DISSING DISCLOSURE: JUST WHAT THE DOCTOR ORDERED

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I. INTRODUCTION

Hippocrates rejected the idea that physicians owe their patients an obligation to disclose the risks and benefits of, and alternatives to, the treatments they were about to administer and to obtain their patients' consent to those treatments. Hippocrates specifically counseled physicians that they should perform their calling "calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity...revealing nothing of the patient's future or present condition."[1] The refusal to disclose was not a product of physician arrogance; it was a necessary correlate to the Hippocratic Oath itself: "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."[2] The physician, as the individual dedicated to restore the patient's health and specifically trained to perform that task, was not to be questioned or influenced by the patient's uneducated opinions, irrational concerns, or emotional worries. The decision, physicians believed, was solely a medical decision, and, by education, training, and experience, only they were qualified to make that decision.[3] Any

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1. Hippocrates, *Decorum*, *in* 2 HIPPOCRATES 279, 297, 299 (W.H.S. Jones trans. 1962).

2. 20 ENCYCLOPEDIA AMERICANA 217 (int'l ed., deluxe libr. ed. 1993) (quoting the Hippocratic Oath); *see also* Hippocrates, *Oath*, *in* 1 HIPPOCRATES 299, 299 (W.H. Jones trans. 1962) (quoting the Hippocratic Oath as containing this statement: "I will use treatment to help the sick according to my ability and judgment...").

3. *See* Alan Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 425–28 (discussing the interests of the medical profession in making medical judgments without interference by patients or the legal doctrine of informed consent).

involvement by the patient in the decisionmaking process was resented as an unwarranted intrusion into the physician's "professional prerogatives."[4]

For twenty-four centuries,[5] physicians heeded Hippocrates' advice,[6] and for twenty-four centuries, society allowed them to do so. Societal acquiescence in physician authoritarianism was premised, not only on the doctor's greater knowledge and expertise, but also on the doctor's singular commitment to restoring the patient's health—a fiduciary obligation to consider only the patient's welfare in the medical judgments that were made.[7] The physician's duty was not merely to make his or her own judgments, but also, to make those judgments for the sole purpose of benefiting his or her patient.[8]

But the world has turned many times in the 2400 years since Hippocrates lived. Patients today no longer accept their place as obedient children, powerless even to question the decisions of their physician-fathers.[9] The physician's acknowledged concern for the patient's physical well-being no longer trumps all other considerations, including the patient's interest in making decisions that

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4. *Id.* at 428.

5. Hippocrates is believed to have lived from 470 B.C. to 377 B.C. 5 THE NEW ENCYCLOPAEDIA BRITANNICA MICROPAEDIA 939 (15th ed. 1998).

6. *See* JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 1–29 (1984) (tracing "a history of silence," i.e., physician unwillingness, from the time of Hippocrates to the present, to disclose to patients information about the treatment the physician was about to administer).

7. Many courts recognize that a fiduciary relationship exists between a doctor and his or her patient and hold that breach of this relationship is actionable as medical malpractice. *See, e.g.*, Neade v. Portes, 739 N.E.2d 496, 500 (Ill. 2000); D.A.B. v. Brown, 570 N.W.2d 168, 171 (Minn. Ct. App. 1997); *see also* Moore v. Regents of Univ. of Cal., 793 P.2d 479, 485 (Cal. 1990), discussed *infra* text accompanying notes 239–43 (holding that when a physician fails to disclose research or economic interests that may affect the physician's judgment, a plaintiff may state separate causes of action for either performance of medical procedures without obtaining the patient's informed consent or breach of fiduciary duty).

8. The essence of physicians' unqualified fidelity to their patients' health "is that physicians will not allow any other considerations to impinge on their decisions as to what measures are in patients' best interests." PAUL S. APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 238 (1987).

9. Dr. Atul Gawande, acknowledged:

> Only a decade ago, doctors made the decisions; patients did what they were told. Doctors did not consult patients about their desires and priorities, and routinely withheld information—sometimes crucial information, such as what drugs they were on, what treatments they were being given, and what their diagnosis was. Patients were even forbidden to look at their own medical records: it wasn't their property, doctors said. They were regarded as children: too fragile and simpleminded to handle the truth, let alone make decisions. And they suffered for it. People were put on machines, given drugs, and subjected to operations they would not have chosen. And they missed out on treatments that they might have preferred.

Atul Gawande, *Whose Body Is It Anyway?*, NEW YORKER, Oct. 4, 1999 at 84, 84.

affect his or her own body.[10] Patients are not automatons to be processed at the will of their physicians. Rather, they are autonomous human beings to be treated—but only if they give their permission. Physician paternalism, demanded by the father of medicine, has been replaced—at least in theory—by patient self-determination.

In the latter half of the twentieth century, the legal requirement of informed consent became well-established in all fifty states;[11] as a practical reality, however, it did not. Researchers Alan Meisel and Loren Roth found

> that informed consent as envisioned by the courts is a relatively rare phenomenon in the clinical settings that we have examined. Patients receive information; consent forms get signed. But rarely do doctors sit down with patients and provide them with thorough explanations of treatment options and then seek their consent to one or another. Instead, information is often given to patients not to enable them to choose, but to encourage them to cooperate with doctors and to comply with decisions that have already been made, not by patients as law envisions, but by doctors.[12]

Continued physician resistance to patient autonomy has reduced the right to patient self-determination to empty rhetoric. Knowledge of treatment options and the risks and benefits of each are systematically withheld by doctors; patient decisions are not independently made but are foreordained by doctor deception.[13] In 1961, at a time when the doctrine of informed consent was in its infancy, most doctors did not inform patients that the doctor had diagnosed a life-threatening disease, such as cancer.[14] Today, after forty years of legal doctrinal development, little has changed. Although doctors now inform patients of a cancer diagnosis, they do not inform those who are dying from cancer of how long they have to live—even in response to specific inquiries from patients who know they are

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10. *See* Leonard L. Riskin, *Informed Consent: Looking for the Action*, 1975 LAW FORUM 580, 596 (suggesting that medical schools train physicians only to be concerned for the patient's physical well-being, ignoring all other patient interests).

11. In 2000, Georgia became the fiftieth state to accept the common law doctrine of informed consent. *See* Ketchup v. Howard, 543 S.E.2d 371 (Ga. Ct. App. 2000). In an appendix, the court summarized the law in the other forty-nine states. *See id.* at 381–86.

12. Alan Meisel & Loren H. Roth, *Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265, 334 (1983).

13. *See* KATZ, *supra* note 6, at 26 (asserting that physicians "shape the disclosure process so that patients will comply with their recommendations"); Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379 (1990) (asserting that information is "slanted" to assure that the patient accepts the alternative favored by the doctor, *see id.* at 400, and that patient decisions are "virtually foreordained" by the way doctors phrase information, *see id.* at 408).

14. Donald Oken, *What to Tell Cancer Patients: A Study of Medical Attitudes*, 175 JAMA 1120, 1122, 1123 tbl.1 (1961) (reporting that eighty-eight percent of physicians do not inform their patients that they have cancer).

dying. Doctors either give overly optimistic estimates—they lie—or they give no answer at all—they conceal the truth.[15]

If informed consent has become what Alexander Capron described as "a charade, a symbolic but contentless formality,"[16] the medical profession is not alone to blame. The law has been a willing accomplice. In Part II, I discuss how the promise of patient medical self-determination has been subverted, and perhaps lost, through pusillanimous court decisionmaking.[17] Deference to doctors has replaced the duty of disclosure. In Part III, I discuss the emergence of managed care, i.e., a rationed health care delivery system, with financial incentives paid to physicians to cut costs by cutting care. No longer can physicians be trusted to make treatment decisions guided solely by their fiduciary obligation to their patients' medical well-being. Insurers will not allow them to do so. Insurers also induce physicians to withhold information about their decisions. No longer can physicians be trusted to disclose clinically appropriate, but uninsured, alternatives to their treatment recommendations. Tort law has not responded adequately to this

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15. *See generally* Elizabeth B. Lamont & Nicholas A. Christakis, *Prognostic Disclosure to Patients with Cancer Near the End of Life*, 134 ANNALS INTERNAL MED. 1096 (2001). In this study of terminal cancer patients who had been referred to hospice palliative care, physicians provided frank survival estimates to only 37% of the patients, provided a knowingly inaccurate and overly optimistic estimate to 40.3% of the patients, and provided no survival estimate to 22.7% of the patients. *See id.* at 1102. The authors speculated that physicians who were unwilling to provide a frank disclosure to inquiring hospice patients would be even less likely to provide a frank disclosure to inquiring nonhospice patients. *See id.* at 1103. In the sample studied, the doctors were able to formulate a survival prognosis in 96.5% of the cases. *See id.* at 1099. For those patients who received a prognosis, the median formulated prognosis was seventy-five days, the median communicated prognosis was ninety days, and median actual survival was twenty-six days. *See id.* at 1100.

16. Alexander Morgan Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 367 (1974). Others have reached similar conclusions. *See, e.g.*, Jones, *supra* note 13, at 398, 408 (describing informed consent procedures used by doctors as a ritual that complies with the letter of informed consent doctrine but not its spirit, *see id.* at 398, and concluding that informed consent is a "facade" that does not protect the patient's autonomy, *see id.* at 409); Jay Katz, *Informed Consent–A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 148 (1977) (hereinafter *Fairy Tale*) (asserting that physicians do not make significant disclosures to their patients, and that, in fact, "disclosure and consent...are alien to medical practice"); Jay Katz, *Informed Consent–Must It Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 81 (1994) (describing informed consent as "a charade"); Alan Meisel & Mark Kuczewski, *Legal and Ethical Myths About Informed Consent*, 156 ARCHIVES INTERNAL MED. 2521, 2522 (1996) (asserting that "[a]s practiced, and certainly as symbolized by consent forms, informed consent is often no more than a medical Miranda warning"); William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1705 n.8 (1999) (questioning whether informed consent truly empowers patients or merely gives "the illusion of self-determination").

17. According to the California Supreme Court, writers who support patient autonomy claim "that the practical administration of the [informed consent] doctrine has been thwarted by a failure of judicial nerve and an unremitting hostility to its underlying spirit by the medical profession." Arato v. Avedon, 858 P.2d 598, 605–06 (Cal. 1993).

new challenge to patient autonomy. In Part IV, I assert that managed care justifies an expansion of the physician's disclosure duty, not its contraction or elimination. I propose two guiding principles to assure that patients are informed of medically appropriate treatment options, even if their insurance only pays for medically necessary treatment. In Part V, I suggest that expansion of the disclosure duty may even be welcomed by physicians as a means of restoring trust in the physician-patient relationship. But the requirement of disclosure plays a role, not only in restoring patients' trust in their doctors, but also in restoring victims' faith in the judicial system. Courageous court decisionmaking will be required to achieve that result.

II. THE RISE AND FALL OF INFORMED MEDICAL DECISIONMAKING: WRONGING A RIGHT

A. Battery and Negligence: Round Pegs for a Square Hole

1. Battery

In *Schloendorff v. Society of New York Hospital*,[18] Justice Cardozo declared: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[19] This early twentieth century quotation is often cited as the starting point for the law's recognition of the patient's right to control physician decisionmaking.[20] Ironically, the case did not involve the surgeon's tort liability, but rather, the question of whether a charitable hospital could be held liable for the surgeon's trespass when it could not be held liable for his negligence.[21]

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18. 105 N.E. 92 (N.Y. 1914).

19. *Id.* at 93.

20. *See, e.g.*, Sheldon F. Kurtz, *The Law of Informed Consent: From "Doctor Is Right" to "Patient Has Rights"*, 50 SYRACUSE L. REV. 1243, 1246 (2000) (asserting that "the seeds of the informed consent doctrine are often said to have been planted with...*Schloendorff*"); Geoffrey R. Marczyk & Ellen Wertheimer, *The Bitter Pill of Empiricism: Health Maintenance Organizations, Informed Consent and the Reasonable Psychotherapist Standard of Care*, 46 VILL. L. REV. 33, 88–89 (2001) (asserting that "the origins of the doctrine of informed consent can be traced back to 1914 and Judge Cardozo's opinion in *Schloendorff*"); Fay A. Rozovsky, Book Review, 20 J. LEGAL MED. 513, 513 (1999) (reviewing CARL E. SCHNEIDER, THE PRACTICE OF AUTONOMY: PATIENTS, DOCTORS, AND MEDICAL DECISIONS (1998) and asserting that "Justice Cardozo, in his endlessly quoted *Schloendorff* decision, set the stage for what was to become a decades-long exploration of [the concept of autonomy and individual choice-making]").

21. Because the surgeon was acting as an independent contractor and not an agent of the hospital, the court affirmed a judgment for the defendant. *See Schloendorff*, 105 N.E. at 94–95. The patient claimed that she had specifically agreed to be anesthetized so that a lump in her stomach could be examined. According to her testimony, she specifically forbade any operation on her stomach. Nevertheless, while she was

One might well question, however, why it took until the early twentieth century for the idea of patient self-determination in medical decisionmaking to be recognized. After all, an informed citizenry making the judgments necessary to govern itself was fundamental to our democracy from the time of the American Revolution.[22] As Jefferson asked, rhetorically, in his first inaugural address: "Sometimes it is said that man cannot be trusted with the government of himself.... [H]ave we found angels in the forms of kings to govern him?"[23] If kings could not be trusted to govern us in our interactions with each other, why were physicians trusted to govern us in our interactions with our own bodies?

It is easy to understand why battery was the tort first chosen to champion the patient's right to medical self-determination. *Schloendorff*, and the two earlier twentieth century cases[24] cited as authority by Justice Cardozo in *Schloendorff*,[25] involved fact situations in which the patient either specifically prohibited any operation,[26] or authorized an operation different than the one performed by the surgeon.[27] Under such circumstances, it was easy for the courts to find that the tort of battery had been committed. That tort protects the inviolability of one's person, described by writers of the day as the first and greatest right of a free citizen, one that underlies all other rights.[28] An operation performed without permission on an anesthetized patient[29] violates that patient's bodily integrity. The tort is committed

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unconscious, the surgeon removed a tumor. The patient developed gangrene in her arm, and fingers had to be amputated. Because the trial court directed a verdict for the plaintiff, the New York Court of Appeals accepted the plaintiff's version of the facts as true. *See id.* at 93.

22. *See generally* RICHARD A. BROWN, THE STRENGTH OF A PEOPLE—THE IDEA OF AN INFORMED CITIZENRY IN AMERICA, 1650–1870, at 49–84 (1996).

23. Thomas Jefferson, First Inaugural Address (March 4, 1801), *in* JOHN BARTLETT, FAMILIAR QUOTATIONS 344 (Justin Kaplan, gen. ed., Little, Brown & Co. 16th ed. 1992).

24. *See* Pratt v. Davis, 79 N.E. 562 (Ill. 1906); Mohr v. Williams, 104 N.W. 12 (Minn. 1905).

25. *See Schloendorff*, 105 N.E. at 93.

26. The plaintiff consented to exploratory surgery only. While she was anesthetized, the surgeon removed a tumor in her stomach. *See id.* at 93.

27. In *Pratt*, the husband of an incompetent woman consented to an operation to remove his wife's ovaries. In a second operation, performed without consent, the surgeon removed the wife's uterus. *See Pratt*, 79 N.E. at 564. In *Mohr*, the patient consented to an operation on her right ear. While she was unconscious, the surgeon examined her left ear and performed surgery on the patient's left ear. *See Mohr*, 104 N.W. at 13.

28. *See Mohr*, 104 N.W. at 14.

29. Although the tort of battery can be committed on a patient who is not anesthetized, Jay Katz suggested that the use of anesthesia in the early twentieth century concerned judges, such as Cardozo, who were unwilling to allow doctors to render their patients unconscious and then to operate on them without even informing them of what the doctors intended to do. *See* KATZ, *supra* note 6, at 62.

by the unauthorized contact,[30] no matter how medically appropriate the surgery and no matter how skillfully it is performed.[31]

Neither an intent to harm the patient, nor negligence in the operation itself, are required for the tort of battery, only knowledge that the contact is made without the patient's consent.[32] Actual physical harm to the patient is not a prerequisite for tort liability; battery is a dignitary tort, protecting individuals from offensive as well as harmful contact.[33]

When the operation was performed without any consent, the tort of battery was well-suited to protect the patient's autonomy interest. Over the years, however, patients demanded more for their autonomy right. Self-determination meant more than simply accepting or rejecting the doctor's decision; it meant the right for patients to make the decision themselves. And to make those decisions, patients needed the information about the proposed treatment or surgery that only their doctors could provide to them. But courts were far more reluctant to characterize as batteries treatments or operations that were performed with the patient's consent but without an adequate disclosure by the surgeon of the risks, benefits, and alternatives to the agreed upon procedure.[34]

In developing a disclosure duty a half century after *Schloendorff*, courts distinguished between "real" or "basic" consent, necessary to avoid liability for battery, and "informed" consent, which most courts characterized as negligence. The Supreme Court of Wisconsin identified five reasons why negligence became the preferred theory of liability.[35] First, the doctor in treating the patient or in performing surgery is typically acting in good faith for the patient's benefit. The

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30. RESTATEMENT (SECOND) OF TORTS §18 cmt. d, illus. 1 (1965). In *Mohr*, the court noted that in an emergency when a patient is unconscious, the consent of the person is implied, and the surgeon may operate to preserve the patient's life or health without further consent. The *Mohr* facts, however, did not involve a medical emergency. *See Mohr*, 104 N.W. at 15.

31. *See* DAN B. DOBBS, THE LAW OF TORTS 654 (2000) (asserting that "[t]he wrong done is not a negligent operation but a failure to respect the patient's right of choice"); W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS 190 (W. Page Keeton gen. ed. 5th ed. 1984) (asserting that if the patient is not adequately informed, the physician may be held liable for an adverse consequence even if the operation is skillfully performed).

32. RESTATEMENT, *supra* note 30, §§ 16, 18. The intent required to commit the tort of battery is not the intent to make a harmful contact. The requisite intent is found if the actor "intends to bring about an offensive contact." *Id.* § 16 cmt. a.

33. *Id.* §§ 16, 18. "[T]he essence of the plaintiff's grievance consists in the offense to the dignity involved in the unpermitted and intentional invasion of the inviolability of his person and not in any physical harm done to his body.... " *Id.* § 18 cmt. b.

34. *See* DOBBS, *supra* note 31, at 654 (asserting that most courts construe the patient's informed consent claim as negligence, not battery); KEETON ET AL., *supra* note 31, at 190 (asserting that negligence has generally displaced battery as the tort used for informed consent claims).

35. *See* Trogun v. Fruchtman, 207 N.W.2d 297, 312–13 (Wis. 1973).

failure to inform the patient of the risks of the procedure cannot be equated to a completely unauthorized removal of a bodily organ with no consent.[36] Second, failure to disclose does not constitute affirmative conduct. It is not conceptualized as an intentional act that is required for intentional tort liability to attach.[37] Third, failure to disclose is not conceptualized as contact or touching required for intentional tort liability to attach.[38] Fourth, the doctor's malpractice insurance may not cover intentional misconduct. If not, should the doctor be forced to pay out of his or her own pocket for the failure to inform the patient of the risks—a failure that is essentially an act of negligence?[39] And fifth, an award of punitive damages seems inappropriate for a physician's failure to disclose—again suggesting that negligence and not battery is a more appropriate cause of action.[40]

The reasons given are not persuasive. No one claimed that the *Schloendorff* surgeon was acting in bad faith when he removed the tumor from the patient's stomach, although he was authorized only to perform exploratory surgery. And yet, he was held liable for battery for performing the operation without consent. No one claimed that the surgeons in the two early twentieth-century cases relied on by Justice Cardozo in *Schloendorff* were acting in bad faith when they exceeded the consent given and performed additional surgery. And yet, they were held liable for battery for operating without consent. The fact that performing the additional surgery was viewed by the medical profession as "correct surgical practice"[41] or that it "was skillfully performed and of a generally beneficial nature"[42] does not negate the fact that it was performed without permission. Surgery performed without the patient's permission is offensive contact and is a battery. The absence of hostile intent or malicious motive, the absence of an intent to injure, or the existence of the defendant's good faith in making the contact does not preclude the imposition of intentional tort liability.[43]

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36. *See id.* at 313.
37. *See id.*
38. *See id.*
39. *See id.*
40. *See id.*
41. Pratt v. Davis, 79 N.E. 562, 565 (Ill. 1906).
42. Mohr v. Williams, 104 N.W. 12, 14 (Minn. 1905).
43. Even the conferring of some direct benefit to the plaintiff does not preclude the imposition of intentional tort liability. *See, e.g.*, Longenecker v. Zimmerman, 267 P.2d 543, 545 (Kan. 1954) (holding that the defendant committed the intentional tort of trespass by his unpermitted entrance onto the plaintiff's property, even though the defendant trimmed trees that benefited the plaintiff). The court stated: "From every direct invasion of the person or property of another, the law infers some damage, without proof of actual injury. In an action of trespass the plaintiff is always entitled to at least nominal damages, even though he was actually benefited by the act of the defendant." *Id.* Nevertheless, courts were reluctant to characterize as the intentional tort of battery the good faith conduct of the surgeon, who acted for the purpose of benefiting the patient and who performed the surgery without negligence. *See, e.g.*, Natanson v. Kline, 350 P.2d 1093 (Kan. 1960). The court stated: "What appears to distinguish the case of the unauthorized surgery or treatment from traditional assault and battery cases is the fact that in almost all of the cases the physician is

Ironically, in rejecting the battery tort as too harsh,[44] courts focused on the surgeon's good faith affirmative conduct in performing the unauthorized surgery. Nevertheless, courts also claimed that the failure to disclose does not constitute affirmative conduct that constitutes either an intentional act or a touching required for the tort of battery. The courts cannot have it both ways, relying on the surgery to show the defendant's good faith and ignoring the surgery to find no intentional act or touching. The surgery is intentionally performed, and it is a touching. The absence of the plaintiff's consent to that intentional touching properly characterizes the defendant's conduct as intentionally tortious—a battery.

