aneurysm surgeons reported morbidity and mortality rates of fifteen percent for basilar bifurcation aneurysms. Furthermore, the plaintiff introduced expert testimony indicating that the estimated morbidity and mortality rate one might expect when a physician with the defendant’s relatively limited experience performed the surgery would be close to thirty percent. *Id.*
186. *Id.* at 499.
187. *Id.* at 509 (noting “[a]rticles from the medical literature introduced by the plaintiff also stated categorically that the surgery at issue should be performed at a tertiary care center while being ‘excluded’ from the community setting.”)
Although the defendant clipped the aneurysm, "rendering the surgery a technical success," and the plaintiff dismissed her negligent treatment claim prior to trial, as a result of the surgery "the plaintiff, who had no neurological impairments prior to surgery, was rendered an incomplete quadriplegic. She remains unable to walk or to control her bowel and bladder movements. Furthermore, her vision, speech and upper body coordination are partially impaired."

During the liability phase of the bifurcated trial, the trial court admitted, as relevant to the plaintiff's informed consent, the following evidence: (1) the defendant's relative lack of experience; (2) his failure to refer the plaintiff to a tertiary care center; and (3) his failure to advise the plaintiff of the statistical percentage of morbidity and mortality for a basilar bifurcation aneurysm surgery when performed by an experienced surgeon, as opposed to one performed by a surgeon with the defendant's level of experience. Significantly, the defendant's experts conceded that the risk of the surgery was two to five times the figure represented by the defendant to the plaintiff, and admitted that they would divulge their level of experience with a particular procedure if questioned by a patient. The jury concluded that the defendant failed to adequately inform the plaintiff of the risks associated with her surgery, and that a reasonable patient, if fully informed of the risks of the surgery, would have withheld consent from the defendant.
On appeal, defendant argued that the trial court’s evidentiary rulings constituted an abuse of discretion. A split court of appeals agreed with the trial court on the materiality, admissibility of the defendant’s relative lack of experience, and the morbidity and mortality comparative risk data. However, the court reversed on the issue of the defendant’s failure to refer the plaintiff to a tertiary care center, holding that “evidence about the defendant’s failure to refer the plaintiff to more experienced physicians was not relevant to a claim of failure to obtain the plaintiff’s informed consent.”

The state supreme court confronted three issues, i.e., whether the defendant-neurosurgeon breached the informed consent doctrine by: (1) not disclosing to the patient prior to the difficult brain surgery the neurosurgeon’s limited experience in the performance of such surgery; (2) failing to advise the patient of the rate of morbidity and mortality for this particular procedure between surgeons with his level of experience and more experienced surgeons; and (3) not referring the plaintiff-patient to a tertiary care center staffed with physicians more experienced in the particular type of surgery.

Calling the issues presented one of first impression before the court and noting the lack of appellate cases on point, the supreme court sided entirely with the evidentiary rulings of the trial court, and reversed the court of appeals on the referral issue. Citing the applicable statutory provision, Wisconsin Stat. Section 448.30, which provides that “[a]ny physician who treats a patient shall inform the patient about the availability of all alternate, viable modes of treatment and about the benefits and risks of these treatments,” the court rejected the defendant’s proposed bright line rule precluding the admission of evidence of a physician’s level of experience as a matter of law in informed consent matters. The court also rejected the defendant’s proposed bright line rule on the morbidity and mortality comparative risk

196. Id.
197. Id. at 498.
198. Id. at 498.
199. See Kokemoor, 545 N.W.2d at 497.
200. Id. at 498.
201. Id. (holding “We conclude that all three items of evidence were material to the issue of informed consent in this case.”).
202. Id. at 501 (citing Wis. Stat. § 448.30 (1997)).
203. Kokemoor, 545 N.W. 2d at 504.
data.\textsuperscript{204} The court noted that the statutory doctrine of informed consent in Wisconsin was based on the materiality standard of\textit{Canterbury v. Spence}\textsuperscript{205} and required the disclosure of "all of the viable alternatives and risks of the treatment proposed."\textsuperscript{206} The court then reiterated that its prior opinion in\textit{Martin v. Richards}\textsuperscript{207} had already rejected the defendant's argument that the statutory disclosure requirement was limited to risks inherent to a treatment option.\textsuperscript{208} The court held:

In this case information regarding a physician's experience in performing a particular procedure, a physician's risk statistics as compared with those of other physicians who perform that procedure, and the availability of other centers and physicians better able to perform that procedure would have facilitated the plaintiff's awareness of "all of the viable alternatives" available to her and thereby aided her exercise of informed consent. We therefore conclude that under the circumstances of this case, the circuit court [trial court] did not erroneously exercise its discretion in admitting the evidence.\textsuperscript{209}

This article is mainly concerned with the\textit{Kokemoor} court's decision to allow evidence of a physician's level of experience in informed consent matters on a case-by-case basis. The court's analysis of disclosure of comparative risk data and of physician referrals where appropriate centers are available for a patient's recommended procedure are beyond the scope of this article's discussion. However, this author applauds the\textit{Kokemoor} court's holdings on these other issues.

Some commentators greeted the\textit{Kokemoor} decision with alarm, and attacked its foundation as unsound.\textsuperscript{210} They failed to see it as a necessary

\begin{flushright}
\textsuperscript{204} \textit{Id.} at 506.
\textsuperscript{205} \textit{See id.} at 502.
\textsuperscript{206} \textit{Id.} (quoting Martin v. Richards, 531 N.W.2d 70 (Wis. 1995)).
\textsuperscript{207} 531 N.W. 2d 70 (Wis. 1995).
\textsuperscript{208} \textit{See Kokemoor}, 545 N.W. 2d at 505 (observing that "[t]he Martin court rejected the argument that Wis. Stat. \textsection448.30 was limited by its plain language to disclosures intrinsic to a proposed treatment regimen.").
\textsuperscript{209} \textit{See id.} at 498 (alteration in the original).
\textsuperscript{210} \textit{See, e.g.,} Richard A. Heinemann,\textit{Pushing the Limits of Informed Consent: Johnson v. Kokemoor and Physician-Specific Disclosure}, 1997 Wis. L. REV. 1079, 1080-81 (1997) (calling the doctrinal foundation of the opinion ambiguous, and asserting that the "new disclosure requirements are not sufficiently tailored to the reality of how contemporary health care is delivered.")
\end{flushright}
evolution of the informed consent doctrine. Reactions from other jurisdictions to Kokemoor were splintered. A year after the ruling in Kokemoor the intermediate appellate court in Washington State declined to hold that a physician’s level of experience was material to informed consent.21 In Whiteside v. Lukson,212 evidence revealed that prior to obtaining the patient’s consent for the removal of the patient’s gallbladder via a method known as a laparoscopy, the defendant had only performed the procedure on three pigs, and never on a human.213 Defendant failed to advise the patient of this fact.214 During the plaintiff’s procedure the defendant misidentified the bile duct and damaged it resulting in multiple complications.215 The patient sued, alleging lack of informed consent on account of the defendant’s failure to disclose his lack of experience in performing the procedure.216 The jury agreed with the plaintiff’s contentions, and rendered a verdict in her favor.217 The trial judge, however, determined that the defendant’s lack of experience was not a material fact requiring disclosure, and consequently granted the defense’s motion for judgment notwithstanding the verdict.218 The court of appeals affirmed, on the ground that such a requirement was expansive, and that the state of Washington still adheres to a ‘traditional approach’ which only requires disclosure of facts “which relate to the proposed treatment.”219 Strangely enough, the court failed to explain why the physician’s lack of experience was not material information relating to the procedure.

On the opposite side of Whiteside, both the Delaware Supreme Court in Barriocanal v. Gibbs220 and the highest state court of Maryland in Dingle v. Belin221 embraced the rationale of Kokemoor. In Barriocanal, the Delaware Supreme Court concluded that the trial court erred in
precluding the testimony of the plaintiffs' expert. The facts in this case show that on April 19, 1992 the defendant Dr. Martin Gibbs performed brain aneurysm surgery on the plaintiffs’ decedent, Mrs. Emiliana Barriocanal. During the surgery Dr. Gibbs clipped the decedent’s right distal internal carotid artery instead of the aneurysm. The clipping of the carotid artery caused the decedent to suffer a massive cerebral injury, resulting in her death. Pretrial the plaintiffs’ expert opined that Dr. Gibbs deviated from the standard of care regarding informed consent by not disclosing prior to the procedure that he had not performed aneurysm surgery recently. Defense counsel filed a motion in limine to exclude the plaintiffs’ informed consent testimony on the basis that the expert “had not unequivocally stated that this type of information is customarily given to patients in order to secure their informed consent.”