Additionally, a doctor who is under a duty to disclose information cannot escape intentional tort liability by claiming that his or her failure to disclose is simply a nonaction. It may well constitute intentional conduct. In 1881, the Michigan Supreme Court imposed intentional tort liability upon a doctor for failing to disclose that his assistant, who held the patient's hand as she experienced labor pains, was not also a professional.[45] Although the patient consented to the assistant's presence at her bedside and to the contact he made with her during childbirth, the court upheld the jury verdict for the plaintiff. The defendant intruded on the plaintiff's privacy and deceived her by failing to reveal the assistant's lack of qualifications.[46] Although the defendant's failure to disclose did not itself constitute the contact required for liability in battery to attach, the plaintiff's consent to the contact was vitiated by the defendant's breach of his duty to disclose.[47]

In deciding whether a doctor's denial of a patient's right to informed medical decisionmaking is actionable as a battery, courts should not be influenced by the possibility that the doctor's malpractice insurance does not cover intentional misconduct.[48] Neither Justice Cardozo in *Schloendorff*, nor the judges

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acting in relatively good faith for the benefit of the patient." *Id.* at 1100. Writers have asserted that in deciding to analyze informed consent cases as negligence rather than battery, the "most important factor" to courts is the physician's good faith. Riskin, *supra* note 10, at 593.

44. *See* Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 225 (1985) (asserting that courts rejected battery as an appropriate cause of action because "actions for battery...threatened to yield unacceptably harsh results").

45. *See* De May v. Roberts, 9 N.W. 146, 149 (Mich. 1881). This venerable case helped pave the way for courts to recognize the tort of invasion of privacy. Although the decision was rendered nine years prior to the publication of the seminal article on privacy by Samuel Warren and Louis Brandeis, the court stated, "The plaintiff had a legal right to the privacy of her apartment at such a time, and the law secures to her this right by requiring others to observe it, and to abstain from its violation." *Id.*

46. *See id.*

47. *See id.*

48. Leonard Riskin suggests that as courts began to consider physician failure to disclose cases, plaintiffs' lawyers may have characterized those claims as negligence rather than as battery because they doubted that the physician's malpractice insurance would

in the other early twentieth-century cases that imposed liability in battery for surgery performed without consent, considered whether the wrongdoer had insured himself, or was able to insure himself, against such liability. If a wrong has been done, should the victim be denied compensation because the wrongdoer must pay the judgment out of his or her own pocket instead of out of the pockets of innocent insurance policyholders? Of course not. If anything, a requirement that wrongdoers pay directly instead of spreading the loss through insurance better assures that in the future they, and others like them, will conform their conduct to the law's requirements. In all likelihood, if courts characterized breach of the disclosure duty as battery, and if existing malpractice insurance contracts did not include battery coverage, the contracts would have been modified—perhaps at some increase in premium—to cover such liability.

Although punitive damages are often awarded when intentional torts are committed, they are awarded not because the defendant committed an intentional tort, but rather, because the defendant committed the tort with the requisite malice or ill will.[49] A defendant who intentionally enters the land of another reasonably believing it to be his own commits the tort of trespass to land;[50] a defendant who dispossesses another of a chattel is liable for trespass to chattels or conversion even if the defendant mistakenly believes that he or she either is entitled to possess it or has the plaintiff's consent to possess it.[51] Neither defendant, however, would be held liable for punitive damages. The question of whether punitive damages should be awarded is irrelevant to whether an intentional tort has been committed. Breach of the disclosure duty that resulted in unconsented contact could constitute an intentional tort without necessarily subjecting the defendant to punitive damages.

In some nondisclosure cases, however, punitive damages might well be appropriate. If, for example, the plaintiff proves that the defendant deliberately deceived him or her by knowingly providing false information about the risks, benefits, or alternatives to proposed surgery in order to obtain the plaintiff's consent, such deception may warrant the award of punitive damages.[52] Intentional

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cover a battery claim, and courts may have accepted such characterization to assure that a successful claim would be collectable. *See* Riskin, *supra* note 10, at 593.

49. The Restatement (Second) of Torts provides: "Punitive damages may be awarded for conduct that is outrageous, because of the defendant's evil motive or his reckless indifference to the rights of others." RESTATEMENT, *supra* note 30, § 908(2) (1973). Punitive damages are appropriate only when the conduct involves "some element of outrage similar to that usually found in crime." *Id.* cmt. b.

50. *Id.* § 164 (1965).

51. *Id.* § 244. Similarly, a defendant who shoots the plaintiff's dog reasonably believing it to be a wolf is liable for the value of the dog. Although the defendant acts in good faith, the mistake is not excused. *See* Ranson v. Kitner, 31 Ill. App. 241 (1889).

52. For example, in *De May v. Roberts*, the failure of the doctor to disclose that his assistant was not medically trained, characterized by the court as deceit, might well constitute outrageous conduct justifying the award of punitive damages. 9 N.W. 146 (Mich. 1881); *see supra* text accompanying notes 45–47.

misrepresentation—fraud—has been described as "the very essence of wrong; conduct that has always been and always will be wrong, according to the common judgment of mankind; conduct that cannot be dressed up or manipulated or associated so as to invest it with any element of right."[53] Conduct that is "the very essence of wrong" certainly is sufficiently outrageous to qualify for punitive damages.

2. Negligence

During the last half-century, breach of the physician's disclosure duty has been fitted, rather imperfectly, into the tort of negligence.[54] The patient's right to medical self-determination has been embodied in the doctrine of informed consent.[55] The term "informed consent" was first used in 1957 in *Salgo v. Leland Stanford Jr. University Board of Trustees*.[56] Nevertheless, the idea that a physician owed a duty to inform the patient about the risks, benefits, and alternatives to the treatment or surgery being proposed and to obtain the patient's consent before proceeding, was of far more ancient origin. For example, in a basic battery case decided in 1905—a case relied on by Justice Cardozo in *Schloendorff*—the Minnesota Supreme Court stated: "If the physician advises his patient to submit to a particular operation, and *the patient weighs the dangers and risks incident to its performance*, and finally consents, he thereby, in effect, enters into a contract authorizing his physician to operate to the extent of the consent given, but no further."[57] Without mentioning the words "informed consent," the court assumed that for the patient's consent to be effective, the physician was obligated to disclose the risks of the operation to her. Although the physician's expanded duty of disclosure for obtaining the patient's informed consent could have been incorporated into the tort of battery, courts chose instead to do so in the tort of negligence. Battery, if used at all, was relegated to cases in which the physician either operated without obtaining any consent from the patient or the patient specifically declined the operation.[58]

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53. Knox v. Phoenix Leasing Inc., 35 Cal. Rptr. 2d 141, 147 (Cal. Ct. App. 1994) (quoting Morton v. Petitt, 177 N.E. 591, 593 (Ohio 1931)).

54. Marjorie Shultz asserted that the judgment to use the tort of negligence to protect the patient's autonomy interest "rests upon assumptions that are insufficiently examined and ultimately erroneous." Shultz, *supra* note 44, at 227. For a more complete discussion demonstrating why negligence law does not adequately protect the patient's autonomy interest, see generally *id.* at 232–56.

55. Jay Katz suggested that the doctrine of informed consent may have been developed in response to technological developments in medicine, developments that not only promised great benefits to patients, but also exposed them to great risks. The doctrine assures that patients are informed of those risks before the treatment is administered. KATZ, *supra* note 6, at 63.

56. 317 P.2d 170, 181 (Cal. Ct. App. 1957).

57. Mohr v. Williams, 104 N.W. 12, 15 (Minn. 1905) (emphasis added).

58. *See* Cobbs v. Grant, 502 P.2d 1, 7 (Cal. 1972) (holding that battery is appropriate only when the doctor obtains consent to one type of treatment but performs

Ostensibly, the doctrine of informed consent imposes an obligation on the physician to disclose information about proposed treatment for the patient to consider in deciding whether to permit that treatment. As such, the law embraces the principle of medical self-determination and requires physicians to accept, if not embrace, that principle. However, by focusing on whether the patient's consent was informed, negligence law deflects the court's attention from the conduct of the doctor, i.e., did he or she wrongfully deprive the patient of the right to decide what shall be done with his or her body, to the narrow issue of whether the patient's body was injured by a breach of that duty, i.e., would the patient have rejected the proposed operation if the undisclosed information about risks and alternatives had been revealed.[59] Ironically, the court in *Salgo* mentioned the words "informed consent," not as a new and separate doctrine centering on the patient's state of mind, but rather, in a portion of the case entitled "Duty to Disclose," centering on the conduct of the physician.[60]

Right from the start, courts using the tort of negligence to validate the patient's right to medical self-determination demonstrated, at best, an unenthusiastic commitment to the principle they so boldly asserted. In *Salgo*, for example, the court declared: "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."[61]

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another). *But see* Gouse v. Cassel, 615 A.2d 331 (Pa. 1992) (holding that informed consent is included within the scope of consent). The Pennsylvania Supreme Court stated: "Lack of informed consent is the legal equivalent to no consent; thus, the physician or surgeon who operates without his patient's informed consent is liable for damages which occur, notwithstanding the care exercised." *Id.* at 334. Applying a battery rather than a negligence standard to the issue of causation, the court ruled that if the doctor fails to make the requisite disclosure, the patient may recover damages without having to prove that the disclosure, if it had been given, would have affected the patient's decision to proceed with the operation. *See id.* However, to prevent the physician from being held liable for insignificant risks that were not disclosed, the court departed from a traditional battery analysis by limiting the physician's disclosure obligation to "those material facts, risks, complications and alternatives to surgery that a reasonable person in the patient's situation would consider significant in deciding whether to have the operation...." *Id.*

59. *See* Joseph Goldstein, *For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent, and the Plea Bargain*, 84 YALE L.J. 683, 685–86 (1975) (suggesting that the attention of decisionmakers should be focused on the conduct of the doctor, not on the state of mind of the patient).

The question of whether the patient would have consented to or rejected the proposed operation if the undisclosed information had been revealed involves a consideration of causation. *See infra* text accompanying notes 101–13, discussing the causation requirement as applied to negligence-based informed consent claims.

60. *Salgo*, 317 P.2d at 181. In *Salgo*, the California Court of Appeal reversed a jury verdict and judgment for the plaintiff because of error in jury instructions on the applicability of res ipsa loquitur. *See id.* at 178. The court discussed the physician's duty to disclose only because that issue was likely to be raised again when the case was retried.

61. *Id.* at 181.

However, in unfathomably ambiguous language,[62] the court immediately added that in discussing the risks of the proposed surgery, "a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent."[63] Thus, by the court's standard, the physician is obligated to fully disclose all facts. The physician, we are told, will be held liable for withholding any such facts. Nevertheless, the court also tells us that the physician retains discretion to withhold facts. Like Humpty Dumpty,[64] when the court uses the words "full disclosure," they mean just what the court chooses them to mean—neither more nor less.

The patient's right to autonomous judgment could be constrained, said the *Salgo* court, by the physician's primary duty to "place the welfare of [the] patient above all else."[65] Thus, explained the court, if the disclosure of a remote risk might so alarm an unduly apprehensive patient that he or she would refuse surgery involving this minimal risk, or if the disclosure would increase the risk of psychological injury to the patient, the physician in fulfilling the duty of "full disclosure" had discretion not to disclose such risk.[66] Even as the court announced a duty of full disclosure, it created a therapeutic exception to that duty. Critics have warned that if the therapeutic exception is not carefully circumscribed, that exception threatens to "devour the disclosure rule itself."[67]

In 1960, the Kansas Supreme Court acknowledged, in dictum, that a therapeutic privilege probably exists to withhold a diagnosis of cancer or other dread disease from an unstable, temperamental, or severely depressed patient when disclosure would seriously jeopardize the patient's recovery.[68] The court noted, however, that suppression of facts would not be warranted in the ordinary case.[69] Rather than using the therapeutic privilege to limit the patient's right to autonomous medical decisionmaking, the court chose a more pervasive methodology. Although declaring that "Anglo-American law starts with the

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62. Jay Katz described the court's language as "perfectly ambiguous" and "a startling piece of work." *Fairy Tale*, *supra* note 16, at 149–50.

63. *Id.* at 181.

64. "'When I use a word,' Humpty Dumpty said in rather a scornful tone, 'it means just what I choose it to mean—neither more nor less.'" LEWIS CARROLL, ALICE'S ADVENTURES IN WONDERLAND AND THROUGH THE LOOKING-GLASS 188 (New York, Hartsdale House n.d.).

65. *Salgo*, 317 P.2d at 181.

66. *Id.*

67. Canterbury v. Spence, 464 F.2d 772, 789 (D.C. Cir. 1972); *see also* Meisel, *supra* note 3, at 461. Meisel notes that although "the therapeutic privilege is the best known and most discussed" of all exceptions to the informed consent doctrine, "the contours of the privilege are unclear...." *Id.* at 460. In addition to discussing the therapeutic exception, *see id.* at 460–70, Meisel discusses three other exceptions to the physician's disclosure duty: emergency, *see id.* at 434–38, incompetence, *see id.* at 439–53, and waiver, *see id.* at 453–60.

68. *See* Natanson v. Kline, 350 P.2d 1093, 1103 (Kan. 1960).

69. *See id.*

premise of thorough-going self determination,"[70] and, therefore, that physicians are not permitted to deceive patients in order to substitute their own judgment for that of their patients,[71] the physician's duty to disclose "is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances."[72] Although citing *Salgo* as expressing the proper rule for compelling physician disclosure to obtain the patient's informed consent,[73] the court engrafted onto the disclosure requirement the medical custom standard of care that is used to determine professional malpractice. So long as the defendant conformed to the level of disclosure of other physicians in good standing—and the defendant was presumed to have conformed in the absence of expert medical testimony to the contrary—no breach of duty would be found.[74] Under the court's analysis, the patient retains the right to decide whether to permit the proposed surgery or treatment. However, the patient's right to be informed of the risks of and alternatives to the proposed procedure—information that is essential to the patient's exercise of his or her judgment—is limited to what physicians generally decide to inform patients about those risks and alternatives.

The medical custom rule erroneously assumes that the question of how much information should be disclosed to the patient is a judgment requiring medical expertise. Doctors are trained to diagnose disease. They are trained to treat the diseases they have diagnosed. They are trained to evaluate the risks and benefits of the procedures they are considering and alternatives to them. Doctors are not trained to evaluate what information must be given to patients to assure that they can make intelligent choices on whether to accept or reject the treatment that the doctor proposes. Doctors are not trained to determine what information should be withheld from their patients because it is not material to their patients' decisionmaking, or because the disclosure itself risks significant psychological harm to patients, or because doctors generally withhold such information for other clinically valid reasons, or even for no reason at all. Although knowledge of the risks and alternatives requires medical expertise, deciding whether to disclose such knowledge does not.

Courts that use the reasonable doctor standard to measure the doctor's disclosure duty assume that a medical custom exists that sufficiently protects the

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70. *Id.* at 1104.
71. *See id.*
72. *Id.* at 1106.
73. *See id.*
74. *See id.* Within four months of the *Natanson* decision, the Kansas Supreme Court, in denying a motion for rehearing, clarified its earlier opinion. Natanson v. Kline, 354 P.2d 670, 671 (Kan. 1960). The court ruled that the patient, as plaintiff, was not required to introduce expert medical testimony that the physician's failure to disclose any of the inherent risks and hazards of the proposed treatment was contrary to accepted medical practice. *See id.* at 673. The physician's silence—his complete failure to disclose anything to the patient—constituted a breach of the disclosure duty as a matter of law. *See id.*

patient's legally recognized interest in autonomous decisionmaking.[75] But, as Dr. Jay Katz observed, the requirement that doctors disclose information to their patients and obtain their patients' consent to proposed treatment or surgery "are obligations alien to medical practice."[76] The "Hippocratic tradition against disclosure" is "deeply ingrained,"[77] and its existence cannot be assumed away by courts' wishful thinking. Would we trust tobacco companies to tell us the dangers of the product they are selling? Should we trust doctors to tell us the dangers of their "product," i.e., the surgery or other treatment they are proposing? A medical custom standard assures us only that less, not more, information is told to those who supposedly have the decisionmaking authority, i.e., patients, not their physicians.[78]

Despite critical commentary exposing its obvious flaws,[79] the medical custom standard remains the prevailing standard to measure whether the physician's disclosure duty has been breached.[80] In part, the dominance of this standard was assured by the legislative response to the perceived medical malpractice crisis of the mid-1970s. As one "reform" to reduce physician liability and malpractice insurance costs, several states enacted legislation adopting the

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75. *See* KATZ, *supra* note 6, at 2–3 (asserting that "judges believed or wished to believe that their pronouncements on informed consent gave legal force to what good physicians customarily did; therefore they felt that they could defer to the disclosure practices of 'reasonable medical practitioners'...").

76. *Fairy Tale*, *supra* note 16, at 148.

77. *Id.*; *see also* Shultz, *supra* note 44, at 248–49 (asserting that "[b]ecause doctors are trained to take active responsibility and are concerned first and foremost with *outcomes*, historically they have been reluctant to disclose risks and share decisionmaking").

78. Howard Brody proposed that courts that use the medical custom standard should employ a "transparency standard," requiring physicians to disclose all the risks that they weighed before deciding what intervention to recommend. *See* HOWARD BRODY, THE HEALER'S POWER 115–18 (1992). Even such a broad disclosure requirement, however, seems inadequate to protect the patient's autonomy interest because it focuses solely on the physician's thought process and not at all on what the patient would want to know.

79. *See, e.g.*, Theodore J. Schneyer, *Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices*, 1976 WIS. L. REV. 124, 170 (challenging use of the medical custom standard to determine adequacy of disclosure as not a matter of professional expertise and subject to potential physician bias); Gerald F. Tietz, *Informed Consent in the Prescription Drug Context: The Special Case*, 61 WASH. L. REV. 367, 379 (1986) (critiquing the underlying assumption made by courts in adopting the medical custom rule—"that patients are not capable of participating in therapy decisionmaking and that the physician, the only party that understands the choices, should unilaterally determine the correct therapy").

80. *See, e.g.*, RICHARD A. EPSTEIN, TORTS at 144–45 (1999) (asserting that "the dominant view today [requires the plaintiff] to present expert medical evidence on the question of what information should be disclosed, and thus tends to reinstate customary standards..."); Jones, *supra* note 13, at 396 (describing the medical custom rule as the standard used in a majority of jurisdictions; citing cases and statutes); Shultz, *supra* note 44, at 249 (asserting that "most states" use the medical custom rule); Tietz, *supra* note 79, at 372 (describing the medical custom rule as "the most widely accepted model").

medical custom standard to measure breach of the physician's disclosure duty.[81] In those states, common law development of the informed consent doctrine has ceased.[82]

Not all jurisdictions, however, allow physicians to establish their own standard for measuring disclosure. In *Canterbury v. Spence*,[83] the United States Court of Appeals for the District of Columbia Circuit rejected the medical custom approach, asserting: "[I]t is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie."[84] "In our view," wrote the court, "the patient's right of self-decision shapes the boundaries of the duty to reveal."[85] The adequacy of the physician's disclosures to the patient "must be measured by the patient's need, and that need is the information material to the decision.... [A]ll risks potentially affecting the decision must be unmasked."[86]

But *Canterbury* did not measure the physician's duty to disclose by the information that was material to the patient's decision. *Canterbury* did not require that all risks potentially affecting the patient's decision be unmasked. Although the court claimed that "respect for the patient's right of self-determination...demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves,"[87] the court, in setting that legal standard, did not respect the patient's right to self-determination.

Concerned that physicians might not know what risks would be material to their patients,[88] the *Canterbury* court defined "material risks" as those which a reasonable person in the patient's position would be likely to consider significant.[89] Although the court acknowledged that "orthodox negligence doctrine" measures "the reasonableness of the physician's divulgence in terms of what he knows or should know to be *the patient's* informational needs,"[90] the court transformed the individual patient's informational needs into those of the hypothetical, reasonable patient. Although the court declared that foresight, not

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81. *See* Jones, *supra* note 13, at 396 n.70 (asserting that almost all states that enacted legislation on the standard of care to be applied to the physician's disclosure duty adopted the medical custom rule; citing statutes); Alan J. Weisbard, *Informed Consent: The Law's Uneasy Compromise with Ethical Theory*, 65 NEB. L. REV. 749, 761 (1986) (asserting that malpractice crisis legislation adopted the medical custom rule and accorded presumptive validity to informed consent forms signed by patients).

82. *See* Weisbard, *supra* note 81, at 762 (claiming that in states adopting the medical custom rule by statute, the promise of patient self-determination has not been achieved and that the informed consent doctrine has stagnated).

83. 464 F.2d 772 (D.C. Cir. 1972).

84. *Id.* at 781.

85. *Id.* at 786.

86. *Id.* at 786, 787.

87. *Id.* at 784.

88. *See id.* at 787.

89. *See id.*

90. *Id.* (Emphasis added).

hindsight, measures the physician's disclosure duty,[91] it failed to consider whether physicians should be expected to inquire of their individual patients whether they had any unusual concerns that might need to be addressed in the disclosure process—concerns that might not be significant to "the reasonable patient," whoever he or she might be. And yet, just such inquiry, and physician disclosures based on patient responses to that inquiry, are exactly what is needed for the patient to exercise his or her right to medical self-determination.

The patient, the court tells us, has no duty to ask for information from the physician.[92] The physician is obligated, despite the patient's silence, to volunteer information that the patient needs to make his or her decision.[93] "Caveat emptor is not the norm for the consumer of medical services,"[94] says the court. But *Canterbury* allows the physician to avoid asking the silent patient what that patient would like to know, i.e., what is important to that patient's decisionmaking.

The doctrine of informed consent supposedly assures the patient that the information material to his or her judgment will be disclosed before the patient makes a decision. The right to medical self-determination means that the individual can accept or reject proposed treatment for whatever idiosyncratic reasons the individual chooses. The patient is under no obligation to make a reasonable decision, i.e., to accept whatever treatment a hypothetical, reasonable patient would accept. And yet, by not obligating physicians to ask their patients what their concerns are, and then to respond to those concerns, the *Canterbury* court, in reality, ruled that the physician's disclosure duty is owed, not to his or her patient, but only to the reasonable patient.

Commentators have criticized *Canterbury*'s choice of an objective, reasonable patient test instead of a subjective, "this patient" test. "To eliminate the 'subjective' elements that relate to the particular patient-subject," wrote Alexander Capron, "is to make the informed consent doctrine an engine of depersonalization rather than personalization."[95] Self-determination means the right to make one's own decisions, even if they are regarded by others as foolish or unreasonable.[96] By homogenizing all patients into reasonable patients, *Canterbury* renounces the very principle it espouses.

The *Canterbury* court erected other barriers to the patient's right to self-determination. If the physician fails to reveal the risks and alternatives that a

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91. *See id.*
92. *See id.* at 783.
93. *See id.*
94. *See id.*
95. Capron, *supra* note 16, at 408–09.
96. *See* 3 FOWLER V. HARPER ET AL., THE LAW OF TORTS §17.1, at 562 (2d ed. 1986) (asserting that "Individual freedom...is guaranteed only if people are given the right to make choices that would generally be regarded as foolish ones." The authors also assert that if the person is competent, he or she should be free to forego treatment even if the decision to do so is viewed by the medical profession and by society as unwise and the exercise of a "warped or perverted" sense of values.).

reasonable patient would consider material to his or her judgment, negligence law requires the patient to prove that this breach of duty caused harm. The harm requirement is satisfied, said the court, only if an unrevealed risk that the physician was obligated to disclose, materializes,[97] and the causation requirement is satisfied only if a reasonable person in the patient's position would have declined the treatment if the risk had been revealed.[98]

Harm, according to the court, is limited to the patient's interest in his or her physical well-being, i.e., was the patient physically injured by the physician's breach of the disclosure duty? The court assures us that "[t]he patient obviously has no complaint if he would have submitted to the therapy notwithstanding awareness that the risk was one of its perils."[99] The patient, however, does have a complaint. The patient has been deprived of the right to decide. That loss of individual autonomy, in and of itself, is an injury. Nevertheless, this dignitary loss—the right to make one's own choice as to what shall be done to one's own body—is not compensable. For the patient to succeed in a negligence claim against the physician, *Canterbury* tells us that the plaintiff must suffer physical injury from the physician's breach of the disclosure duty.[100]

The *Canterbury* court's analysis of causation is even more dubious. The court boldly announces that the very reason for requiring the physician to disclose risks is to preserve the patient's interest in deciding for himself or herself whether to accept or reject proposed treatment.[101] "The patient," we are told, "is free to decide for any reason that appeals to him."[102] If the physician does not breach the disclosure duty, the patient's decision to accept or reject the proposed treatment or surgery will not be disturbed. But if the physician breaches the disclosure duty, depriving the patient of his or her right to decide—for any reason that appeals to him or her—then causation of harm will not be measured by what he or she would have decided, but rather, by what a reasonable person in the patient's position would have decided. The causation requirement is magically metamorphosed from an inquiry about what *would* have happened if the patient had not been deprived of information material to his or her judgment into an inquiry about what *should* have

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97. *See Canterbury*, 464 F.2d at 790.

98. *See id.* at 791.

99. *Id.* at 790.

100. *See* Roger B. Dworkin, *Medical Law and Ethics in the Post-Autonomy Age*, 68 IND. L.J. 727, 729 (1993) (claiming that "[t]he loss of dignity, autonomy, free choice, and bodily integrity that is so exalted in the rhetoric of informed consent is worth nothing at judgment time"); Goldstein, *supra* note 59, at 691 (asserting that current law does not recognize that a person can be wronged even if he or she is not physically harmed, i.e., that a person's dignity as a human being has been violated when a deceiving physician begins therapy).

101. *See Canterbury*, 464 F.2d at 790.

102. *Id.* Although the patient is free to base his or her decision on any rational or irrational reason, or on any combination of rational and irrational reasons, the court clarifies that the physician's disclosure duty assures that the patient has the information necessary for him or her to make an intelligent decision. *Id.*

happened—should the patient have consented because a reasonable person in the patient's position would have consented. The patient who has been wronged by the physician's nondisclosure is permitted to win only if he or she would have made a decision that the jury considers to be reasonable. As Dan Dobbs aptly noted, this rule is not a true measure of causation, but rather, an "additional and most unusual obstacle"[103] to a patient's ability to succeed against a physician who has breached his or her disclosure obligation.

The *Canterbury* court chooses the objective, reasonable person test of causation in order to protect the duty-breaching physician from unwarranted liability. A subjective, "this patient" test, we are told, would "place...the physician in jeopardy of the patient's hindsight and bitterness."[104] The jury would decide causation solely by assessing the credibility of the patient who, in response to a hypothetical question about circumstances he or she did not confront, would testify that he or she would have refused the operation if he or she had been informed of the risk that has now materialized.[105]

The court's obsession with assuring fairness to physicians seems unwarranted. In assessing issues of causation, juries often have to consider hypothetical questions. When a swimming pool operator negligently fails to provide a lifeguard, the jury must consider whether the presence of a lifeguard would have prevented the drowning that occurred. Can anyone ever say with certainty that he or she would have done so? Obviously not. But no one suggests that the test used to determine causation should be altered to protect the negligent pool operator from the jury's speculation. To the contrary, some courts have even shifted the burden of disproving causation to the wrongdoing defendant whose conduct not only deprived the innocent plaintiff of the protection to which he or she was entitled, but also deprived the innocent plaintiff of a means of definitively establishing that the defendant's wrongful act caused harm to the plaintiff.[106] Such shift may be necessary to prevent a defendant—whether a lifeguardless pool operator or a nondisclosing physician—from gaining an unfair advantage from the lack of proof inherent in the situation that the defendant's negligence created.[107]

The *Canterbury* court expresses concern about the jury's ability to assess the credibility of the plaintiff who will testify that he or she would not have

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103. DOBBS, *supra* note 31, at 657.

104. *Canterbury*, 464 F.2d at 790–91.

105. *See id.* The Supreme Court of Oregon disagreed with the *Canterbury* court's analysis, noting: "Factfinders are not bound to take the patient's word on [whether he or she would have declined what proved to be an unsatisfactory procedure] but may decide it themselves on the available evidence." Arena v. Gingrich, 748 P.2d 547, 550 (Or. 1988).

106. *See, e.g.*, Haft v. Lone Palm Hotel, 478 P.2d 465, 474–75 (Cal. 1970). When the defendant pool operators breached a statutory duty to either provide a lifeguard or post a warning sign, the California Supreme Court shifted the burden of proof to the defendants to establish that the absence of a lifeguard did not cause the drowning deaths that occurred. *See id.* at 470. In the absence of such proof, causation was established as a matter of law. *See id.* at 473.

107. *See id.* at 475.

authorized the operation if only the physician had disclosed the risk of a result that has now occurred.[108] But in any civil case, juries are called upon to evaluate the credibility of every witness who testifies. That's what juries do. They often hear testimony of plaintiffs who say things that support their claims. And they are called upon to decide whether or not to believe those plaintiffs. There is nothing unique about physician-defendants who are being sued for not disclosing information that the law requires them to disclose. Why should we assume that physicians alone will be unfairly disadvantaged if juries determine the causation issue by assessing the plaintiff's credibility when juries make the same credibility assessment in cases involving other defendants? Do we really believe that juries suddenly lose their competence to perform this task if the defendant has an M.D. title following his or her name?[109] Do we really believe that juries are so inherently biased against physician-defendants that to protect these defendants, juries must be instructed to measure causation by a different test—a test that does not even measure causation and that undermines the innocent plaintiff's right to autonomous decisionmaking?[110]

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108. *See Canterbury*, 464 F.2d at 791.

109. Aaron Twerski and Neil Cohen question whether causation in any informed consent case is a practically justiciable issue. Juries are not capable of considering "the multitude of factors that influence the way people actually make decisions." Aaron D. Twerski & Neil B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation*, 1988 U. ILL. L. REV. 607, 608. They discuss extensive psychological research demonstrating the impossibility of predicting how a patient would analyze information—whether logically or illogically, to reach a decision. *See id.* at 626–41. Nevertheless, they conclude that substituting an objective, reasonable patient test for the subjective, "this patient" test does not cure the problem, and in fact, exacerbates it. To what extent would a reasonable person consider irrational factors in making a judgment? *See id.* at 642.

I do not claim that jurors actually have the competence to assess the credibility of witnesses. I merely assert that jurors are no less competent to assess the credibility of plaintiff witnesses in physician nondisclosure cases than in other cases in which a plaintiff claims that his or her judgment would have been affected by information that the defendant was obligated to disclose, but failed to do so.

110. In adopting a subjective, "this patient" test of causation, the Supreme Court of Oklahoma expressed far less concern than did the *Canterbury* court about the need to safeguard the duty-breaching physician from the jury's inability to assess the credibility of the patient's testimony: "Although it might be said this approach places a physician at the mercy of a patient's hindsight, a careful practitioner can always protect himself by insuring that he has adequately informed each patient he treats. If he does not breach this duty, a causation problem will not arise." Scott v. Bradford, 606 P.2d 554, 559 (Okla. 1979).

Marjorie Shultz suggested that a court applying a subjective, "this patient" test of causation could use a protective device to shield the defendant from a jury that might be unduly sympathetic to the plaintiff. The court could presume that the plaintiff would have decided as would a reasonable person, but allow the plaintiff to rebut the presumption by introducing evidence of reasons why he or she would have deviated from the reasonable person's judgment. Shultz, *supra* note 44, at 289. *But see* Tietz, *supra* note 79, at 414–15 (proposing that to protect the patient's dignitary interest, courts apply a subjective, "this

Courts that reject the medical custom test to measure adequacy of the physician's disclosure to the patient recognize that the weighing of risks inherent in a proposed medical procedure against the individual, subjective concerns of the patient is not a matter for an expert's judgment. It is a nonmedical judgment that is reserved to the patient alone.[111] But when those courts substitute for that patient's judgment, the judgment of a reasonable person, they show disrespect, not only for the individual patient's right to autonomous medical decisionmaking, but also for the jurors who are called upon to determine whether a breach of the disclosure duty occurred and whether it caused injury. Within the last ten years, the California Supreme Court declared: "[W]e can conceive of no trier of fact more suitable than lay jurors to pronounce judgment on those uniquely human and necessarily situational ingredients that contribute to a specific doctor-patient exchange of information relevant to treatment decisions...."[112] For jurors to perform their task, however, they must be permitted to consider what risks were material to *this* patient's judgment, and if those risks were not disclosed, whether disclosure would have altered the consent that *this* patient gave.[113]

Despite its doctrinal deficiencies, *Canterbury*'s reasonable patient test—for measuring both breach of the disclosure duty and causation—has become *the* "liberal" alternative to the conservative reasonable doctor test.[114] For nearly half

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patient" test of causation and create a presumption that the patient would not have consented if the physician had made an adequate disclosure of risks and alternatives).

111. *See* Cobbs v. Grant, 502 P.2d 1, 10 (Cal. 1972).

112. Arato v. Avedon, 858 P.2d 598, 607 (Cal. 1993).

113. In *Arato*, the California Supreme Court's vote of confidence in the jury's competence to decide whether an undisclosed risk was material to the patient's decisionmaking was accompanied by a requirement that the jury be instructed to use the reasonable patient test to assess materiality. *See id.*

114. Within six months of the *Canterbury* decision, the supreme courts of California and Rhode Island, citing *Canterbury* repeatedly, seemingly adopted the *Canterbury* approach to informed consent. *Cobbs*, 502 P.2d at 11; Wilkinson v. Vesey, 295 A.2d 676, 688 (R.I. 1972). These cases are often linked together with *Canterbury* as the cases that first used the reasonable patient test. *See, e.g.*, James F. Blumstein & Frank A. Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849, 905–07 (1981) (discussing "the *Canterbury-Cobbs-Wilkinson* approach"). Nevertheless the two cases depart from the *Canterbury* analysis. *Canterbury* applied an objective, reasonable patient test both to the disclosure duty issue and the causation issue. Canterbury v. Spence, 464 F.2d 772, 787 (disclosure duty), 791 (causation) (D.C. Cir. 1972). Although the *Wilkinson* court applied a reasonable patient test to the disclosure duty issue, *Wilkinson*, 295 A.2d at 689, it applied a subjective test to the causation issue, ruling that "the plaintiff must prove that if he had been informed of the material risk, he would not have consented to the procedure and that he had been injured as a result of submitting to the procedure." *Id.* at 690.

Although the *Cobbs* court applied a reasonable patient test to the causation issue, *Cobbs*, 502 P.2d at 11–12, the court applied a subjective test to the disclosure duty, ruling: "The scope of the physician's communications to the patient...must be measured by the patient's need, and that need is whatever information is material to the decision. Thus, the test for determining whether a potential peril must be divulged is its materiality to the patient's decision." *Cobbs*, 502 P.2d at 11. Although this language is borrowed nearly

the states,[115] *Canterbury* did not become a new point of departure; it became a final destination. Twelve years after the decision, Jay Katz observed: "The law of informed consent has undergone little analytic development since *Canterbury*."[116] His observation remains equally accurate today.[117]

To summarize, in twentieth century American society, courts could not ignore or completely deny patients' demands for self-determination in medical decisions that affect their own bodies and their own lives. However, courts fashioned an informed consent doctrine that allows physicians to circumvent any meaningful disclosure requirement.[118] Even as that doctrine has been most liberally formulated, patients do not receive the information they need to make medical decisions—only the information that reasonable patients would need.[119]

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verbatim from *Canterbury*, the *Cobbs* court did not go further, borrowing *Canterbury's* tortured attempt to equate a real patient's informational needs only with those of a reasonable patient. Although *Canterbury* tells us that "the patient's right of self-decision *shapes the boundaries* of the duty to reveal," *Canterbury*, 464 F.2d at 786 (emphasis added), for *Cobbs*, "the patient's right of self-decision *is the measure* of the physician's duty to reveal." *Cobbs*, 502 P.2d at 11 (emphasis added). Despite this distinction, however, and despite the California Supreme Court's insistence that "we do not mean to signal a retreat from the patient-based standard of disclosure explicitly adopted in *Cobbs*," the court subsequently accepted as an appropriate interpretation of *Cobbs*, a jury instruction formulation that merely required the physician to disclose information that a reasonable person in the patient's position would regard as significant. *Arato*, 858 P.2d at 607. The jury instruction formulation appears in a book of approved jury instructions (BAJI) prepared by the Committee on Standard Jury Instructions, Civil, of the Superior Court of Los Angeles County. 1 CALIFORNIA JURY INSTRUCTIONS CIVIL BAJI 6.11 (Paul G. Breckenridge, Jr. ed. 8th ed. 1994).

115. Marjorie Shultz, writing in 1985, asserted that "[a] substantial minority of states...have adopted a reasonable patient standard to measure the content and adequacy of disclosure." Shultz, *supra* note 44, at 249. Arnold Rosoff, writing in 2001, opined that the reasonable patient standard is followed in "roughly half of United States jurisdictions." Arnold J. Rosoff, Book Review, 22 J. LEGAL MED. 307, 308–09 (2001) (reviewing FAY A. ROZOVSKY, CONSENT TO TREATMENT: A PRACTICAL GUIDE (2000)); *see also* Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 314 (1999) (declaring that a recent survey found that roughly half the states apply the reasonable patient test but noting that a majority of states that have enacted informed consent statutes apply the medical custom test).

116. KATZ, *supra* note 6, at 80. Leanna Darvall described *Canterbury* as "the high water mark of common law protection for self-determination and freedom of choice." LEANNA DARVALL, MEDICINE, LAW AND SOCIAL CHANGE 38 (1993). She noted that some courts have specifically rejected *Canterbury*, adopting the medical custom test as the standard for measuring physician disclosure. *See id.*

117. A quarter century after the case was decided, Joan Krause wrote: "*Canterbury* continues to be the starting point for most modern discussions of the doctrine of informed consent." Krause, *supra* note 115, at 271. But the law has moved little beyond that starting point. The requirements for obtaining an informed consent have remained "relatively constant." Rosoff, *supra* note 115, at 308.

118. *See supra* text accompanying notes 11–17.

119. In Cobbs v. Grant, 502 P.2d 1, 11 (Cal. 1972), the California Supreme Court appeared to adopt a subjective, "this patient" standard to measure breach of the disclosure

When physicians wrongfully deprive their patients of even this minimal information, the law places no monetary value on the loss of patients' legal right to make their own decisions. To succeed in an informed consent claim against their physicians, patients must prove that the breach of the disclosure duty caused them physical injury. In all but a few states,[120] causation is not measured by a true test of causation. The law does not ask whether the actual patients would have consented if their doctors had not breached the disclosure duty, but rather, whether reasonable patients would have consented. Although doctors might still prefer to be under no disclosure duty, the doctrine of informed consent, even as formulated in the most liberal jurisdictions, is just what the doctor ordered.

B. The Disclosure Duty: When Nothing Means Something

From the preceding discussion, one might suppose that the patient's right to medical self-decisionmaking is promoted more by the tort of battery than by the tort of negligence. In fact, Alan Meisel asserts that courts need simply invoke established principles of battery law to appropriately acknowledge the patient's dignitary interest in adequate disclosure of the risks of and alternatives to the proposed treatment.[121] Battery, after all, not only protects a person's interest in

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duty. *See* Capron, *supra* note 16, at 407. Nevertheless, in a case decided twenty-one years after *Cobbs*, the court adopted the reasonable patient standard instead, without discussing whether it was altering the *Cobbs* standard. *See* Arato v. Avedon, 858 P.2d 598, 607 (Cal. 1993), discussed *supra* note 114.