The trial court in Barriocanal granted the defense’s motion in limine and excluded the testimony of the plaintiffs’ expert on informed consent. The plaintiffs filed a petition for reconsideration of the ruling, and attached therein a letter from their expert expressly stating, among other things, that “Dr. Gibbs should have conveyed the paucity of his recent aneurysm surgery including no such operations in the prior year.”

Although the record on appeal does not indicate whether the trial court ruled on the petition, the trial court excluded the plaintiffs’ evidence on informed consent at trial. Following a verdict for the defendant, the plaintiffs moved for a new trial, alleging, among other things that based on Kokemoor, the trial court improperly excluded their evidence on informed consent relating to the experience of the defendant-neurosurgeon with aneurysm surgery. The trial court denied the motion for a new trial.

On appeal, the Delaware Supreme Court held that it was reversible

222. Barriocanal, 697 A.2d at 1172-73.
223. Id. at 1170.
224. Id.
225. Id.
226. Id.
227. Id.
228. Id.
229. Id. at 1171.
231. Id.
error to exclude the opinion of the plaintiffs' expert regarding the necessity of the defendant's disclosure "of his recent aneurysm surgery."232 By so holding, the court at worst implicitly, and at best, expressly adopted the rationale of Kokemoor regarding the necessity of physician experience to a valid informed consent.

In Dingle v. Belin,233 plaintiff Deborah Belin underwent gall bladder surgery under the care of defendant-surgeon Dr. Lenox Dingle. During the surgery fourth year resident physician Dr. Magnuson who was assisting Dr. Dingle, dissected the gall bladder and took it out.234 However, during the dissection of the gall bladder Dr. Magnuson dissected the bile duct instead of the cystic duct, resulting in the drainage of bile into the plaintiff's abdomen. As a result of the bile drainage into the plaintiff's abdomen she had to undergo extensive corrective surgery, and suffered much pain and discomfort.235

Ms. Belin filed suit alleging, among other claims, that Dr. Dingle breached the informed consent doctrine by allowing the resident, Dr. Magnuson, to play a very active role in the surgery, i.e., by allowing her to do the cutting, clamping, and stapling. In support of her breach of consent claim, Ms. Belin alleged that prior to the surgery she received assurances from Dr. Dingle that he would perform the surgery "and only use a resident to assist him as was absolutely necessary."236 Further, Ms. Belin testified that she insisted on Dr. Dingle doing the actual surgery because, as a surgical technician at the same hospital, she knew that surgeons allowed residents to play a major part in surgery as part of the teaching process.237

After the presentation of evidence, the trial judge's instruction to the jury apparently merged the negligence claim with the informed consent claim.238 Perhaps as a result of the merging of the two claims, the verdict sheet simply asked the jury whether Dr. Dingle was negligent in causing the plaintiff's injuries, without distinguishing between negligence in the performance of the surgery, and negligence in failing to obtain the

232. Barriocanal, 697 A.2d at 1172.
233. 749 A.2d 157 (Md. 2000).
234. Id.
235. Id.
236. Id.
237. Id. at 160.
238. Id. at 162.
plaintiff’s informed consent. The jury answered in the negative and returned a verdict for Dr. Dingle.

On appeal to the Maryland Court of Special Appeals, the informed consent claim was essentially treated as a breach of contract action. In a split decision, the Maryland Court of Special Appeals found the plaintiff’s claim meritorious. The court of appeals granted certiorari “principally to consider whether a physician who, as part of his or her contractual undertaking with a patient, agrees to an allocation of tasks between the physician and other physicians, may be liable for breach of contract if that agreement is violated.” Noting that the relationship between a doctor and a patient which results in a malpractice action is ordinarily a contractual one, the court observed that due to the potentially greater recovery under a tort action, i.e., availability of damages for pain, suffering, and disfigurement, “malpractice actions have traditionally been tort-based, the tort arising from the underlying contractual relationship.” In addressing the plaintiff’s claim, the court stressed that although claims based on lack of informed consent usually involve allegations that the physician failed to make adequate disclosure of a material risk or collateral effect of the contemplated procedure or of an available alternative not carrying that risk or effect, the duty is not so limited. Risks, benefits, collateral effects, and alternatives normally must be disclosed routinely, but other considerations, at least if raised by the patient, may also need to be discussed and resolved.