120. *See, e.g.*, Scott v. Bradford, 606 P.2d 554, 559 (Okla. 1979) (refusing to jeopardize the patient's right to medical self-determination by applying the reasonable person standard to the issue of causation); Arena v. Gingrich, 748 P.2d 547, 548–49 (Or. 1988) (finding that the objective test of causation is anomalous and makes no sense, and applying a subjective, "this patient" test to the issue of causation); Millard v. Nagle, 587 A.2d 10, 13 (Pa. Super. Ct. 1991) (holding that the jury should not be instructed that for the plaintiff to be entitled to a verdict, the "plaintiff must show that a reasonable person in his place, having been properly advised by his doctor, would not have consented to surgery"); Flanagan v. Wesselhoeft, 712 A.2d 365, 370 (R.I. 1972) (citing Wilkinson v. Vesey, 295 A.2d 676, 687 (R.I. 1972), discussed *supra* note 114, and declaring: "The essential inquiry then is not which course of treatment the trial justice, expert medical professionals, or even a reasonable person might elect. Rather, 'the patient's right to make his decision in the light of his [or her] own individual value judgment is the very essence of his freedom of choice.'"); *see also* McPherson v. Ellis, 287 S.E.2d 892, 897 (N.C. 1982) (holding "that the subjective test is the proper standard to apply in determining whether a patient would have undergone treatment had he known of the risks the physician neglected to relate to him"). The *McPherson* court, however, cited legislation that became effective after the *MacPherson* fact situation arose that adopted the reasonable patient standard for measuring causation. *See id.* at 894 n.1.

121. *See* Alan Meisel, *A "Dignitary Tort" as a Bridge between the Idea of Informed Consent and the Law of Informed Consent*, 16 LAW, MED. & HEALTH CARE 210, 212 (1988); *see also Fairy Tale*, *supra* note 16, at 165 (suggesting that the tort of battery "offered a more rigorous protection of patients' right to self-decisionmaking...[and] if adopted, could, in turn, have led to a broader judicial inquiry into the physician-patient dialogue and particularly into the quality of consent necessary to safeguard patients' freedom of choice").

bodily integrity against harmful contacts but also protects a person's dignitary interest against offensive contacts.[122] In a battery claim, the plaintiff does not need to prove that the defendant's nondisclosure did not conform to the medical custom of disclosure, or that the undisclosed information could be characterized as material to a reasonable patient's judgment, or that a reasonable patient would not have consented to the procedure if the information had been disclosed, or that the operation performed without consent resulted in physical harm to the patient from a risk that was not revealed. The defendant may not escape liability by hiding behind a therapeutic privilege to withhold information material to the patient's judgment. All these negligence law barriers to recovery could be circumvented if courts allowed plaintiffs to use battery in the informed consent context.[123] All that the plaintiff would have to prove is that the physician performed the procedure or operation without obtaining the patient's consent and that the nonconsensual touching caused the plaintiff's injury.[124] The physician's breach of the disclosure duty negates the patient's pre-operative consent.

The tort of battery, however, is constrained by its own definition. It is a tort that requires the defendant to make unpermitted contact with the plaintiff. If the physician's proposed course of action is nonaction, involving no physical contact with the patient, no battery is committed even if the physician fails to disclose the risks of and alternatives to the nontreatment option that the physician has selected. Thus, the physician does not commit a battery by a decision not to order additional laboratory tests to better diagnose a patient's medical condition, or to simply monitor the patient's condition but not to administer any treatment, or to terminate treatment because, in the physician's judgment, a successful outcome has been achieved.[125]

But does a negligence-based informed consent doctrine require the physician to disclose the risks of and alternatives to these nontreatment options, at least if a reasonable physician would disclose them or if a reasonable patient would find them material to his or her decisionmaking? After all, nontreatment can result in physical injury to the patient just as assuredly as can active mistreatment. Recently, in *Matthies v. Mastromonaco*,[126] the New Jersey Supreme Court held that such a duty is owed. The plaintiff, an eighty-one-year-old woman who lived alone, fell in her apartment and fractured her hip.[127] The defendant, a board-certified orthopedic surgeon, "treated" her with bed rest rather than

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122. *See supra* text accompanying notes 28–33.

123. *See supra* text accompanying notes 35–53, discussing the reluctance of courts to use the tort of battery to handle breaches of the physician's disclosure duty.

124. *See* JOHN HEALY, MEDICAL NEGLIGENCE: COMMON LAW PERSPECTIVES 180 (1999).

125. *See* Shultz, *supra* note 44, at 230. Marjorie Shultz asserts that courts should not limit protection of the patient's autonomy interest to situations involving control over physical contact. *See id.* at 229–32.

126. 733 A.2d 456, 457 (N.J. 1999).

127. *See id.* at 458.

performing surgery to pin her hip with steel screws.[128] The defendant's decision was based, in part, on medical considerations—the plaintiff's age and frail physical condition, the osteoporosis from which she suffered that may have made her bones too porous to hold the screws, and partial paralysis that limited her mobility.[129] The defendant's decision was also based, in part, on his belief that the plaintiff should not continue to live independently, but rather, should live in a long-term care facility where she would receive professional care.[130]

The New Jersey Supreme Court was unwilling to limit a negligence-based informed consent doctrine to nonconsensual touchings proposed, but not adequately explained, by the physician. The tort of battery might require an invasive procedure, such as surgery, but the tort of negligence does not.[131] The court specifically upheld the patient's right to make an informed *decision* about medically reasonable alternatives, not merely to give an informed *consent* to the alternative that the physician recommends. The court would not allow the physician to, in essence, decide for the patient by discussing only the physician's treatment (or nontreatment) of choice.[132] Although the physician's choice might be medically appropriate and conform to the physician's standard of care, nevertheless, it might not be the choice that the patient would make. The absence of malpractice does not assure the presence of the patient's informed choice.

In expanding the physician's disclosure duty to include affirmative alternatives to the physician's proposed inaction, the New Jersey Supreme Court's *Matthies* decision is exceptional.[133] Even in New Jersey itself, the first three intermediate appellate court decisions to cite *Matthies* distinguished that case from the facts presented, and the plaintiff's informed consent claim was defeated in each.[134] In two of those cases, the court subsumed the physician's disclosure duty

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128. *See id.*

129. *See id.*

130. *See id.* at 459.

131. *See id.* at 460–61.

132. *See id.* at 461–62. The court stated:

> Physicians may neither impose their values on their patients nor substitute their level of risk aversion for that of their patients.... The choice is not for the physician, but the patient in consultation with the physician. By not telling the patient of all medically reasonable alternatives, the physician breaches the patient's right to make an informed choice.

Id. at 463.

133. It should be noted, however, that the New Jersey Supreme Court specifically distinguished the physician's duty to disclose treatment alternatives from a potential duty "to disclose the details of alternative diagnoses," which was an issue not before the court. *Id.* at 462.

134. Gilmartin v. Weinreb, 735 A.2d 620, 624–25 (N.J. Super. Ct. App. Div. 1999); Eagel v. Newman, 739 A. 2d 986, 990 (N.J. Super. Ct. App. Div. 1999); Farina v. Kraus, 754 A.2d 1215, 1222–23 (N.J. Super. Ct. App. Div. 1999). In *Gilmartin*, the court ruled "that a physician has no duty to inform a patient of the risk of negligent treatment." *Gilmartin*, 735 A.2d at 624. Thus the physician was under no duty to inform the patient that

within the physician's treatment duty despite the New Jersey Supreme Court's careful separation of the two issues. According to the New Jersey Superior Court, a physician who prescribes bed rest but who does not inform the patient of complications that may develop from that course of treatment may be negligent in treating the patient but is not liable for failing to obtain an informed consent.[135] Thus, for example, a physician who treats mononucleosis with bed rest but who does not warn his or her patient that a ruptured spleen is a possible complication of that disease may be liable for improperly treating the patient but is not liable for failing to obtain the patient's informed consent to that treatment option.[136] In claiming to distinguish between the course of the disease (informed consent is not an issue) and the course of treatment (informed consent is an issue), the court failed to consider whether the patient might choose a different course of treatment if the risks of that treatment were disclosed, especially if the risks can be reduced with alternative, more aggressive treatment.[137] If so, then disclosure of that information is material to the patient's judgment.

In California, the state's supreme court has broadly interpreted the physician's disclosure duty. In addition to requiring physicians to inform patients of the risks of and alternatives to procedures and diagnostic tests that the physician proposes, if the patient declines the proposed treatment, the physician must disclose the risks of that decision.[138] The disclosure obligation not only assures that the patient gives an informed *consent* to treatment, but it also assures that the patient's *refusal* of treatment is also informed. "The duty to disclose was imposed," said the California Supreme Court, "so that patients might meaningfully exercise their right to make decisions about their own bodies."[139] Despite the California Supreme Court's guidance, however, numerous California Court of Appeal decisions refuse to impose a disclosure duty on physicians who fail to inform patients of available treatment options when the physician proposes no

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the drug he had prescribed could be lethal if the patient received an overdose. *See id.* at 632. The court, however, considered *sua sponte*, the question of whether disclosure was required by the doctrine of informed consent when the patient, who in this case was a chemical engineer, suggested to the physician that he had received an overdose and the physician suspected that the patient was correct. *See id.* Although the court noted that "disclosure of the drug's lethality in the event of an overdose may be the equivalent of informing a patient of available alternative diagnostic techniques," *id.* at 632-33, the court did not decide whether the physician's disclosure duty was breached, leaving further consideration of this issue to the parties and the trial court. *Id.* at 633.

135. *Eagel*, 739 A.2d at 990–91.

136. *Id.* (positing the mononucleosis/ruptured spleen example to explain why the physician's disclosure duty is not implicated); *Farina*, 754 A.2d at 1223 (quoting the mononucleosis/ruptured spleen example originally used in *Eagel*).

137. *Eagel*, 739 A.2d at 991 (discussing the distinction between course of disease and course of treatment).

138. *See* Truman v. Thomas, 611 P.2d 902, 906 (Ca. 1980).

139. *Id.*

treatment.[140] To the court of appeal, a patient's right to make decisions about his or her own body is limited to situations in which the treating physician is proposing some affirmative course of action.

Surely, the court of appeal decisions are in error. Under a negligence theory, the disclosure duty is imposed not to protect the patient from an unconsented touching, but rather, to protect the patient's right to medical self-determination.[141] Why else would the California Supreme Court impose a duty on physicians not merely to explain the risks and benefits of proposed therapy, but also the risks and benefits of refusing the physician's recommendation? To make decisions about what shall be done and what shall not be done to their bodies, patients need information on the risks of and alternatives to the nontreatment option. They need that information, not only when they refuse a treatment proposed by the physician, but also when the physician proposes no treatment. After all, "the patient's right of choice is not limited to a veto power over treatment recommended by [the] doctor."[142]

If a physician does not prescribe antibiotics for a respiratory infection suffered by a patient whose spleen has been removed, would it be material to that patient's decisionmaking to know that other physicians of a recognized different school of thought believe that antibiotics should be routinely given to patients in similar circumstances?[143] Obviously, the answer is yes, but the court imposed no duty on the patient's physician to disclose this information.[144] When a physician recommends an MRI (magnetic resonance imaging) scan to detect a possible brain abscess on a patient who suffers a seizure, would it be material to that patient's decisionmaking that a CT (computerized tomography) scan is more promptly

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140. *See, e.g.*, Parris v. Sands, 25 Cal. Rptr. 2d 800, 802–03 (Ca. Ct. App. 1993) (holding that a physician who was not prescribing antibiotics for a respiratory infection suffered by a patient whose spleen had been removed was under no duty to inform the patient that other physicians of a recognized different school of thought believe that antibiotics should be routinely given to patients in similar circumstances); Mathis v. Morrissey, 13 Cal. Rptr. 2d 819, 826–27 (Ca. Ct. App. 1992) (holding that a physician who is not recommending surgery was under no duty to inform the patient that there are different schools of thought on whether surgery should be performed); Vandi v. Permanente Medical Group, 9 Cal. Rptr. 2d 463, 464 (Ca. Ct. App. 1992) (holding that a physician was under no duty to inform the patient of the availability of a computerized tomography (CT) scan after the patient suffered a seizure, rather than waiting for a magnetic resonance imaging (MRI) scan that the physician recommended to detect a possible brain abscess); Munro v. Regents of Univ. of Cal., 263 Cal. Rptr. 878, 885 (Ca. Ct. App. 1990) (holding that a physician was under no duty to inform patients of a genetic blood test to detect Tay-Sachs disease that is a remote risk for such patients); Scalare v. Stenson, 260 Cal. Rptr. 152, 153–54 (Ca. Ct. App. 1989) (holding that a physician who concludes that a patient was progressing satisfactorily after surgery and who was not recommending any further diagnostic tests or therapy was under no duty to inform the patient of such tests or therapy).

141. *See Scalare*, 260 Cal. Rptr. at 157 (Johnson, J., dissenting).

142. *Id.* at 158.

143. *See Parris*, 25 Cal. Rptr. 2d at 802–03.

144. *Id.* at 803.

available and is capable of detecting that abscess?[145] Again, the answer is yes, but the court imposed no duty on the patient's physician to disclose this information.[146] If, following cardiac catheterization (an angiogram), a patient reports pain, discomfort, swelling and little, if any, pulse in her right arm, would it be material to that patient's decisionmaking to know that diagnostic tests and therapy are available to identify the cause of her symptoms and to alleviate them, despite her physician's belief that she is progressing satisfactorily without them?[147] Once again, the answer is yes, but the court imposed no duty on the patient's physician to disclose this information.[148] Without such information, the patient has no right to medical self-determination. The patient receives only what the doctor orders—or fails to order!

The courts' refusal to require physician disclosure of the risks of and alternatives to nontreatment cannot be reconciled with orthodox "no duty" analysis. If a person is in a position of peril, the failure of another to rescue him or her is not tortious even if harm is foreseeable from the nonaction and even if a hypothetical, reasonable person would act to prevent the harm. The nonintervention is considered to be mere nonfeasance, not affirmative misfeasance.[149] The nonrescuer did not create the situation of peril, and his or her

145. *See Vandi*, 9 Cal. Rptr. 2d at 464–65.

146. *Id.* at 468.

147. *See Scalare*, 260 Cal. Rptr. at 153–54.

148. *Id.* at 156. The failure of a physician to order diagnostic tests poses a difficult problem for courts. As one court noted, "At the time of treatment, there may be dozens, perhaps even hundreds, of diagnostic procedures which could reveal a rare and unforeseen medical condition but which are not medically indicated." *Vandi*, 9 Cal. Rptr. 2d at 467. A physician who orders some, but not all, diagnostic tests may conform to prevailing medical practice and thus is not liable for malpractice. But is the patient entitled to know of other tests that might reveal or confirm a diseased condition? Generally, courts have said no. For example, in one case, an elderly patient complaining of inability to urinate and vaginal bleeding saw a urologist in 1990. Although the urologist performed a number of diagnostic tests, those tests failed to detect bladder cancer. Although the patient saw the urologist several times over the next three years, none of his tests revealed her true condition. In 1993, when she saw another physician for an unrelated medical condition, he discovered a massive tumor on her bladder. The patient was diagnosed with metastatic cancer and died a year and a half later. Farina v. Kraus, 754 A.2d 1215, 1216–18 (N.J. Super. Ct. App. Div. 1999). Although the defendant did not order cytology tests when he saw the patient in 1990 and did not order them when he saw her in subsequent appointments, and although these tests might have revealed her cancerous condition, the New Jersey Superior court refused to impose a duty to disclose the availability of that diagnostic test to the patient. Liability could not be imposed, said the court, because the defendant was not negligent in failing to recommend the test. Because he did not deviate from accepted medical practice in his choice of diagnostic tests, tort liability could not be imposed on him for failing to inform the patient of other tests that he did not recommend. *Id.* at 1223.

149. *See generally* KEETON ET AL., *supra* note 31, at 373–74. Dan Dobbs notes that unless the defendant has assumed a duty to act, his or her failure to act for the plaintiff's benefit is not actionable even if the defendant foresees harm to the plaintiff from

nonintervention did not create a new risk of harm to the imperiled person.[150] But if the potential rescuer engages in affirmative conduct to assist the imperiled person,[151] or if he or she is contractually obligated to act,[152] the rescuer must act with reasonable care and will be liable for misfeasance.[153]

Can it be said that a physician owes no obligation to his or her patients to protect them from the nontreatment option that the physician proposes? Although a physician's "decision" to prescribe bed rest instead of surgery or to order some diagnostic tests but not others may conform to acceptable medical practice and thus not constitute malpractice, the physician's professional duties to the patient are not circumscribed by his or her judgment calls. The physician also owes the patient an independent duty of disclosure. If, as the *Canterbury* court announced, and numerous other courts echoed, "the patient's right of self-decision shapes the boundaries of the duty to reveal,"[154] the physician should be obligated to disclose information about alternative treatment options—including surgery and diagnostic testing—that the physician is not recommending. That information is not only material to the patient's decision, it is often critical to that decision. The decision on what treatment—or nontreatment—is acceptable belongs to the patient whose life will be affected by that decision, not to the physician who can only recommend options based on his or her professional expertise.

By accepting the patient as a patient, the physician accepts the duty to treat according to medically accepted standards.[155] The physician also accepts the duty to disclose the information material to the patient's decisionmaking. When the physician prescribes bed rest instead of surgery or orders some diagnostic tests but not others, the physician is exercising professional judgment. The physician's recommendation is his or her affirmative response to the patient's complaint, or

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the failure to act. Dobbs asserts that this proposition is "widely accepted and acted upon." DOBBS, *supra* note 31, at 853.

150. *See generally* RESTATEMENT, *supra* note 30, § 314; DOBBS, *supra* note 31, at 853–55.

151. *See generally* RESTATEMENT, *supra* note 30, at § 324; DOBBS, *supra* note 31, at 859–60.

152. *See generally* RESTATEMENT, *supra* note 30, at § 324A; DOBBS, *supra* note 31, at 860.

153. *See generally* RESTATEMENT, *supra* note 30, at § 323 (suggesting that liability is imposed for failure to exercise reasonable care in performing the undertaking if such failure increases the risk of harm to the imperiled person); KEETON ET AL., *supra* note 31, at 377 (suggesting that one who is under a duty to rescue must exercise reasonable care).

154. Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir. 1972); *see supra* text accompanying notes 83–86.

155. Although, as a general rule, tort liability is not imposed for nonfeasance, it is imposed for misfeasance. Thus, for example, a physician is not legally obligated to render gratuitous care to someone who needs medical attention. If, however, the physician accepts the person as a patient, that affirmative conduct imposes on the physician the duty to treat that patient with the level of care required for all other patients. *See* KEETON ET AL., *supra* note 31, at 378.

symptoms, or diagnosed condition. It is not inaction and should not be construed as such. The physician cannot be equated with a potential rescuer who declines to become involved. The physician is involved. His or her patient is entitled to make a treatment decision, and the physician is obligated to disclose the information that the patient needs to make that decision. Failure to disclose when there is an obligation to disclose is not nonfeasance; it is misfeasance.