In support of this statement the court cited, among others, Kokemoor. The Court then held that in surgical procedures, which may involve collaborations between the chosen surgeon and other medical professionals who may be unknown to the patient, the chosen surgeon must discuss and resolve with the patient the identity of which persons

239. Id.
240. Id.
241. Id.
242. Id.
243. Id. at 163.
244. Id. at 164 (internal citation omitted).
245. Id. at 165 (emphasis added).
246. Id.
will be performing aspects of the surgery, if the identity of those persons is important to the patient. The court emphasized that

> [d]espite Dr. Dingle’s protestation to the contrary, a physician who agrees to a specific allocation of responsibility or a specific limitation on his or her discretion in order to obtain the consent of the patient to the procedure and then, absent some emergency or other good cause, proceeds in contravention of that allocation or limitation has not obtained the informed consent of the patient.

In 2001, the Pennsylvania Supreme Court decided *Duttry v. Patterson* and expressly repudiated the holding of *Kokemoor* regarding the materiality of disclosure of physician experience in the informed consent setting. Plaintiff Cloma Duttry was diagnosed with esophageal cancer in February 1989. Soon after, she consulted with defendant, Dr. Lewis T. Patterson, who recommended surgical intervention. During the surgical consultation, Mrs. Duttry allegedly asked Dr. Patterson about his experience with the recommended procedure and specifically inquired how many times he had in fact performed that type of surgery. Dr. Patterson responded that he had performed the recommended surgery about once a month for the past five years.

On June 5, 1989, Dr. Patterson performed the surgery, after which serious complications arose that required a subsequent emergency surgery. Complications from the June 5, 1989 surgery permanently

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247. *Id.* at 166.
248. *Id.*
250. *Id.* at 1256.
251. *Id.*
252. *Id.* at 1256-57 (stating “[plaintiff] Duttry claims that she questioned [defendant] Patterson about his experience in performing the type of operation he recommended.”).
253. *Id.* (“Patterson allegedly told Duttry that he had performed this particular procedure approximately once every month.”). In particular, see *id.* at 1260, observing that the defendant advised the plaintiff that he had performed the procedure about sixty times, when in reality he had performed it only nine times (Nigro, J) (dissenting opinion).
254. See *id.* at 1257. The surgery on the plaintiff-patient involved a resection of portions of her esophagus and stomach. Three days subsequent to the
damaged the plaintiff's lungs, resulted in development of a serious medical condition known as adult respiratory disease syndrome and rendered her unable to work.255

Mrs. Duttry and her husband sued Dr. Patterson and his practice group, alleging medical malpractice and lack of informed consent. At trial the plaintiffs attempted to introduce evidence showing that Dr. Patterson had performed the relevant surgery only nine times in the preceding five years, contrary to his representation of a figure close to sixty.256 The trial judge held the evidence inadmissible on the ground that it was irrelevant to a claim of informed consent.257 The jury returned a verdict for the defense.258 On appeal the superior court reversed and remanded for a new trial.259 The superior court held that evidence relating to Dr. Patterson's experience in performing the surgery was relevant to the informed consent claim.260

On further appeal, the Pennsylvania Supreme Court framed the issue as "whether the Superior Court erred as a matter of law when it determined that information concerning a surgeon's personal qualifications and experience is relevant to an informed consent claim."261 Calling the superior court's holding an "expansive approach," the supreme court observed that the common law approach to informed consent in Pennsylvania has traditionally been limited.262 Rejected
rationale of Kokemoor, the court held that "information personal to the physician, whether solicited by the patient or not, is irrelevant to the doctrine of informed consent." Justifying its holding, the court emphasized that adoption of the superior court's approach and that of Kokemoor would result in a redundant cause of action, since the inexperience of a physician and a physician's deception may be the basis for other grounds of action such as misrepresentation.

In a strong dissenting opinion Justice Russel Nigro argued that it is unreasonable to deem the consent informed when such consent was procured by the physician's gross exaggeration of his experience. More importantly, Justice Nigro argued that information regarding a physician's experience with a surgical procedure would certainly be considered material by a reasonable patient, thus warranting disclosure.