C. Proposals for Reform: One Step Forward, One Step Back

Seventeen years ago, Marjorie Shultz discussed at length the failure of courts, using the torts of battery and negligence, to adequately protect the patient's right to medical self-determination.[156] "Serious deficiencies exist in the protection presently accorded to patient autonomy,"[157] she asserted. "[T]he present doctrinal schema is inadequate and inconsistent. A new model for the allocation of authority between doctors and patients is needed."[158] Professor Shultz proposed that patient autonomy be recognized and protected as a distinct legal interest.[159] That new tort would impose a duty on the physician to disclose whenever the physician possesses information that is important and relevant to the patient's decision rather than when the physician proposes to touch the patient.[160]

Professor Shultz was not the first commentator to propose that the patient's dignitary interest in medical self-determination should no longer be viewed through the myopic lenses of battery and negligence.[161] Nor is she the last to urge that a new tort is needed to replace the doctrine of informed consent, a tort that would truly value the patient's right to informed decisionmaking.[162] As Mark

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156. *See* Shultz, *supra* note 44, at 229–57.
157. *Id.* at 276.
158. *Id.*
159. *Id.* at 299.
160. *Id.* at 283–91.
161. *See* Capron, *supra* note 16, at 350.
162. *See, e.g.*, Capron, *supra* note 16, at 350, 404 (proposing that breach of the physician's disclosure duty should be reconstituted as a new tort, "with its own rules of conduct, causation, and damages." The new tort would be "a hybrid of negligence and battery theories that is controlled by its own logic and is not confined by the rules which attach to either of its parent causes of action."); Meisel, *supra* note 121, at 211 (asserting that informed consent law should recognize that a doctor's inadequate disclosure of information to a patient is itself a wrong to the patient's dignitary interest); Riskin, *supra* note 10, at 600–04 (proposing a new tort to protect the patient's dignitary interest in deciding the course of his or her medical treatment); Twerski & Cohen, *supra* note 109, at 648–64 (proposing that the law value the process of decisionmaking and the patient's right to participate in medical decisions rather than merely valuing the avoidance of bad results that may or may not occur when risks are not disclosed); Weisbard, *supra* note 81, at 763–64 (proposing a new tort that would treat patient self-determination as a separate goal, independent of the avoidance of physical injury); *see also* KATZ, *supra* note 6, at 82–84 (asserting: "The doctrine [of informed consent] has not as yet produced a meaningful blueprint for implementing patient self-determination.... The legal vision of informed consent, based on *self-determination*, is still largely a mirage." *Id.* at 84); *Fairy Tale*, *supra*

Hall noted, "If informed consent law remains tied to its traditional doctrinal moorings, then it may not be free to shape itself into a fully formed 'dignitary tort'—one that would thoroughly protect a patient's right to be involved in all aspects of medical decisionmaking...."[163] As Nancy Levit so eloquently asserted: "To reduce the dignity and worth of human beings to body parts is tangibly to reduce people to physics and chemistry, and to deny value to life other than base physical existence."[164]

But commentators do not decide cases; judges do. With rare exception,[165] judges have not been receptive to proposals to expand the physician's disclosure duty by replacing the narrowly crafted informed consent doctrine with a broader informed medical decisionmaking doctrine. As Jay Katz observed, "Judges toyed briefly with the idea of patients' right to self-determination and largely cast it aside."[166] Although Marjorie Shultz entitled her article: *From Informed Consent to Patient Choice: A New Protected Interest*,[167] her prophesied development did not materialize. To the contrary, the law has not merely stagnated, it has regressed. As discussed below, the move has not been from informed consent to patient choice, but rather, from informed consent to uninformed acquiescence.

III. CONSTRAINING COSTS, CONSTRAINING CARE, CONSTRAINING CHOICE: REPLACING INFORMED CONSENT WITH UNINFORMED ACQUIESCENCE

A. Managed Care and the Physician's Treatment Obligation

The physician's unqualified fidelity to his or her patient's health is at the very core of the physician-patient relationship. The physician may not do anything to impair the patient's health and must do everything within his or her ability to

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note 16 (critiquing the common law development of the informed consent doctrine and concluding: "At present the law of informed consent is substantially mythic and fairytale-like as far as advancing patients' right to self-decisionmaking is concerned." *Id.* at 174); Nancy Levit, *Ethereal Torts*, 61 GEO. WASH. L. REV. 136, 151–52 (1992) (discussing the patient's right to information and his or her right to participate in the decisionmaking process as process rights entitled to legal protection even if no tangible injury results).

163. Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 538 (1997).

164. Levit, *supra* note 162, at 189.

165. *See* Scalare v. Stenson, 260 Cal. Rptr. 152, 157 (Ca. Ct. App. 1989) (Johnson, J., dissenting) (asserting that "a doctor's duty of disclosure includes the duty to explain the risks and benefits of non-treatment," and that "the purpose of disclosure is not to protect the patient from an unconsented touching but rather to protect the broader right of the patient to self-determination over what is done with her own body"); Munro v. Regents of Univ. of Cal., 263 Cal. Rptr. 878, 886 (Ca. Ct. App. 1990) (Johnson, J., concurring and dissenting) (asserting that the physician's disclosure duty applies whether a physician proposes to perform a diagnostic test or whether the physician proposes not to do so).

166. KATZ, *supra* note 6, at 82.

167. Shultz, *supra* note 44, at 219.

promote the patient's health.[168] The physician is obligated, Hippocrates tells us, to use his ability and to exercise his judgment for the benefit of his patient and to abstain from anything deleterious to his patient.[169] The American Medical Association's Principles of Medical Ethics echo that same categorical imperative: "A physician shall, while caring for a patient, regard responsibility to the patient as paramount."[170] Fidelity to the patient's medical interest—i.e., restoring the patient's health—is to be placed above all other interests, including any personal or financial interest of the physician.[171] The physician's fidelity to the patient assures the patient's trust in the physician.[172] Such trust is vitally important for therapeutic purposes.[173] With trust, the patient is willing to share sensitive and confidential information, to be confident in the physician's clinical judgment, and to comply with the physician's recommended treatment.[174] "Trust," wrote Mark Hall, "is the core, defining characteristic of the doctor/patient relationship, or, as is sometimes said, the 'glue' that holds the relationship together and makes it possible."[175]

Within the last thirty years, however, the practice of medicine has undergone a revolutionary change. The physician's allegiance to his or her patient's medical interest—a duty of undivided loyalty—is being challenged as it has never been challenged before. Previously, physicians offered services to their patients and either patients paid directly for those services and obtained

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168. *See* CHARLES FRIED, MEDICAL EXPERIMENTATION: PERSONAL INTEGRITY AND SOCIAL POLICY 50–51 (1974).

169. *See supra* text accompanying note 2, quoting the Hippocratic Oath.

170. AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS, PRINCIPLE VIII, (adopted by the AMA's House of Delegates, June 17, 2001).

171. *See* Alexander M. Capron, *Containing Health Care Costs: Ethical and Legal Implications of Changes in the Methods of Paying Physicians*, 36 CASE W. RES. L. REV. 708, 710 (1986). According to Capron, the patient's medical interest includes: confidentiality of patient information, *see id.* at 733–34, appropriate care for the patient's condition, *see id.* at 735–36, and a relationship of trust in the treating physician and in the health care system, *see id.* at 737–39. Thomas Boyd identifies as falling within the physician's fiduciary obligation to the patient the duty to inform the patient of the physician's findings, to maintain the confidentiality of the relationship, and to treat the patient in accordance with accepted professional standards. *See* Thomas H. Boyd, *Cost Containment and the Physician's Fiduciary Duty to the Patient*, 39 DEPAUL L. REV. 131, 137 (1989).

172. *See* M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 JAMA 268, 272 (1999).

173. *See* Mark A. Hall, *Trust, Law, and Medicine: Towards a Therapeutic Jurisprudence of Health Care Delivery* (2001) (unpublished manuscript at 21, on file with the author). This article is scheduled for publication as: Mark A. Hall, *Trust, Law, and Medicine*, 55 STAN. L. REV. (forthcoming, Nov. 2002).

174. *See* Bloche, *supra* note 172, at 272.

175. Hall, *supra* note 173, at 9; *see also* Frances H. Miller, *Trusting Doctors: Tricky Business When It Comes to Clinical Research*, 81 B.U. L. REV. 423, 426–27 (asserting that a patient's trust in his or her physician is a critical component in the healing process).

reimbursement from their insurance companies or physicians were paid for their services directly by the patients' insurance companies.[176] Admittedly, in this fee-for-service system, physicians had a financial incentive to provide more, not less, care so long as they were paid for their services.[177] Who would second guess a physician who asked the patient to return for a follow-up visit or ordered an additional test before making a diagnosis? If the patient's insurance paid for the visit or the test, the physician's clinical judgment was not questioned. Only the physician's obligation to his or her patient's medical interest served as a check on the physician's decisions.[178] One can surely question whether it served as an adequate check,[179] but at least the patient and the physician were allied in their pursuit of diagnostic information (through testing) and treatment that would further the patient's medical interest.

Eventually, the cost of fee-for-service medicine became prohibitive. Health care expenditures rose from five percent of the country's Gross National Product in 1950 to thirteen percent forty years later, and health insurance costs were escalating at an annual rate of fifteen to twenty percent.[180] To contain costs, insurers, businesses, and the government turned to a new model of health care delivery.[181] Health maintenance organizations (HMOs) emerged as "managed care" became the accepted euphemism for reduced and rationed care. To be sure, managed care has existed since the mid-eighteenth century, promising employees access to health care at a fixed price so long as they remain employed, and assuring employers a healthy workforce through preventive health care and

176. *See* Pegram v. Herdrich, 530 U.S. 211, 218 (2000); Krause, *supra* note 115, at 278.

177. *See Pegram*, 530 U.S. at 218; Krause, *supra* note 115, at 279–81 (discussing physicians' financial incentive to overtreat patients in a fee-for-service system).

178. *See Pegram*, 530 U.S. at 218.

179. Theodore Schneyer suggests that under a fee-for-service arrangement, physicians' treatment decisions may be affected by the financial gain they receive from recommending treatment. *See* Schneyer, *supra* note 79, at 136–38. Using radical mastectomy as an example, Schneyer asserts that surgery is ordered for ostensibly irrelevant economic reasons instead of clinical reasons. *See id.* at 166–68.

180. *See* Krause, *supra* note 115, at 281; *see also* Barry R. Furrow, *'Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 421 (1997) (asserting that health care costs rose an average of 14.6% per year from 1980 to 1985 and 12.6% per year from 1985 to 1990); Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 396 (2001) (asserting that health care costs rose an annual average of .37 of one percent of the gross domestic product from 1980 to 1993 but have remained essentially level at 13.6% from 1993 through 1998); Sage, *supra* note 16, at 1713 (asserting that between 1960 and 1997, health care spending rose from 5.1% to 13.5% of the gross domestic product and currently exceeds one trillion dollars annually).

181. *See* David Mechanic, *Professional Judgment and the Rationing of Medical Care*, 140 U. PA. L. REV. 1713, 1714 (1992) (asserting that "health care rationing, once commonly viewed as unthinkable, has become an increasingly respectable response [to escalating health care costs]").

"wellness" programs.[182] But in responding to the perceived health care cost crisis of the 1970s, the focus of managed care shifted perceptibly.

If "recession" is the dreaded "r" word when applied to the American economy, then "rationing" is the dreaded "r" word when applied to American health care. And yet, rationing is a reality. As the Supreme Court recently acknowledged, rationing of health care and inducement to ration health care are "the very point of any HMO scheme."[183] To reduce costs, patients enrolled in an HMO can only obtain access to health care through a restricted group of primary care physicians. To reduce costs, those physicians are required to employ strict utilization guidelines for the diagnostic testing and treatment they provide, for referrals to medical specialists, and for hospitalizing patients to perform surgery. To reduce costs, decisions of physicians are subject to utilization review by the insurance company before they can be implemented.[184]

HMOs employ a variety of strategies to induce primary care physicians to ration health care. For example, the HMO typically pays them a fixed level of compensation to cover all services they provide to those enrolled in the HMO plan—a method of payment known as capitation—regardless of the quantity of services provided to patients during the covered period. To induce primary care physicians to ration use of diagnostic testing, referrals, and other ancillary services, HMOs may arrange to pay bonuses to them if, at the end of the year, unspent funds remain from a pool set aside at the beginning of the year to pay for those services. Alternatively, HMOs may adopt a fee withhold arrangement, deducting a portion of the physicians' compensation each pay period to pay for ancillary services but returning unused funds to physicians at the end of the year. HMOs may use an expanded capitation scheme, paying physicians a fixed level of compensation to cover not only all services they personally provide to patients but also various ancillary services provided by others.[185]

Are these financial incentives commonly used to induce physician rationing of health care? Let there be no doubt. As Justice Souter recently wrote for a unanimous Supreme Court: "[N]o HMO organization could survive without

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182. *See* Furrow, *supra* note 180, at 427–28.

183. *Pegram*, 530 U.S. at 221.

184. For a more complete discussion of these and other cost reduction examples, see generally Krause, *supra* note 115, at 281–89. *See also* Furrow, *supra* note 180, at 428–33 (discussing capitation), 443–64 (discussing restrictions placed on subscriber treatment choices and physician selection), 473–84 (discussing utilization review rules and the use of the primary care physician as gatekeeper); E. Haavi Mooreim, *Diverse and Perverse Incentives of Managed Care: Bringing Patients into Alignment*, 1 WIDENER L. SYMP. J. 89, 90–92 (1996) (discussing payments based on a pre-determined fee rather than for each service provided, utilization rules, and gatekeeping arrangements).

185. For a more complete discussion of these and other financial incentive examples, see generally David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 158–60 (1996). *See also* Furrow, *supra* note 180, at 465–73; Mooreim, *supra* note 184, at 92–93.

some incentive connecting physician reward with treatment rationing."[186] And, as we know, HMO organizations are surviving.

Although physicians are subject to financial incentives under both a fee-for-service system and a managed care system, the effect of those incentives on patient care is significantly different. Under fee-for-service, the physician's financial interest is to order additional, and perhaps unnecessary, care;[187] under managed care, the physician's financial interest is to order less, and perhaps deficient, care. As Haavi Morreim noted: "Although high quantity of care does not guarantee quality; at some point less care does mean worse care."[188] Even the Supreme Court acknowledged that ruptured appendixes are more likely to occur when health care is rationed.[189] Under managed care, the physician can no longer be viewed as the patient's ally, working in joint pursuit of diagnostic information and treatment to further the patient's medical interest. Rather, the physician must balance the patient's medical interest against the medical interests of other patients or potential patients in the program and the limited resources available to treat them all.[190]

Physicians can no longer be trusted to place the individual patient's medical interest above all other interests.[191] Managed care imposes upon them a

186. *Pegram*, 530 U.S. at 220. *But see* Mark Schlesinger, *Mismanaged Care: The Challenges Facing Judicial Interpretation of Contemporary Health Policy*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 203, 208 (2001) (asserting that although physician financial incentives exist in up to 70% of managed care plans, such incentives "certainly are not essential for a health plan to be viable").

187. *See supra* text accompanying notes 177–79.

188. Mooreim, *supra* note 184, at 101.

189. *See Pegram*, 530 U.S. at 221. The Court noted, however, that unnecessary appendectomies were less likely to occur. *Id.*

190. *See, e.g.*, Nancy S. Jecker, *Dividing Loyalties: Caring for Individuals and Populations*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 177, 178 (2001) (asserting that under managed care, physicians have been characterized as double agents, "responsible not only to advocate for their own patients, but also to advocate for the entire population of patients served by a health plan"); Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821, 1821 (1995) (asserting that physicians "are increasingly being required to be both caregiver and cost manager"); Mechanic, *supra* note 181, at 1732 (asserting that "under managed care, the role of the physician as the patient's agent and advocate may shift in subtle ways to one in which the physician consciously balances her actions on behalf of the patient against budgetary considerations").

191. As Dr. Alan Stone observed:

> It is one thing to entrust your life and health at times of crisis to a physician who is committed to the practical ethics that involves a quest for excellence and who may err on the side of doing too much. It is quite another to entrust your life and health at times of crisis to a physician whose diagnostic and therapeutic interventions are limited by new regulatory constraints or incentives of competitive efficiency that "place the provider at economic risk."

Alan A. Stone, *Law's Influence on Medicine and Medical Ethics*, 312 NEW ENG. J. MED. 309, 312 (1985).

requirement that they divide their loyalties.[192] And financial incentives paid to physicians for rationing care is the thumb on the scale that assures their compliance with the new regime.[193]

Some would contend that although fidelity to the individual patient's medical interest is an important value for physicians, it is not an ethical absolute.[194] Physicians, they claim, have social responsibilities that require them to place the interests of others, or of society as a whole, above the interests of their patients.[195] Nancy Jecker, for example, notes that even Hippocrates expected physicians to care for the indigent,[196] and public health laws today require physicians to report communicable diseases—despite their patients' interest in maintaining confidentiality.[197] It is but a small step, she argues, to claim that physicians, in making treatment decisions, have a duty of loyalty to "the entire population of patients served by a health plan."[198]

The argument is not persuasive. To promote the welfare of society, the physician may have an ethical obligation to treat indigent patients. But the physician's clinical judgment about what treatment is medically appropriate for a specific patient, whether a paying patient or a nonpaying patient, is not influenced by that societal obligation. To promote the welfare of society, the physician may have a legal obligation to report a patient's communicable disease. But the physician's clinical judgment about what treatment is medically appropriate to treat that patient's disease is not influenced by the physician's duty to report. The physician's duty of undivided loyalty to the patient's medical interest remains intact. When, however, the HMO calls upon the physician to ration health care, to balance the medical interest of the patient he or she is treating against the medical interests of others served by the health plan, the interests are in direct conflict. And yet, it is precisely at the moment when the physician is deciding what diagnostic test to order, or what treatment to utilize, or whether to recommend a consultation with a specialist, or whether to recommend hospitalization, that the patient is most vulnerable and most in need of an ally who can be trusted to consider only that

192. *See, e.g.*, Matthew Robert Gregory, *Hard Choices: Patient Autonomy in an Era of Health Care Cost Containment*, 30 JURIMETRICS J. 483, 493 (1990) (asserting: "The doctor's allegiance is now divided"); Jecker, *supra* note 190, at 177 (characterizing, within the title to her article, the physician's obligations under managed care with the words: "*Dividing Loyalties*").

193. Eighty-three percent of the 1549 physicians responding to a recent nationwide survey expressed their belief "that personal financial incentives to encourage restraint in testing, treatment, and referrals are not ethically acceptable." Daniel P. Sulmasy et al., *Physicians' Ethical Beliefs About Cost-Control Arrangements*, 160 ARCHIVES INTERNAL MED. 649, 651, 653 (2000).

194. *See* Jecker, *supra* note 190, at 180.

195. *See id.*

196. *See id.* at 179.

197. *See id.* at 180.

198. *Id.* at 178.

patient's medical interest. Unfortunately, managed care deprives the patient of that ally.

B. Managed Care and the Physician's Disclosure Obligation

Managed care not only denies patients medically appropriate diagnostic tests, treatment options, and referrals, it denies them information about those tests, treatments, and referral options. As Dr. Daniel Sulmasy observed, a "new medical paternalism" has emerged.[199] "[P]atients are not only denied the exercise of their autonomy, they are also denied access to the knowledge that they have lost this autonomy."[200]

HMOs not only employ a variety of strategies to induce physicians to ration health care, they employ a variety of strategies to induce physicians to withhold information from their patients about rationing decisions. Until recently, HMOs did so directly by inserting so-called "gag clauses" in their contracts with physicians.[201] Such clauses specifically preclude physicians from informing patients about medically appropriate treatment options that might not be covered by the HMO or that the HMO might wish to discourage for financial or other reasons.[202] In June 1996, the American Medical Association's Council on Ethical and Judicial Affairs issued an opinion declaring such clauses "inappropriate barriers to necessary communications between physicians and patients."[203] Opinions of the Council "represent official ethics policy of the AMA."[204] State legislatures responded to the concerns of individual physicians and organized medicine by enacting legislation prohibiting gag clauses.[205] By the end of the year,

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199. Daniel P. Sulmasy, *Managed Care and the New Medical Paternalism*, 6 J. CLINICAL ETHICS 324, 325 (1995).

200. *Id.*

201. *See generally* Joan H. Krause, *The Brief Life of the Gag Clause: Why Anti-Gag Clause Legislation Isn't Enough*, 67 TENN. L. REV. 1 (1999) (discussing gag clauses and anti-gag clause legislation).

202. *See* GEN. ACCOUNTING OFFICE, MANAGED CARE: EXPLICIT GAG CLAUSES NOT FOUND IN HMO CONTRACTS, BUT PHYSICIAN CONCERNS REMAIN, GAO/HEHS-97-175, at 5 (Aug. 1997) (defining "gag clause").

203. AM. MED. ASS'N, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS § 8.053 (1996), *available at* http://www.ama-assn.org/ama/pub/category/2503.html.

204. AM. MED. ASS'N, CODE OF MEDICAL ETHICS: CURRENT OPINIONS, *available at* http://www.ama-assn.org/pub/category/2503.html.

205. In January 1996, Massachusetts became the first state to enact anti-gag clause legislation. *See* MASS. GEN. LAWS ANN. ch. 175, § 108(11) (West 1998) (providing: "An insurer shall not refuse to contract with or compensate for covered services an otherwise eligible provider or nonparticipating provider solely because such provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the insurer's products as they relate to the needs of such provider's patients"). By July 1997, thirty-two states had enacted patient protection legislation addressing the gag clause issue. *See* GEN. ACCOUNTING OFFICE, *supra* note 202, at 4 (listing the thirty-two states).

the HMOs acknowledged defeat. The Board of Directors of the American Association of Health Plans issued a policy statement, declaring that "health plans, by contract or policy, will not prohibit physicians from communicating with patients concerning medical care, medically appropriate treatment options (whether covered or not), or from making factual and nonproprietary statements regarding the plan."[206] In August 1997, the General Accounting Office (GAO) reported that none of the 1150 physician contracts submitted by 529 HMOs contained a gag clause.[207]

HMOs, however, have not abandoned their efforts to curtail physician communication with patients.[208] They simply use other methods to achieve the same result. For example, physician-patient communication is inhibited by the insertion of various business purpose clauses into their contracts. A nondisparagement clause prohibits physicians "from making statements that could undermine patient, employer, union, or public confidence in the health plan."[209] A nonsolicitation clause prohibits "physicians from providing patients with information that might encourage them to enroll in another health plan."[210] A business confidentiality clause prohibits physicians from disclosing "such proprietary information as the plan's payment and incentive structure, medical management criteria, and clinical practice protocols."[211] Although, ostensibly, these clauses are inserted to protect legitimate business interests of the contracting HMO, physicians charge that they are inserted to discourage disclosure.[212] Physicians who breach any of these clauses risk termination of their participation in the plan. When a factually accurate critique that tarnishes the HMO's image can be construed by the HMO as disparagement warranting dismissal, communication is chilled.[213] Although acknowledging the right of managed care organizations to protect proprietary information, the American Medical Association cautions that such right should "not inhibit physicians from raising or disclosing relevant information to patients."[214] The Association urges removal of those clauses "that could be applied to prevent physicians from raising or discussing matters relevant to patients' medical care."[215]

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206. The policy statement is quoted in GEN. ACCOUNTING OFFICE, *supra* note 202, at 4.

207. *Id.* at 1, 3.

208. Joan Krause asserts that anti-gag clause legislation is not an adequate response to the problem of assuring that patients receive the information they need to make informed treatment choices. *See* Krause, *supra* note 201, at 3. Such legislation, she contends, demonstrates "that quick fixes to ban egregious practices will not be enough." *Id.* at 44.

209. GEN. ACCOUNTING OFFICE, *supra* note 202, at 6.

210. *Id.* at 7.

211. *Id.* at 8.

212. *See, e.g.*, David U. Himmelstein & Steffie Wollhandler, *Bound to Gag*, 157 ARCHIVES INTERNAL MED. 2044 (1997).

213. *Id.*

214. AM. MED. ASS'N, *supra* note 203.

215. *Id.*

Contract clauses are not the only constraints to communication. The GAO cautioned that physician nondisclosure can be achieved through "guidelines, protocols, physician profiling, counseling, and approval procedures"[216]—methods not even addressed in the GAO study. And the real incentive to comply with perceived HMO restrictions on communication is not any announced policy or procedure, but rather, "the contractual relationship itself—its short duration and provision for termination without cause—that may make physicians feel constrained from speaking openly with their patients."[217] For physicians who are economically dependent on managed care, the threat of termination without cause coerces compliance.[218] If the per capita cost of care for a physician's patients is higher than an HMO-imposed norm, i.e., the physician provides them too much care, the physician risks termination. If his or her patients contest HMO treatment refusals, i.e., the physician provides them too much information, the physician also risks termination.

C. Expanding the Disclosure Duty Beyond Inherent Risks: Tort Law's Response—or Failure to Respond—to Managed Care Communication Constraints

In the typical case in which an informed consent claim is successful, liability is imposed when the physician recommends a procedure but fails to disclose to the patient a risk of injury inherent in the procedure, and that injury results.[219] Within the last decade, however, a few courts, especially ones in jurisdictions that apply *Canterbury*'s reasonable patient test,[220] have required disclosure of other risks. For example, the Louisiana Court of Appeal affirmed a judgment against a surgeon for failing to disclose his chronic alcohol abuse in obtaining his patient's consent to a lumbar laminectomy.[221] Disclosure was required because this condition increased the potential for injury to the patient during surgery, and thus was a material risk to him.[222] The court found this disclosure to be equal in importance, if not more important, than disclosure of the

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216. GENERAL ACCOUNTING OFFICE, *supra* note 202, at 2.

217. *Id.* at 15. When disclosure can result in loss of income, one could readily assert that "silence is gold."

218. *See id.* at 13.

219. In *Canterbury*, for example, the patient, who was not informed of the risk of paralysis from an operation on his back, suffered paralysis in the lower half of his body as a result of that surgery. *See* Canterbury v. Spence, 464 F.2d 772, 776 (D.C. Cir. 1972). In *Cobbs v. Grant*, a patient, who consented to surgery for a peptic duodenal ulcer, suffered a severed artery at the hilum of his spleen, developed a gastric ulcer that required removal of 50% of his stomach, and was rehospitalized due to the premature absorption of a suture. The patient was not informed prior to the surgery that injury to the spleen occurs in approximately 5% of duodenal ulcer operations such as that performed on the patient, and that the development of a new ulcer and premature absorption of a suture are also inherent risks of the surgery performed on him. Cobbs v. Grant, 502 P.2d 1, 4–5 (Cal. 1972).

220. *See Canterbury*, 464 F.2d at 786; *supra* text accompanying notes 83–117.

221. *See* Hidding v. Williams, 578 So. 2d 1192, 1198 (La. Ct. App. 1991).

222. *See id.* at 1196.

potential for loss of bowel and bladder control,[223] another risk that was not disclosed[224] and that materialized from the surgery.[225]

The Maryland Court of Appeals held that a complaint against a surgeon for failing to disclose his HIV-positive status before operating on patients should not have been dismissed.[226] Plaintiffs alleged that the risk of HIV transmission during invasive surgery was foreseeable, even though proper barrier techniques could make the risk extremely low. The seriousness of the potential harm—death to the patients if the AIDS virus is transmitted—was a factor to be considered in determining whether disclosure was required.[227] The New Jersey Superior Court made a similar analysis.[228] The court found that the quantifiable risk of HIV transmission from surgeon to patient was small—indeed, at the time of trial, no such case had been reported. Nevertheless, the risk did exist.[229] Although disclosure of the physician's HIV-positive status may effectively end his or her surgical career, inclusion of the patient into the decisionmaking process was deemed essential to prevent the physician from continuing to perform surgery based solely on his or her own self-interest.[230] "If there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon," said the court, "the arbiter will be the fully-informed patient. The ultimate risk to the patient is so absolute—so devastating—that it is untenable to argue against informed consent...."[231]

Just as the surgeon's physical infirmities may increase the risk of harm to the patient and must be disclosed as material to the patient's judgment to accept or reject treatment from that surgeon, other physician-specific factors raise a similar concern. The Supreme Court of Wisconsin ruled that the physician is required to disclose information identifying that physician as an independent risk factor in performing a particular surgical procedure.[232] In the case, the patient consented to basilar bifurcation aneurysm surgery (a clipping of an aneurysm at the rear of the

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223. *See id.* Even though an orthopedic surgeon testified that loss of bowel and bladder functioning occurs only once in every 200,000 lumbar laminectomies, the court required disclosure of the risk because this complication is feared more than any other except death. *See id.* at 1195.

224. *See id.* at 1196. The court held that the surgeon's disclosure that there was a risk of "loss of function of body organs" did "not amount to an understandable communication of any specific real risk." *Id.*

225. *See id.* at 1194.

226. *See* Faya v. Almaraz, 620 A.2d 327, 333 (Md. 1993).

227. *See id.* The court limited plaintiffs' recovery for fear of acquiring AIDS to that period between when they learned of their surgeon's illness and when they received the results of the HIV test that confirmed their HIV-negative status. *See id.* at 338–39. The court described this period as the "legitimate window of mental anxiety." *Id.* at 339.

228. *See* Estate of Behringer v. Med. Ctr. at Princeton, 592 A.2d 1251, 1278–83 (N.J. Super. Ct. Law Div. 1991).

229. *See id.* at 1280.

230. *See id.* at 1278.

231. *See id.* at 1283.

232. *See* Johnson v. Kokemoor, 545 N.W.2d 495, 507 (Wis. 1996).

plaintiff's brain) and was rendered an incomplete quadriplegic.[233] The court ruled that information about the neurosurgeon's limited experience in performing such surgery and the difficulty of the operation should have been disclosed because it was material and would have been considered by the reasonable patient.[234] The plaintiff was not only entitled to introduce evidence about the defendant's limited prior experience,[235] but also to introduce morbidity and mortality rates to demonstrate the defendant's understatement of the surgical risks through statistical differences in result when the operation is performed by physicians of limited experience as compared with experienced physicians.[236] The plaintiff was also entitled to introduce expert testimony that the defendant should have referred the plaintiff to a tertiary care center with a neurological intensive care unit that possessed more extensive microsurgical facilities and more experienced surgeons.[237] Because the defendant was obligated to inform the patient of comparative risk data, the court, citing *Canterbury*, imposed the duty to provide referral information as "a modest and logical next step."[238]

In *Moore v. Regents of University of California*,[239] the California Supreme Court held that to obtain a patient's informed consent, the physician must also disclose any financial or other interest that the physician has that conflicts with, or even potentially conflicts with the physician's fiduciary duty to that patient.[240] In deciding whether to consent to proposed treatment, a patient would want to know of any interest extraneous to the patient's health that may have affected the physician's judgment to recommend that treatment for that patient, even if that conflicting interest was not consciously considered.[241] After all, if a surgeon's HIV-positive status must be revealed because it nominally increases the

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233. *See id.* at 498–99. The patient was "unable to walk or to control her bowel and bladder movements. [H]er vision, speech and upper body coordination [were] partially impaired." *Id.* at 499.

234. *See id.* at 505.

235. *See id.* at 506.

236. *See id.* at 506–08. Eighteen years earlier, in an informed consent claim based on the tort of battery, the Supreme Court of Arizona held that the patient is entitled to receive information about the treating physician's experience in performing the proposed procedure, not merely statistical probabilities of adverse results encountered by other physicians. *See* Hales v. Pittman, 576 P.2d 493, 500 (Ariz. 1978).

237. *See Johnson*, 545 N.W.2d at 508–10.

238. *Id.* at 510. *See also id.* at 510 n.37; *see generally* Richard A. Heinemann, Note, *Pushing the Limits of Informed Consent:* Johnson v. Kokemoor *and Physician-Specific Disclosure*, 1997 WIS. L. REV. 1079 (critiquing ambiguities in the court's analysis that obscure the scope of the physician's disclosure duty, *see id.* at 1099–112, but ultimately concluding that "*Johnson v. Kokemoor* was not wrongly decided," *id.* at 1120).

239. 793 P.2d 479 (Cal. 1990).

240. *See id.* at 485. The court ruled that the patient's complaint stated a cause of action for breach of a fiduciary duty or lack of informed consent. *See id.* at 497. Although the court did not elaborate upon the differences between these two causes of action, breach of a fiduciary duty typically requires the fiduciary to disgorge all profits gained as a result of the breach. *See, e.g.*, D.A.B. v. Brown, 570 N.W.2d 168, 172 (Minn. Ct. App. 1997).

241. *See Moore*, 793 P.2d at 484.

patient's risk of contracting the AIDS virus, a surgeon's research interest or economic interest that may influence a surgeon to recommend surgery that subjects the patient to all the risks of harm inherent in that operation and all the consequences of that operation, should require a similar disclosure. In *Moore*, for example, the plaintiff alleged that the surgeon's research interest in the patient's rare blood and the surgeon's economic interest in patenting a cell line from the plaintiff's cells may well have influenced the surgeon to recommend a splenectomy, the surgical removal of the plaintiff's spleen.[242] If a surgeon's chronic alcohol abuse or inexperience must be revealed because the patient may wish to consider the surgeon's competence to perform the proposed surgery, a surgeon's conflicting loyalties that may influence the surgeon's medical judgment should require a similar disclosure so that the patient can consider the surgeon's competence to recommend the proposed surgery.[243]

Recently, the United States Court of Appeals for the Eighth Circuit, applying Minnesota law, went one step further. The court imposed a duty on physicians to disclose conflicting loyalties even when they do not recommend any affirmative course of treatment. In *Shea v. Esensten (Shea II)*,[244] a forty-year old patient was experiencing symptoms of heart disease. His family doctors did not refer him to a cardiologist. When the patient's symptoms did not improve, the patient offered to pay for the referral himself, but "his physicians persuaded him to trust their judgment that neither his age nor his symptoms justified a visit to a cardiologist."[245] The patient suffered a heart attack and died. In a wrongful death suit, the plaintiff alleged that the physicians failed to disclose financial incentives in the HMO contract designed to minimize referrals to specialists and that if the patient had known of those incentives, he would not have trusted the physicians' medical advice but instead would have obtained the opinion of a specialist at his

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242. *See id.* at 481. The plaintiff alleged that the surgeon

> recognized the peculiar research and commercial value of plaintiff's cells *before* their removal from plaintiff's body. Despite this knowledge, the doctor allegedly failed to disclose these facts or his interest in the cells to plaintiff, either before plaintiff's initial surgery or throughout the ensuing seven-year period during which the doctor continued to obtain additional cells from plaintiff's body in the course of periodic medical examinations.

Id. at 499 (Broussard, J., concurring and dissenting).

243. Requiring a physician to disclose his or her HIV-positive status or substance abuse may implicate his or her privacy interest; disclosure of the physician's financial conflict of interest does not. *See* Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients From Their Physicians*, 55 U. PITT. L. REV. 291, 294 (1994) (recommending that to adequately protect physician privacy interests and patient health, physicians' personal characteristics should be regulated through prohibitory regulation rather than through imposing an increased disclosure obligation. However, Bobinski recommends that an increased disclosure obligation should be imposed for physicians' financial interests that may create conflicting loyalties.).

244. 208 F.3d 712 (8th Cir. 2000).

245. *Id.* at 715.

own expense.[246] Even though the jury found that the physicians had not committed malpractice in the care and treatment of the patient, the court upheld the plaintiff's claim for negligent misrepresentation.[247] Under Minnesota law, physicians have a state-imposed ethical duty to disclose conflicts of interests to their patients.[248] Self-serving financial incentives, such as those found in an HMO contract, conflict with the physician's duty of loyalty to the patient's medical welfare and must be revealed. The injury from this violation is independent from any injury that may occur from negligent treatment and is cognizable under the separate tort of negligent misrepresentation.[249]

Although these precedents for an expanded disclosure duty are important forays for the future, they have not been universally, or even generally, accepted in American jurisprudence. For each case discussed above, there are others—often numerous others—that reach a contrary result. The Pennsylvania Superior Court, for example, affirmed the dismissal of an informed consent claim brought by parents against a surgeon who operated on their now-deceased minor child without informing the parents that he was an alcoholic and not licensed to practice medicine in the state.[250] The court specifically "refuse[d] to expand the informed consent doctrine to include matters not specifically germane to surgical or operative treatment,"[251] such as "facts personal to the treating physician."[252]

In suits against physicians and others, many jurisdictions have refused to allow recovery for a plaintiff's fear of acquiring AIDS absent an actual exposure to the HIV virus.[253] The California Court of Appeal required the plaintiff to prove, not only actual exposure, but also "that it is more likely than not he or she will become HIV seropositive and develop AIDS due to the exposure."[254] The plaintiff alleged that she specifically asked the surgeon, "How is your health?" and that she

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246. *See id.*

247. *See id.* at 716.

248. *See id.* at 717 (citing D.A.B. v. Brown, 570 N.W.2d 168, 172 (Minn. Ct. App. 1997)).

249. *See id.*

250. *See* Kaskie v. Wright, 589 A.2d 213, 214, 217 (Pa. Super. Ct. 1991).

251. *Id.* at 217.

252. *Id.*

253. *See* K.A.C. v. Benson, 527 N.W.2d 553, 560 (Minn. 1995). The court cites ten cases from eight jurisdictions in which courts required exposure to HIV as a prerequisite to recovery and notes that Maryland is the only jurisdiction in which the state's highest court permits recovery without exposure or a positive HIV test. *See id.* at 560 n.9. Although the defendant allegedly performed two gynecological procedures on the plaintiff without disclosing his HIV-positive status, *see id.* at 555, the court rejected the plaintiff's claims of negligent and intentional infliction of mental distress, battery, negligent nondisclosure (breach of the duty to obtain informed consent), and consumer fraud. *See id.* at 560–62. Because the plaintiff tested negative for HIV and thus suffered no harm from the undisclosed, but minuscule risk of HIV exposure, the court did not address the question of whether physicians are under a legal duty to disclose their HIV status to patients. *See id.* at 561.

254. Kerins v. Hartley (*Kerins II*), 33 Cal. Rptr. 2d 172, 179 (Cal. Ct. App. 1994).

consented to the surgeon's removal of a uterine fibroid tumor only after he informed her that he went to a gym regularly and jogged every morning but did not mention that he was possibly infected with HIV or AIDS.[255] Despite the defendant's evasive answer, the court precluded recovery of mental distress damages on grounds of fraud, intentional infliction of mental distress, or battery, because the actual risk that the plaintiff would develop AIDS was statistically insignificant, and thus the plaintiff could not demonstrate that her fear of AIDS was reasonable.[256]

The Court of Appeals of Washington held that a surgeon who had never before performed a laparoscopic cholecystectomy (gall bladder removal) on a human being—he merely attended a two-day class on the surgery that included hands-on participation in performing the procedure on three pigs—was not required to disclose his lack of experience in order to obtain the patient's informed consent.[257] The court expressed concern that if facts relating to the physician's competence can be considered material to the patient's judgment, then the physician might be required to disclose information about his or her own health, financial situation, and even medical school grades.[258] The court preferred instead to limit the physician's disclosure duty to the traditional requirement of risks inherent in the proposed procedure and the availability and risks of alternative treatment or no treatment at all.[259]

Within the last year, the Supreme Court of Pennsylvania held that a physician's personal characteristics and experience are irrelevant to an informed consent claim even when the patient inquires as to the physician's experience before consenting to the operation.[260] The patient, suffering from esophageal cancer, agreed to surgery involving resectioning of her esophagus and stomach. A leak developed at the site of the surgery that eventually ruptured and required emergency surgery. As a result of complications from the rupture, the plaintiff

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255. *Id.* at 175–76. At the time of the operation, the defendant "knew he was in a high risk group for AIDS, and...frequently sought medical attention...for a variety of ordinarily common ailments including colds, flu, and a skin rash." *Id.* at 175. The defendant also submitted to blood tests to confirm his HIV-positive status within two days before or one day after performing the operation on the plaintiff. The exact date the test was administered was uncertain. *See id.* at 174.

256. *See id.* at 179–81.

257. *See* Whiteside v. Lukson, 947 P.2d 1263, 1264 (Wash. Ct. App. 1997). Although at the time the defendant obtained the plaintiff's consent he had not performed the operation on a human being, the plaintiff's surgery was delayed, and at the time of the operation, the defendant had performed the operation on two other patients. During the operation on the plaintiff, the defendant misidentified and damaged the plaintiff's bile duct, and the plaintiff suffered several complications. The jury found that the defendant's mistake did not constitute malpractice but imposed liability for failure to obtain the plaintiff's informed consent. The trial court granted the defendant's motion for judgment notwithstanding the verdict. *See id.*

258. *See id.* at 1265.

259. *See id.*

260. *See* Duttry v. Patterson, 771 A.2d 1255, 1259 (Pa. 2001).

suffered adult respiratory disease syndrome and permanent damage to her lungs.[261] Even though the surgeon misled the patient by informing her that he had performed the proposed surgery once a month for five years, i.e., sixty times, when in fact he had performed it only nine times,[262] the court limited the surgeon's informed consent disclosure duty to the risks inherent in the procedure itself.[263] The court was not persuaded that the plaintiff's inquisitiveness about the physician's experience made the issue material to the patient's judgment.[264]

In *Neade v. Portes*,[265] the Illinois Supreme Court refused to impose on physicians a duty to disclose HMO financial incentives to reduce patient referrals to specialists and outside medical tests.[266] The patient, a thirty-seven-year-old male experienced symptoms of coronary artery blockage—chest pain extending into his arm and shortness of breath. His primary care physician recommended a stress test and an electrocardiogram (EKG). The results were normal and the physician informed the patient that the pain was not cardiac related. Nevertheless, the patient returned four times within the next two months and again eight months later, continuing to complain of chest pain. The physician did not recommend that the patient receive an angiogram, even though that test is more specific for diagnosing coronary artery disease than is a stress test and even though the primary care physician's associate recommended that he order the test. Three months after his last visit to his physician, the patient died from a massive myocardial infarction

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261. *See id.* at 1257.

262. *See id.* at 1260 (Nigro, J., dissenting).

263. *See id.* at 1258–59.