VI. THE RELEVANCE OF PHYSICIAN EXPERIENCE TO A VALID INFORMED CONSENT: ANALYSIS

This article contends that it defies logic to assert that the experience of a physician is immaterial to a patient's informed consent. Since the patient must bear the expense, pain, and suffering of any medical procedure, he or she is certainly entitled to know before consenting whether the physician wielding the scalpel has only practiced the procedure on animals, as was the case in Whiteside v. Lukson, or is truly experienced in the performance of the particular procedure. Any

Court below is in opposition to this Commonwealth's traditional view that the doctrine of informed consent is a limited one.

263. Id. at 1259.

264. While we acknowledge that the learned high courts of some of our sister states have broadened their concept of the informed consent doctrine, we see no compelling reason to follow a similar course. As discussed infra, plaintiffs such as Appellees have recourse against allegedly inexperienced and deceptive physicians via other causes of action. We see no need to alter this commonwealth's definition of informed consent in order to provide what will often be a redundant cause of action.

Id. at 1259.

265. See id. at 1260.

266. Id.

contention that a reasonable patient would consider his or her physician’s level of experience immaterial to a procedure, particularly an invasive procedure, is clearly contradicted by real life experiences. This point was borne out in Taylor v. Albert Einstein Medical Center. In Taylor, the defendant pediatrician determined that the 16-year-old patient needed a diagnostic invasive procedure known as a Swan-Ganz catheterization to better assess her increasingly deteriorating condition. The minor’s parents questioned the defendant-pediatrician about his level of experience in performing the highly technical invasive procedure. Upon learning of his relative lack of experience with the procedure, the parents withheld consent resulting in the appearance of a board-certified cardiologist to carry out the procedure. Unwittingly, however, the pediatrician apparently neither informed the parents that he would perform the procedure while being monitored and assisted by the more experienced cardiologist, nor advised the cardiologist that the parents expected the cardiologist to perform the procedure. The tragic result was that the young patient died while the defendant-pediatrician was performing the major portion of the procedure.

The patient’s autonomy to decide what should be done with his or her own body, and which surgical hands should wield the scalpel over his or her body, is at the center of the informed consent doctrine. This fact was well recognized in Wilkinson v. Vesey where the Supreme Court of Rhode Island wisely emphasized the point that “[T]he keystone of this doctrine is every competent adult’s right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession, or even the community,” and stressed that “the greater the risk, the greater the duty to inform.”

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269. Id. at 1029.
270. Id. at 1030.
271. Id.
272. Id. at 1033.
273. Id. at 1034.
275. Id. at 687.
276. Id. at 690, quoting Morris and Moritz, Doctor and Patient and The Law 217 (5th Ed. 1971).
regressive rulings as Whiteside and Dutry is the judicial fear that disclosure of a physician's level of experience will discourage patients from consenting to treatment by certain inexperienced physicians, the judiciary is well-advised to pay heed to Vesey's point that it is the right of the patient to forego treatment, or even cure, if the consequences of a contemplated procedure are likely to be intolerable.

A physician who is experienced with a particular procedure will invariably be better at performing that procedure, and will in all likelihood obtain a better result. This point is well-recognized by the medical community which requires that physicians undergo extensive internships in medical school, and residency training upon graduation from medical school prior to independently practicing without supervision. Even physicians qualified to practice without supervision realize the importance of experience particularly in serious procedures. Hence the various medical specialty boards would not consider certifying a physician until such a physician has practiced for a certain period of time and/or performed a certain number of procedures. It certainly is reasonable, as shown by Dingle v. Belin to respect a patient's decision that her medical fate not be placed in the hands of a physician undergoing

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277. See The American Board of Obstetrics and Gynecology Rules, available at http://www.abog.org/women/defs.html (last visited April 10, 2002). The rules provide in pertinent part that in order to be certified "a physician must pass a written test to demonstrate that he or she has obtained the special knowledge and skills required for medical and surgical care of women," and an oral examination "given by a team of well-respected national experts; the exam tests the physician's skills, knowledge and ability to treat different conditions. The examiners also review the patients the physician treated during the past year."; see also, Rules and Procedures of The American Board of Orthopaedic Surgery, available at http://www.abos.org/newbuttons.htm (last visited April 10, 2002). The rules pertaining to certifying examinations provide that in order for a physician to become board-certified, he or she must have (1) passed the written test [called Part I of the examination] after successful completion of 60 months of post-doctoral residency, and (2) passed the practice exam [called Part II of the examination], which has as a prerequisite to its taking, the requirement that the applicant "must be continuously and actively engaged in the practice of operative orthopaedic surgery other than as a resident or fellow (or its equivalent) for at least 22 full months immediately prior to the Part II examination." It further provides that the practice "must include hospital admitting and surgical privileges (temporary privileges acceptable) in effect at the time of application and at the time of examination."