264. *See id.* at 1259. The court applied the objective, reasonable patient test, rather than the subjective, "this patient" test and concluded that risks do not become material if the particular patient is inquisitive and not material if the particular patient is passive. *See id.* Although the doctrine of informed consent could not be used, the court suggested that a cause of action for misrepresentation might be appropriate for damages caused when a physician provides inaccurate information regarding his or her experience in performing the procedure. *See id.*

In Pennsylvania, courts analyze informed consent using battery principles, rather than negligence principles. *See* Gouse v. Cassel, 615 A.2d 331, 334 (Pa. 1992) (equating lack of informed consent with no consent and imposing liability on surgeons who operate without their patient's informed consent regardless of the care they exercise); *see also supra* note 58. Nevertheless, Pennsylvania's restrictive disclosure duty can not be justified by the distinction between the torts of battery and negligence. For example, in *Duttry*, 771 A.2d at 1257, and in *Kaskie v. Wright*, 589 A.2d 213, 214 (Pa. Super. Ct. 1991), the surgeon made contact with the patient without providing the information that an expanded disclosure duty would require. These cases were not ones in which the physicians' proposed course of conduct was nonaction, involving no physical contact with the patients. *See supra* text accompanying note 125. Because an intentional touching occurred, the courts could have determined that the tort of battery was committed. When a touching has occurred, the issue of whether the physician's disclosure duty should be interpreted expansively or restrictively can be analyzed identically under battery or negligence.

265. 739 N.E.2d 496 (Ill. 2000).

266. *See id.* at 505.

caused by coronary artery blockage.[267] Although the Illinois Supreme Court acknowledged that a fiduciary relationship exists between a physician and his or her patient, the court was unwilling to recognize a cause of action against the physician for breach of that fiduciary duty.[268] The court cited appellate court decisions from Arizona, Colorado, Minnesota, and New Mexico dismissing breach of fiduciary duty claims as duplicative of medical malpractice claims.[269] The court noted that in a statute that became effective on January 1, 2000, the legislature had required HMOs to disclose physician incentive plans to patients but had not placed a similar burden on physicians.[270] Although the court expressed its belief that patients should be told of financial considerations that may negatively impact their health care, the court was unwilling to place that disclosure burden on physicians.[271]

In its *Neade* opinion, the Illinois Supreme Court attempted to distinguish the California Supreme Court's decision in *Moore*. "[A] physician's failure to disclose HMO incentive plans," wrote the majority, "is significantly unlike the egregious nature of the alleged behavior at issue in *Moore*."[272] Admittedly, a physician who fails to disclose that he wishes to conduct research and benefit financially from the removal of his patient's diseased spleen is engaged in egregious behavior. But is it any less egregious behavior for a physician to refuse to recommend an angiogram for a patient who repeatedly expresses symptoms of coronary artery blockage—a procedure that the physician's associate recommends to that physician—because the profit he would receive from the health plan would

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267. *See id.* at 498–99.

268. *See id.* at 500.

269. *See id.* at 501; *see, e.g.*, D.A.B. v. Brown, 570 N.W.2d 168, 171 (Minn. Ct. App. 1997) (holding that a physician's failure to disclose that he was receiving kickbacks from a manufacturer and distributor of a synthetic hormone drug that he prescribed sounded in medical malpractice rather than breach of a fiduciary duty). The court asserted:

> While we agree that a physician's advice about treatment options should be free from self-serving financial considerations, any cause of action based on that conduct necessarily flows from the therapeutic relationship. Any breach of fiduciary duty that may have occurred during the doctor's prescription of medication to his patients arose while the doctor was examining, diagnosing, treating, or caring for his patients. Thus, the complained-of acts constitute an integral part of the process of rendering medical treatment.

Id. at 172. Ironically, the court, while specifically declaring that "this case is a malpractice action," also added, "The doctor's duty to disclose the kickback scheme presents a classic informed consent issue." *Id.* at 171. The Minnesota Supreme Court characterizes informed consent claims as the tort of "medical malpractice due to negligent nondisclosure of a significant risk of treatment or alternative treatment plan." Cornfeldt v. Tongen (*Cornfeldt II*), 295 N.W.2d 638, 640 (Minn. 1980). The court measures the significance of the risk by asking whether a reasonable person in the patient's position would consider the risk to be significant in deciding whether to consent to treatment. *See id.*

270. *See Neade*, 739 N.E.2d at 504.

271. *See id.* at 505.

272. *Id.*

be diminished?[273] I doubt it. As Chief Justice Harrison, dissenting in *Neade*, noted: "Most people trust their doctors and would never imagine that their own physician might be withholding necessary medical care for personal, financial reasons."[274]

Courts that restrict the disclosure duty to the risks inherent in the physician's proposed procedure pervert the very principle of patient autonomy that they proclaim. For years, physicians have questioned patients' competence to assess those risks, asserting that only physicians are qualified to decide whether the benefits of the proposed intervention outweigh the risks. Who, however, can question the competence of patients to decide whether to trust their own doctors? That judgment requires no medical training or expertise. And yet, courts deny patients the information they need, and, in fact, must have, in order to make that judgment. Should a surgeon be required to inform a child patient's parents that the surgeon is an alcoholic and not licensed to practice medicine within the state?[275] Surely, such information is not just material to their decision to permit him to operate; it is essential. Should a surgeon who recommends that his patient's gall bladder be removed be required to inform the patient that he never before performed that operation on a human being?[276] Again, such information is not just material to the patient's decision to permit him to operate; it is essential. And if the patient specifically inquires about the surgeon's health,[277] or the surgeon's experience in performing a complicated procedure,[278] should the surgeon be required to give a truthful response? Once again, such information is not just material to the patient's decision to permit him to operate; it is essential.[279] So too,

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273. Chief Justice Harrison, dissenting in *Neade*, asserted that the defendant physician specifically refused to make the referral because it would reduce the profits he would receive from the health plan. *See id.* at 508 (Harrison, C.J., dissenting).

274. *Id.*

275. *See* Kaskie v. Wright, 589 A.2d 213 (Pa. Super. Ct. 1991), discussed *supra* text accompanying notes 250–52.

276. *See* Whiteside v. Lukson, 947 P.2d 1263 (Wash. Ct. App. 1997), discussed *supra* text accompanying notes 257–59.

277. *See* Kerins v. Hartley (*Kerins II*), 33 Cal. Rptr. 2d 172 (Cal. Ct. App. 1994), discussed *supra* text accompanying notes 254–56.

278. *See* Duttry v. Patterson, 771 A.2d 1255 (Pa. 2001), discussed *supra* text accompanying notes 260–64.

279. *See Duttry*, 771 A.2d at 1259 (asserting that the calculus of whether a reasonable person would consider a particular risk to be material "does not shift depending on how inquisitive or passive the particular patient is"); *see also* Arato v. Avedon, 858 P.2d 598 (Cal. 1993). In *Arato*, a patient suffering from pancreatic cancer informed his oncologists that he wanted to be told the truth about his condition. *See id.* at 600. They did not disclose to the patient or the patient's wife the high statistical mortality rate of the disease. *See id.* The patient's widow and children claimed that in recommending chemotherapy and radiation, the defendants were obligated to disclose information about the life expectancy of pancreatic cancer patients. *See id.* at 601–02. The plaintiffs asserted that if the deceased had been informed of "the bleak truth concerning his life expectancy, he would not have undergone the rigors of an unproven therapy, but would have chosen to live out his last days at peace with his wife and children, and arranging his business affairs." *Id.* at 602. The California Supreme Court found for the defendants, refusing to mandate as a

is information about HMO financial incentives paid to influence the physician's clinical judgment. No matter how such incentives are justified, if indeed they can be justified at all,[280] they conflict with the physician's fiduciary duty to his or her patient.

A patient's trust cannot be purchased with concealment, subterfuge, or bald-faced lies. It can only be developed through honest communication.[281] "[D]isclosure and consent," wrote Jay Katz, "do not abolish trust. Disclosure and consent only banish unilateral, blind trust; they make mutual trust possible for the first time."[282] When courts do not require that communication, their narrowly crafted informed consent doctrine does not shield patients from their doctors' deceptions; it leaves them naked and exposed.

IV. RETHINKING THE DISCLOSURE DUTY: RESTORING TRUST IN THE PHYSICIAN-PATIENT RELATIONSHIP

Near the beginning of *Casablanca*, that great motion picture classic, Prefect of Police Louis Renault (Claude Rains) engages Rick Blaine (Humphrey Bogart), owner of Rick's Café, in the following dialogue:

> Louis: "What in heaven's name brought you to Casablanca?"
>
> Rick: "My health. I came to Casablanca for the waters."
>
> Louis: "The waters? What waters? We're in the desert."
>
> Rick: "I was misinformed."[283]

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matter of law the disclosure of a specific category of information, such as life expectancy data. *See id.* at 607. Additionally, the court was unwilling to expand the informed consent doctrine to include "a duty to disclose information material to the patient's *nonmedical* interests." *Id.* at 600, 608–09. In the court's opinion, the patient's request to be told the truth did not heighten the physician's disclosure duty. *See id.* at 609. Ironically, the defendants testified that they did not disclose the life expectancy risk because neither the patient nor his wife ever specifically asked for such information in more than seventy visits made within a one-year period. *See id.* at 601.

280. Most physicians continue to believe that financial incentives paid to influence their clinical judgment are not ethically acceptable. *See supra* note 193; *see also* Jerome P. Kassirer, *Managed Care and the Morality of the Marketplace*, 333 NEW ENG. J. MED. 50, 52 (1995) (asserting that physicians take an oath to provide care, not to restrict it).

281. Although suppressing information can maintain a patient's trust in the short run, it does so "only at the cost of long-term erosion of the bedrock of trust on which the profession of medicine rests." David Mechanic & Mark Schlesinger, *The Impact of Managed Care on Patients' Trust in Medical Care and Their Physicians*, 275 JAMA 1693, 1696 (1996). The authors expressed their belief "that interpersonal trust can be preserved only in an atmosphere of complete and honest communication." *Id.* at 1696.

282. KATZ, *supra* note 6, at xvi.

283. *Casablanca* was filmed in the summer of 1942, premiered in November 1942, and was widely released in 1943. *Casablanca* received Oscars for best picture, best screenplay, and best director. Daniel J. Steinbock, *Refuge and Resistance: Casablanca's Lessons for Refugee Law*, 7 GEO. IMMIGR. L.J. 649, 651–52 (1993). For a synopsis of the plot of Casablanca, see *id.* at 703–05.

Rick's assertion is so absurd that it is obvious he was not misinformed about the existence of waters in Casablanca. His answer conceals his real reason for coming to Casablanca—the disastrous end of his love affair with Ilsa Lund (Ingrid Bergman).

Unlike Rick, the American people have been misinformed and their love affair with their physicians has been compromised by their physicians' noxious infidelity. Seriously ill people are highly vulnerable. At the very time when they must confront their pain, their disability, even their own mortality, they are forced to rely on the expertise of others to restore them to health—or at least to try to do so.[284] They *must* trust their physicians to perform the necessary miracles.[285] If, however, the physician has a financial or other interest that conflicts, or even potentially conflicts, with the physician's fiduciary duty to the patient's health, but does not reveal that conflict to the patient, the physician betrays that trust. If the physician knows of his or her own obvious physical infirmities (HIV-positive status, substance abuse) or inexperience that may increase the risk of harm to the patient, but does not disclose them to the patient, the physician betrays that trust. If the physician proposes no treatment—prescribing only bed rest or monitoring the condition through a follow-up visit—but does not inform the patient of more-aggressive treatment alternatives or of tests to more-definitively diagnose the condition, the physician betrays that trust.

Why have courts, with rare, but notable exception, been unwilling to expand the physician's disclosure duty? Mark Hall suggests that courts fear that jurors, perceiving a violation of trust in a highly trusting relationship that has a strong emotional content, will "react with a strong empathic sense of betrayal that can be unduly punitive."[286] However, ignoring physician betrayal does not solve the problem; it worsens it. Patients—and at times we all are patients—become morally outraged, not just at the physicians who have wronged them, but also at the courts that exonerate them.

Can the physician-patient relationship be saved, and will physicians, as well as their patients, undergo the therapy necessary to assure its survival? I propose a two-part solution. The proposal specifically addresses the physician's disclosure obligation in a managed care context, but it is readily adaptable to other situations (physician disability or recommendation of nontreatment) discussed

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284. *See* Hall, *supra* note 173, at 10.

285. Although "patient confidence in medicine collectively has plummeted[,] Americans remain confident in their personal physicians." Mechanic & Schlesinger, *supra* note 281, at 1693. Of 2086 patients interviewed in a recent study, 84% reported that they completely or mostly trusted their physicians. Although there were no significant differences in responses among groups of patients with different perceived methods of physician payment, 94% of patients trusted for their fee-for-service physicians, compared with 77% for salaried physicians, 83% for capitated physicians, and 85% for managed care physicians. *See* Audiey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 JAMA 1708, 1710 (1998).

286. Hall, *supra* note 173, at 42.

above.[287] First, physicians should make clinical judgments about medically appropriate diagnostic testing, treatment, and referrals for each individual patient they treat without considering any managed care obligations that they owe to others insured by the health plan, to the policies and protocols of the HMO that pays for their patients' care, or to the financial incentives they will receive for rationing such care. "The doctor-patient relationship," wrote the Rhode Island Supreme Court, "is a one-on-one affair."[288] Physicians are trained to diagnose and treat the illnesses and diseased conditions of their patients. Their judgment on what is medically appropriate should not be influenced by external considerations. If, for example, two relatively healthy middle-aged men go to their physician complaining of the same symptom—they fainted while arising from bed in the morning—should the physician's clinical judgment as to the tests to be ordered to detect possible heart disease be influenced by each patient's insurance coverage? For patients who are indistinguishable by age, sex, and physical condition, the clinical judgment should be the same. If a static electrocardiogram (cost: $300) and an exercise stress test (cost: $1200) are both medically appropriate for one patient, they are both medically appropriate for the other. If a static electrocardiogram alone is sufficient for one patient; it is sufficient for the other.

Patients and physicians should readily embrace this first principle of the physician-patient relationship. It assures patients of their physicians' undivided loyalty. It reaffirms for physicians that their clinical allegiance is owed to their patients as individuals,[289] not to all potential patients insured by an HMO health plan or to the HMO itself. It assures physicians that managed care cost constraints will not interfere in the professional judgments that they make.[290] These are not new ideas even in this era of managed care. According to the American Medical Association (AMA), loyalty to the individual patient remains the cardinal ethical principle. For example, regarding financial incentives paid to physicians to ration health care, the AMA's Council on Ethical and Judicial Affairs issued an opinion declaring that the physician's "first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice."[291] Physicians are instructed that "[u]nder no circumstances may [they] place their

287. *But see* Bobinski, *supra* note 243, at 294, 375–87 (recommending that an enhanced disclosure duty be imposed for physicians' financial incentives but that a transaction bar—i.e., a prohibition on practice—be imposed for physicians' personal characteristics).

288. Wilkinson v. Vesey, 295 A.2d 676, 688 (R.I. 1972).

289. *See supra* text accompanying notes 168–71.

290. This principle responds to those who believe that managed care requires physicians to alter the way they make medical judgments. *See, e.g.*, Marczyk & Wertheimer, *supra* note 20, at 34 (asserting that HMOs, not physicians or their patients, make decisions on whether a treatment is empirically justified and that HMO decisions are based on economics not patient interests); Mooreim, *supra* note 184, at 96 (asserting that "physicians are hopelessly trapped amidst conflicting demands and obligations"); Sulmasy, *supra* note 199, at 324 (asserting that economic constraints control physician behavior).

291. AM. MED. ASS'N, *supra* note 203, § 8.054 (1997).

own financial interests above the welfare of their patients.... If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit."[292] In essence, the AMA will not allow physicians to internalize into their standard of practice, managed care financial incentives that conflict with the duty of loyalty they owe to each patient they are treating. In their clinical judgments, physicians must adhere to a unitary, wealth-blind standard. Minimal medicine cannot replace good medicine.[293]

This first principle does not eliminate managed care issues, but it defers those issues until after the physician has made his or her clinical judgment. The physician's judgment about what treatment is medically appropriate for his or her patient, however, does not assure that the patient will actually receive that treatment, or that if the patient does receive it, that it will be paid for by the patient's insurance. Typically, HMOs pay only for medically *necessary* treatment, not for medically *appropriate* treatment. Although the "medical necessity" standard has been challenged as legally vague, clinically artificial, unreliable, and unduly restrictive,[294] nevertheless, whatever that standard means, it often means something less than medically appropriate treatment.

Whenever the physician's clinical judgment of medically appropriate treatment differs from the HMO's judgment of medically necessary treatment, the physician should inform the patient of this discrepancy. This, then, is the second principle. Disclosure is required so that the patient can decide whether to forego the physician-recommended treatment and accept only the insurer reimbursable treatment, or to contest the insurer's decision, or to pay for this additional

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292. *Id.* § 8.03 (updated 1994).

293. *See generally* Edmund D. Pelligrino, *Rationing Health Care: the Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23, 34 (1986) (asserting that physician gatekeeping on economic rather than clinical grounds is morally unsound because it violates the physician's "commitment to the patient's welfare that must be the primary moral imperative in medical care"); Shultz, *supra* note 44, at 295 (asserting that physician decisions to ration care, just as other conflicts of interest, necessarily diminish physician loyalty to the best interests of their patients); Daniel P. Sulmasy, *Physicians, Cost Control, and Ethics*, 116 ANNALS INTERNAL MED. 920, 925 (1992) (asserting: "Cost-control efforts that place the physician either in the role of unilateral bedside rationer or restrictive gatekeeper threaten the integrity of medicine"). *But see* Mark A. Hall, *The Malpractice Standard Under Health Care Cost Containment*, 17 L. MED. & HEALTH CARE 347 (1989) (asserting that the belief that cost considerations should play no role in medical decisionmaking is "naive idealism," *id.* at 351, and noting that as physicians alter their decisions to accommodate cost containment incentives, their customary practice changes, and they will not be subject to malpractice liability, *id.* at 350–51).

294. E. Haavi Morriem, *The Futility of Medical Necessity*, REGULATION 22, 23–25 (Summer 2001); *see also* Havighurst, *supra* note 180, at 399–400 (asserting that terms such as "medically necessary," found in health care contracts, make such contracts "opaque" and prevent consumers from making informed decisions about such plans).

treatment himself or herself.[295] The physician's clinical judgment is pertinent medical information that may well affect the patient's decision.[296] If, in my prior example, the physician believes that both a static electrocardiogram and an exercise stress test are medically desirable to diagnose possible heart disease, the patient whose insurer will only pay for the electrocardiogram needs to know that his physician believes that the stress test is also warranted. When a person's health or life is in jeopardy, shouldn't that person have the option of choosing whether to forego a vacation, or a big-screen TV, or a new car, to pay for that medically indicated procedure, if insurance will not pay for what he or she determines to be a wise investment?

These are not isolated incidents or rare occurrences. As David Mechanic noted, "Much of the cost of medical care is an aggregation of small and intermediate cost procedures repeated frequently and among large numbers of patients, such as common radiology and laboratory procedures."[297] When an individual's life or health is at issue, no physician, health insurance plan, or government policy should deprive that patient of the information he or she needs to decide how he or she will confront that crisis or what personal financial resources he or she will devote to that cause. After all, that patient, not the physician, health insurance plan, or government policy, is most directly impacted by the decision that must be made.[298]

The shift of health care delivery to a managed care system necessitates an expansion of the physician's disclosure obligation, not its contraction or elimination. I reject proposals, such as Mark Hall's theory of "economic informed consent,"[299] that would merely require a global disclosure of cost containment incentives, rules, and mechanisms to the patient when he or she enrolls in a health insurance plan but not require physicians to make treatment-specific disclosures when a health problem arises and individual medical spending decisions are made.[300] Under Hall's proposal, disclosure at the time of enrollment would either constitute "blanket advance consent to the subsequent denials of marginally beneficial care brought about by the rules, procedures, and incentives disclosed at

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295. *See* Frances H. Miller, *Denial of Health Care and Informed Consent in English and American Law*, 18 AM. J.L. & MED. 37, 71 (1992).

296. Even if the patient accepts only the insurer reimbursable treatment for this particular illness or condition, the patient may use the information in deciding whether to switch insurance carriers in the future in order to obtain the benefit. Howard Brody, *Gag Rules and Trade Secrets in Managed Care Contracts*, 157 ARCHIVES INTERNAL MED. 2037, 2039 (1997). The patient may also become active in the political process to advocate change in managed care policies that detrimentally impact him or her. *See* Miller, *supra* note 295, at 71.