278. 749 A.2d 157 (Md. 2000).
training. Even the defendant's own medical experts in *Kokemoor* tacitly agreed with this point when they acknowledged that if a patient inquired they would advise her of the presence of physicians more experienced with her procedure.279 It defies logic and common sense to take away the right of a patient to consider a physician's experience before going under the surgical knife, particularly when the patient takes the time, and musters the courage to inquire.

Considering physician experience immaterial to informed consent smacks of pre-*Salgo* judicial paternalism (physician knows best). For even in situations such as those in *Duttry* and *Whiteside*, it is obvious that some physicians know better than others. Declaring physician experience immaterial in *Duttry* and *Whiteside* is tantamount to a judicial burying of the head in the sand. It ignores the medical reality that complex medical procedures such as surgical removal of aneurysms and lumbar fusion surgeries, among other procedures, are operator dependent. Successful outcomes of such procedures are greatly influenced by the experience of the surgeon. By refusing to consider the experience of the attending physician material to informed consent, courts could be assuring the inexperienced practitioner a pool of patients, and thus preserving his or her livelihood, but such decisions clearly run the risk of protecting and encouraging medical secrecy.280 The physician's inexperience or other personal characteristics such as chronic drug dependency and abuse may be withheld from the patient to his or her utter detriment.281

The *Duttry* court's position is unpersuasive where it states that the recognition of physician experience as essential to a valid informed consent claim would result in a redundant cause of action.282 An analysis of *Duttry*'s admonition in a previous article shows that a

279. See Johnson v. Kokemoor, 545 N.W. 2d 495, 500 (Wis. 1996).

280. See, e.g., Barry R. Furrow, *Doctors' Dirty Little Secrets: The Dark Side of Medical Privacy*, 37 WASHBURN L. J. 283, 308 (1998) (analyzing the dangers of medical secrecy and observing that the defendant-physician in Johnson v. Kokemoor "misrepresented the statistical risks [confronting the plaintiff] deliberately for the sake of his own benefit, that is, a chance to perform the surgery. He concealed a secret, lying to induce a patient to allow him to perform surgery." (citation omitted)).

281. See Iheukwumere, *supra* note 75, at 615 (observing that although legislatures play important roles in safeguarding patients from negligent acts and omissions, the judiciary has an equal role in protecting the interest of patients).

misrepresentation or negligence cause of action under Pennsylvania law is neither equivalent to, nor synonymous with an informed consent action, which is treated as a battery under Pennsylvania and Tennessee law. Although Duttry correctly observed that a misleading statement by a physician can form the basis for a misrepresentation action, and may even support a negligence action, informed consent, misrepresentation, and negligent actions under Pennsylvania law carry different burdens of proof, and require different elements for a prima facie case. First, unlike a purely medical negligence action where the plaintiff, through expert testimony, must show a breach of the prevailing standard of care, and a causal connection between the breach and the plaintiff's injury, once it is shown in a battery action that the physician engaged in the unlawful touching of the patient, i.e., performed a surgical procedure without consent, the plaintiff is entitled to recovery of damages, even if the procedure was performed entirely in accordance with the prevailing standard of care. Second, a misrepresentation action, unlike a battery action, requires a detrimental reliance by the plaintiff in order to recover. Therefore, it is clear that a battery action, which the superior


284. See, e.g., Grabowski v. Quigley, 684 A.2d 610, 615 (Pa. Super. Ct. v. 1996) (noting “it is generally the case that expert medical testimony is required to support a claim of medical malpractice. In the usual medical malpractice case, the requirement is two-fold: 1) to establish whether the physician breached the standard of professional care, and 2) to establish the causal nexus between the act and the injury.”).