297. Mechanic, *supra* note 181, at 1734.

298. Marjorie Shultz notes that questions of utility and value, including allocation of scarce resources, are properly "referred to the individual who will enjoy the benefits and suffer the consequences of the choice." Shultz, *supra* note 44, at 271.

299. Hall, *supra* note 163, at 515, 556–81.

300. *Id.* at 515, 582.

the outset"[301] or a waiver of the right to be informed when medical spending decisions are made.[302] Hall acknowledges that his provocative proposal is "a rather relentless attack on full-bodied application of informed consent law to cost-constrained medical decisions."[303]

Hall presumes that "when consumers make fully informed purchasing decisions to join a constrained insurance plan rather than an unlimited one, they knowingly opt into an economizing style of medicine in exchange for lower premiums or more comprehensive coverage."[304] But people who are insured by an HMO do not "choose" a constrained insurance plan rather than an unlimited one. Typically, they merely accept a health insurance benefit made available to them through their employer. Rarely are they given a choice of unlimited insurance coverage. At best, they can choose between a constrained insurance plan and an even more constrained insurance plan. Often they have no choice at all.[305] Whatever their insurance coverage, they are certainly not agreeing to "an economizing style of medicine," even if they are agreeing to an economizing style of insurance reimbursement. When people go to their physicians for an annual physical, or because they experience symptoms of illness, they are not health care consumers making marketplace purchasing decisions. They are patients entering into a relationship with their physician to preserve or restore their health. That relationship depends on the physician's fidelity to the patient's medical well-being. Anything that interferes with that fidelity—whether it is financial incentives paid to the physician to practice "an economizing style of medicine" or policies that inhibit or eliminate the physician's duty to disclose information material to the patient's judgment on tests, treatments, or referrals—is an anathema to that relationship. Although an HMO may deny payment for life-saving, but experimental, procedures that are not covered by the plan—saying to the patient,

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301. *Id.* at 557.

302. *See id.* at 566. Hall questions whether patient trust can survive a physician's disclosure that some potentially beneficial, medically appropriate test or procedure will not be recommended by the physician or paid for by the insurer because of cost constraints imposed by the health plan—constraints that if adhered to by the physician will ultimately result in financial reward to the physician. *See id.* at 547–48. Hall also asserts that informed consent is designed to foster patient trust. *See id.* at 548. But Hall errs. Informed consent is designed to foster patient autonomy. Trust in one's physician is merely a by-product, although a highly desirable one. As discussed above, real trust can not be achieved through concealment and deception, but only through honesty and communication. *See supra* text accompanying notes 281–82.

303. Hall, *supra* note 163, at 581.

304. *Id.* at 556.

305. Even Hall acknowledges that his theory of economic informed consent "requires for its legal and ethical justification some reasonable range of consumer choice among insurance plans so that silent rationing is not forced on anyone by his or her dire need to remain insured." *Id.* at 585. He admits that such choice "does not presently exist for many—perhaps the majority—of subscribers to managed care plans." *Id.* at 582. Whatever the merits of global disclosure at time of enrollment, Hall's theory is premised on ideal circumstances that rarely, if ever, exist.

in effect, "we will not cover you because you should be dead,"[306] physicians in deciding whether a life-saving option exists must consider only the patient's medical interest. And if that option does exist, fidelity to the patient requires them to disclose it—whether or not the patient's insurance will cover the cost, and whether or not the patient will pay for it or be able to pay for it if insurance does not.[307]

Paul Appelbaum, responding to Hall's proposal, asserts that "keeping patients in the dark about the basis for particular rationing decisions is the motive force behind such proposals."[308] But people are not mushrooms that thrive in darkness and deception. Only through the light of disclosure can they gain the information they must have to make decisions concerning their own health and life. Even the AMA appears to be moving toward this position. The AMA's Council on Ethical and Judicial Affairs, in its opinion addressing managed care contract restrictions on physician disclosures of treatment options, declared, "The right of patients to be informed of all pertinent medical information must be reaffirmed by the medical profession, and *individual physicians must continue to uphold their ethical obligation to disclose such information.*"[309] In expressing its objection to HMO gag clauses that restrict the ability of physicians to provide information to their patients, the AMA chose language that does not merely *permit* physicians to disclose information; it *requires* them to do so. Although the AMA supports global disclosure by HMOs of cost containment incentives, rules, and mechanisms when patients enroll in their health plans,[310] such disclosure does not displace the individual physician's treatment-specific disclosure obligation when conferring with his or her own patients.[311]

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306. Loyola Univ. of Chicago v. Humana Ins. Co., 996 F.2d 895, 903 (7th Cir. 1993). Perhaps cases such as this one inspired the July 19, 2001 *Non Sequitur* comic strip picturing an insurance company representative at the side of a physician performing surgery, saying: "We have a saying in the front office—a dead patient is a cost-effective patient. So I'll be handling the nurses' duties from now on." Cartoonist Wiley Miller added the statement: "Your HMO—caring for you 'til your dying day." Wiley Miller, *Non Sequitur*, July 19, 2001, *at* http://www.non-sequitur.com/index (last visited Mar. 15, 2002).

307. In *Humana*, 996 F.2d at 896–97, the patient, while undergoing insurance-authorized coronary artery bypass surgery, could not be weaned from the cardiac bypass machine. Instead of allowing the patient to die, the surgeon inserted an artificial heart to prolong his life until a heart donor could be located. The expenses for the artificial heart and subsequent heart transplant totaled $500,000.

308. Paul S. Appelbaum, *Must We Forgo Informed Consent to Control Health Care Costs? A Response to Mark A. Hall*, 71 MILBANK Q. 669, 673 (1993). For another excellent critique of Hall's proposal, see generally Krause, *supra* note 115, at 352–61.

309. AM. MED. ASS'N, *supra* note 203, § 8.053 (1996) (emphasis added).

310. *See id.* § 8.054(4) (1997) (asserting that the health plan should assume the responsibility of assuring that patients, prior to their enrollment, are aware of financial incentives paid to physicians).

311. *See id.* § 8.08 (1981) (asserting that "[t]he physician's obligation is to present the medical facts accurately to the patient...and to make recommendations for management in accordance with good medical practice").

Some might contend that my proposal is too simple for the complex world of modern health care delivery. It does not specifically address the question of whether physician financial incentives are salvageable, ethically and legally, even if their existence is disclosed.[312] It does not specifically address the physician's obligation to advocate for the patient with the managed care organization to pay for medically desirable, but arguably not medically necessary, treatment.[313] But my proposal is not a comprehensive plan to solve all health care delivery issues. It is written to affirm patients' legitimate interests in their relationships with physicians. It clarifies physicians' fiduciary obligation to their patients, and insists that this obligation be maintained. For without such obligation, there can be no trust. And without trust, there can be no physician-patient relationship, only a merchant and a customer, each with competing interests, dealing at arms length in a commercial transaction.

V. CONCLUSION

In this Article, I have traced the historical development—or lack of development—of the physician's disclosure duty. That development can be summed up in three quotations, each coming from a person who's name starts with "H." The journey began with Hippocrates who advised physicians to "conceal[] most things from the patient while you are attending to him...revealing nothing of the patient's future or present condition."[314] The Hippocratic Oath has been described as "an oath of secrecy and loyalty to one's medical colleagues,"[315] not one's patients. For twenty-four centuries that ethic prevailed.

In the latter half of the twentieth century, tort law developed the doctrine of informed consent. But the principle of patient medical self-determination, reflected as it is through the tort prism of battery and negligence, proved inadequate to protect the patient's autonomy interest. Many jurisdictions apply a medical custom rule to the disclosure obligation, merely requiring physicians to reveal the risks that a reasonable physician would reveal.[316] *Canterbury*, however, held that the physician's duty to reveal "must be measured by the patient's need, and that need is the information material to the decision....[A]ll risks potentially

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312. *See, e.g.*, Bryan A. Liang, *The Practical Utility of Gag Clause Legislation*, 13 J. GEN. INTERNAL MED. 419, 419–20 (1998) (discussing deleterious consequences of physician financial incentives. For example, if a physician is "deselected" from a plan because he or she recommends experimental or expensive procedures, nonformulary medications, resources outside the plan, or uncovered care, will the patient who suffers from a chronic, expensive illness be able to find another equally compassionate and caring physician to care for him or her within the HMO's selected provider list?).

313. *See generally* William M. Sage, *Physicians as Advocates*, 35 HOUS. L. REV. 1529 (1999) (examining physician advocacy in a managed care health delivery system and asserting that physicians should not become lawyer-type advocates).

314. Hippocrates, *supra* note 1, at 297, 299; *see supra* text accompanying notes 1–8.

315. ROBERT M. VEATCH, CASE STUDIES IN MEDICAL ETHICS 113 (1977).

316. *See supra* text accompanying notes 68–82.

affecting the decision must be unmasked."[317] Nevertheless, courts applying this liberal alternative test typically limit the disclosure duty only to those risks that the reasonable patient would consider material.[318] The real concerns of a flesh-and-blood patient are of no concern to the courts if a hypothetical being would not consider them material. Even when the disclosure duty is breached, courts, in deciding the causation issue, generally do not consider whether the actual patient would have consented if he or she had received the required information, but only whether a reasonable patient would have consented.[319] For converting the real patient's interest in making an idiosyncratic judgment about what shall be done with his or her own body into the hypothetical person's interest in making only the "correct" judgment, the quotation from Humpty Dumpty seems most appropriate: "When I use a word (like autonomy or self-determination), it means just what I choose it to mean—neither more nor less."[320] And if the physician proposes no treatment, most courts impose no duty to disclose treatment alternatives, even if a reasonable patient would want to consider those options.[321] No touch, no foul, seems to be the courts' guiding principle.

Today, managed care challenges the very nature of the physician-patient relationship. Loyalty to the patient's medical interest is jeopardized by financial incentives paid to physicians to induce them to reduce costs and ration care.[322] But at a time when patients need more information to respond to this changed medical landscape, HMOs provide them with less. A muzzle is placed upon the physician—the patient's best source of information about his or her medical problem and the medically appropriate response to it.[323] Patients can truly say, as did Humphrey Bogart in *Casablanca*, "I was misinformed."[324]

Some authors question whether tort law can adequately respond to the challenge. "Traditional informed consent law," wrote Joan Krause, "is simply too fragile, too slender a reed on which to rest the burden of protecting patient informational rights in an era of health care cost containment."[325] But a legislative response does not appear to be forthcoming. "Congress," wrote Peter Hammer, "has demonstrated itself singularly incapable of making national health care policy. Federal legislation, whether it is the patients' bill of rights[326] [or other

317. Canterbury v. Spence, 464 F.2d 772, 786, 787 (D.C. Cir. 1972); *see also* Cobbs v. Grant, 502 P.2d 1, 11 (Cal. 1972) (using virtually identical language).

318. *See supra* text accompanying notes 87–96.

319. *See supra* text accompanying notes 101–15.

320. CARROLL, *supra* note 64, at 188.

321. *See supra* text accompanying notes 121–55.

322. *See supra* text accompanying notes 168–98.

323. *See supra* text accompanying notes 199–218.

324. *See supra* text accompanying note 283.

325. Krause, *supra* note 115, at 386. Krause asserts that the tort system does not value the injuries that result from a failure to disclose and that changes in tort doctrine are unlikely to resolve patient informational concerns in a timely manner. *See id.*

326. The Patients' Bill of Rights, currently engrossed in the Senate, prohibits group health plans from restricting health care professionals from advising patients about

managed care reforms] continues to languish."[327] Some authors believe that tort law, however imperfect, may be the only mechanism for assuring that patients get the information they need to weigh their physicians' recommendations, especially when those recommendations may be tainted by a financial conflict of interest.[328] One author suggested that a recent Supreme Court decision[329] signals the Court's desire for state tort law to play a greater role in policing managed care decsionmaking.[330]

If the patient's right to medical self-determination is truly worth protecting, tort courts have ample precedent to guide their efforts to do so. They can rely upon the New Jersey Supreme Court's decision in *Matthies*[331] to expand the informed consent disclosure obligation to include alternatives to the nontreatment option that the physician recommends. They can use appellate court decisions from Louisiana,[332] Maryland,[333] New Jersey,[334] and Wisconsin[335] to expand the informed consent disclosure requirement to include physician-specific risks such as chronic alcoholism, HIV-positive status, and inexperience. They can cite the California Supreme Court's decision in *Moore*[336] to expand the informed consent disclosure requirement to include the physician's financial or other interests that conflict with, or potentially conflict with, the physician's fiduciary duty to the patient.

If the state's informed consent doctrine has been narrowly construed, stymieing expansion of the disclosure obligation through the torts of battery and

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the health status of the patient or treatment for the patient's condition or disease. Patients' Bill of Rights Plus Act, S. 1344, 106th Cong. §§ 727, 9827 (1999). The bill, however, does not address the physician's duty to disclose information to the patient.

327. Peter J. Hammer, Pegram v. Herdich: *On Peritonitis, Preemption, and the Elusive Goal of Managed Care Accountability*, 26 J. HEALTH POL. POL'Y & L. 767, 777 (2001).

328. *See* McGraw, *supra* note 190, at 1844. Barry Furrow asserts "that the often criticized tort system, properly fine-tuned, may be the most powerful irritant and goad to change [managed care and achieve system-wide reforms]." Furrow, *supra* note 180, at 509.

329. *See* Pegram v. Herdrich, 530 U.S. 211 (2000). In *Pegram*, the Court ruled that the Federal Employee Retirement Income Security Act (ERISA) does not impose fiduciary obligations on HMOs. *Id.* at 214, 237.

330. *See* Hammer, *supra* note 327, at 780.

331. *See* Matthies v. Mastromonaco, 733 A.2d 456, 457 (N.J. 1999); *supra* text accompanying notes 126–32.

332. *See* Hidding v. Williams, 578 So. 2d 1192, 1198 (La. Ct. App. 1991); *supra* text accompanying notes 221–25.

333. *See* Faya v. Almaraz, 620 A.2d 327, 333 (Md. 1993); *supra* text accompanying notes 226–27.

334. *See* Estate of Behringer v. Med. Ctr. at Princeton, 592 A.2d 1251, 1278–83 (N.J. Super. Ct. Law Div. 1991); *supra* text accompanying notes 228–31.

335. *See* Johnson v. Kokemoor, 545 N.W.2d 495, 507 (Wis. 1996); *supra* text accompanying notes 232–38.

336. *See* Moore v. Regents of Univ. of Cal., 793 P.2d 479, 485 (Cal. 1990); *supra* text accompanying notes 239–43.

negligence, courts can look to other torts. In *Shea*,[337] the United States Court of Appeals for the Eighth Circuit used the tort of negligent misrepresentation to require physicians to reveal financial incentives they receive through an HMO contract. The California Supreme Court held that a physician's failure to disclose financial or other conflicts of interest is a breach of a fiduciary duty.[338] Even in states that use a restrictive medical custom test to measure informed consent, malpractice can be found if a physician fails to disclose what he or she is ethically obligated to disclose. Unethical practice does not qualify as acceptable, customary practice.[339] According to the AMA, individual physicians are ethically obligated to disclose all pertinent medical information to their patients.[340]

Courts can heed Dean Prosser's timeless call, to "[strike] out boldly to create a new cause of action, where none had been recognized before."[341] They can accept proposals made by Alexander Capron,[342] Alan Meisel,[343] Marjorie Shultz,[344] and other torts scholars[345] to replace the informed consent doctrine with a new tort that recognizes and protects the patient's dignitary interest in informed medical

337. *See* Shea v. Esensten (*Shea II*), 208 F.3d 712, 717 (8th Cir. 2000); *supra* text accompanying notes 244–49. In business transactions, fraudulent concealment or nondisclosure of material information subjects the wrongdoer to the same liability as if he or she had actively misrepresented that information. *See* RESTATEMENT, *supra* note 30, §§ 550–51; Bortz v. Noon, 729 A.2d 555, 560 (Pa. 1999) (noting that the elements for the tort of intentional nondisclosure are the same as for intentional misrepresentation). In a physician-patient relationship, the physician's fiduciary obligation to the patient demands that no lesser requirement of disclosure be imposed.

338. *See Moore*, 793 P.2d at 485; *supra* note 240.

339. *See, e.g.*, St. Paul Fire & Marine Ins. Co. v. Love, 459 N.W.2d 698, 701–02 (Minn. 1990) (relying upon professional standards of care and ethical standards of behavior to hold that therapists have a duty to refrain from a sexual relationship with their patients and that such conduct constitutes the providing of improper professional services).

340. *See* AM. MED. ASS'N, *supra* note 203, § 8.053 (1996); *supra* text accompanying note 309.

341. Dean Prosser asserted that "[n]ew and nameless torts are being recognized constantly, and the progress of the common law is marked by many cases of first impression, in which the court has struck out boldly to create a new cause of action, where none had been recognized before." KEETON ET AL., *supra* note 31, at 3. Courts have relied upon the physician's ethical obligations and fiduciary duty to his or her patient to create other new torts. *See, e.g.*, Biddle v. Warren Gen. Hosp., 715 N.E.2d 518, 523 (Ohio 1999) (relying on the AMA's Principles of Medical Ethics, as well as the fiduciary character of the physician-patient relationship, to recognize an independent tort action for a physician's unauthorized disclosure of a patient's confidential medical information); McCormick v. England, 494 S.E.2d 431, 435–37 (S.C. 1997) (relying upon the Hippocratic Oath and principles of medical ethics to recognize as tortious a physician's breach of duty to maintain patient confidences in the absence of a compelling public interest or other justification for disclosure).

342. *See* Capron, *supra* note 16, at 350, 404.

343. *See* Meisel, *supra* note 121, at 211.

344. *See* Shultz, *supra* note 44, at 299.

345. *See, e.g.*, Riskin, *supra* note 10, at 600–04; Twerski & Cohen, *supra* note 109, at 648–64; Weisbard, *supra* note 81, at 763–64.

decisionmaking.[346] In 1348, a British court held that a person's dignitary interest in mental tranquility—freedom from fear of harmful contact—was entitled to legal protection even though the plaintiff received no physical injury from the defendant's assault.[347] "There is harm done,"[348] said the court more than 650 years ago.[349] Can courts today continue to deny a person's dignitary interest in making decisions about what shall be done to restore health to his or her own body?[350]

At a time when managed care heightens patients' need for information about physician treatment recommendations, a major impediment to law reform may be disintegrating. Physicians, anxious to retain—or regain—control over their clinical decisionmaking, now seek support from the very patients that they treat. To obtain that support, they must divulge information about the treatment they recommend—or wish to recommend, but cannot because of managed care cost constraints. In a recent survey of 1549 physicians, 87.3% expressed their belief that efforts by health care payers to discourage physicians from revealing coverage restrictions to their patients were not ethically acceptable, and 78.4% expressed their belief that efforts to discourage disclosure of physician financial incentives were not ethically acceptable.[351]

It would be indeed ironic if patients became allied with their physicians in the struggle against the evil axis of ignorance (nondisclosure) and injustice (diminished quality of health care). If that alliance materializes, then perhaps one more quote from a person whose name starts with "H" is appropriate to end this Article. In the final scene of *Casablanca*, after Rick (Humphrey Bogart) shoots Colonel Strasser, Louis, instead of having Rick arrested, tells the police to round up all the usual suspects. Louis then suggests that he and Rick should leave Casablanca and join the free French garrison in Brazzaville. Rick responds: "Louie, I think this is the beginning of a beautiful friendship."

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346. *See supra* text accompanying notes 156–64.

347. *See* I de S et ux v. W de S, Y.B. Lib. Assn. Folio 99, placitum 60, 1366 Y.B. 40 Edw. III 40, placitum 19 (at the Assizes, 1348), *reprinted in* VICTOR E. SCHWARTZ ET. AL., PROSSER, WADE AND SCHWARTZ'S TORTS 34 (10th ed. 2000).

348. *Id.*

349. This case is the oldest principle case used in the Prosser, Wade and Schwartz casebook. *See* SCHWARTZ ET. AL., *supra* note 347.

350. In 1894, a New York court stated: "It is the peculiar merit of the common law that its principles are so flexible and expansive as to comprehend any new wrong that may be developed by the inexhaustible resources of human depravity." Johnson v. Girdwood, 28 N.Y.S. 151, 152 (C.P.N.Y. City), *aff'd*, 39 N.E. 21 (N.Y. 1894) (mem.). That statement remains as accurate today as when it was written more than one hundred years ago.

351. *See* Sulmasy et al., *supra* note 199, at 651.

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