285. See id. (observing “because the theory of recovery is battery, Appellant need not establish that the surgery was performed in a negligent manner. In other words, “said surgery could have been done perfectly, and could even have had a beneficial effect on the patient, yet a cause of action could still exist; for it is the very conduct of the unauthorized procedure which constitutes the tort[” quoting Moure v. Racuchle, 604 A.2d 1003, 1008 (Pa. 1992)).

court's approach in *Duttry* would have allowed, is not synonymous with either a negligence or misrepresentation action under Pennsylvania law.

In the context of legal practice, many jurisdictions consider experience so material to effective legal representation, particularly in homicide cases, which involve risks of lengthy incarceration or the death penalty, that before a judge could appoint a lawyer for an accused the lawyer must demonstrate that he or she has either tried major felony cases as the lead counsel and/or been in practice for a substantial period of time.\(^{287}\) Is the life of a patient going under a surgeon's knife any less worthy than that of a criminal defendant?

Along with the goal of maximizing patient safety, common sense and public policy also militate in favor of requiring a physician to truthfully disclose his or her experience, particularly when the patient inquires. A patient's direct inquiry is certainly indicative of the importance the patient attaches to the level of experience of the hand that will wield the scalpel. Also, truthful disclosure of physician experience may result in less litigation. Just as in the practice of law, it may encourage less experienced physicians to refer more difficult cases to their more experienced peers, thus arguably resulting in better care for patients. The goal of patient safety and the need for a better health care system requires a balance between protecting the interest of the physician and the safety and autonomy interests of the patient such that courts should be mindful of imposing too many disclosure obligations upon physicians.\(^{288}\)

The rulings in *Duttry* and *Whiteside* are neither surprising, nor unexpected, in light of the history of judicial paternalism chronicled in the early sections of this article. For one reason or another, the judiciary, particularly in some jurisdictions, appears overly protective of the medical community, and correspondingly, almost indifferent to the autonomy interests of patients. Note how long it took to get from the recognition of

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287. See, e.g., PHILA. CRIM. R. 406-1, available at http://www.courts.state.pa.us/judicial-council/local-rules/philadelphia/philadel_08cp-criminal.pdf. (last visited Apr. 6, 2002) (providing that before a judge may appoint a lawyer lead counsel in a homicide case, the lawyer must show, among other things, at least five years criminal trial experience; service as sole or lead counsel in at least ten jury trials of serious and complex cases, and experience in the use of expert testimony and evidence).

basic consent in *Schloendorff v. Society of New York Hospital*\(^{289}\) in 1914 to informed consent in *Salgo v. Leland Stanford Jr. University Board of Trustees*\(^{290}\) in 1957. However, despite the wrong-headed refusals in cases such as *Duttry* and *Whiteside*, to recognize physician experience as material to a valid informed consent, the reality is that patients consider experience material. The common sense position that experience is material, as evidenced in *Taylor v. Albert Einstein Medical Center*,\(^{291}\) and the compelling legal commentary in *Kokemoor* will result in an eventual, if reluctant, judicial about face, just as the courts experienced in moving from mere consent to informed consent.

**CONCLUSION**

Judicial recognition of the right of the patient to not only basic consent, but informed consent to medical procedures was a long and tedious process, which was probably hampered by strident physician opposition to the sharing of treatment decision with the patient. However, since *Salgo* first adopted the concept of informed consent, and *Canterbury* placed its judicial imprimatur on the patient standard of disclosure, much progress has been made in the evolution of the doctrine. The decision in *Kokemoor* is a necessary evolution of the informed consent doctrine, which made explicit that which common sense, logic, and legal and medical practice already recognize, i.e., experience is material. Although *Duttry* and *Whiteside* refused to recognize this reality, it is predicted that judicial recognition of the soundness of *Kokemoor*’s rationale by cases such as *Barriocanal v. Gibbs*,\(^{292}\) and *Dingle v. Belin*,\(^{293}\) and continuing scholarly commentary on the necessity of physician experience to a valid informed consent, and better medical care, will turn the tide in favor of requiring physicians to truthfully disclose their experience levels with certain medical procedures, particularly when queried by patients.

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289. 105 N.E. 92 (N.Y. 1914).
292. 697 A.2d 1169 (Del. 1997).
293. 749 A.2d 157, 165-66 (Md. 2000).