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## INFORMED CONSENT IN NEW YORK UNDER THE MEDICAL MALPRACTICE INSURANCE ACT

In December 1974, the Argonaut Insurance Company, an insurance carrier which provided malpractice liability insurance to 80 percent of the physicians practicing in New York, announced that it would be forced to triple malpractice insurance premiums within 6 months or drop malpractice coverage altogether.<sup>1</sup> Soon thereafter many New York physicians, who were already paying premiums between \$766 and \$14,326 annually, declared that they would not pay higher premiums and threatened to terminate all but emergency medical services unless malpractice insurance was made available at reasonable rates.<sup>2</sup> Under the impending threat of a major disruption of medical services, the New York State Legislature passed the Medical Malpractice Insurance Act<sup>3</sup> in an effort to lower premium rates by reducing the number of malpractice suits.

The primary focus of this article will be on Section 1 of the Act, which adds section 2805-d<sup>4</sup> to the Public Health Law. Sec-

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1. N.Y. Times, April 17, 1975, at 43, col. 4 (city ed.).

2. *Id.*

3. Ch. 109 [1975] McKinney's Laws of N.Y. 134, *as amended*, ch. 476 [1975] McKinney's Laws of N.Y. 715. The Act attempts to solve the problem of medical malpractice insurance in the following ways: it institutes significant substantive and procedural changes in the tort law system; creates a Medical Malpractice Insurance Association to supply malpractice insurance if such insurance becomes unavailable in the private market; establishes a Medical and Hospital Malpractice Fund within the State Insurance Fund to provide malpractice insurance in the event that the Medical Malpractice Insurance Association created by the Act becomes insolvent; and provides certain procedures for the professional discipline of doctors.

4. N.Y. PUB. HEALTH LAW § 2805-d (McKinney Supp. 1975). This section reads as follows:

§ 2805-d. Limitation of medical malpractice action based on lack of informed consent.

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

2. The right of action to recover for medical malpractice based on a lack of informed consent is limited to those cases involving either (a) non-emergency treatment, procedure or surgery, or (b) a diagnostic procedure which involved invasion or disruption of the integrity of the body.

3. For a cause of action therefor it must also be established that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought.

tion 2805-d codifies certain principles which had been developed by the courts pertaining to causes of action based on lack of informed consent. Sections 2805-d (1)<sup>5</sup> and (3)<sup>6</sup> establish the elements of the cause of action. Section 2805-d (2)<sup>7</sup> limits the action to cases involving non-emergency treatment or a diagnostic procedure which invades or disrupts the integrity of the body. In addition, section 2805-d (4)<sup>8</sup> provides the defendant-physician with four defenses which may justify treatment despite the lack of an informed consent.

According to common law, a lack of consent is "part of the definition of an assault."<sup>9</sup> The first New York decision considering the issue of consent in a medical context was *Schloendorff v. Society of New York Hospital*<sup>10</sup> where Mr. Justice (then Judge) Cardozo stated:<sup>11</sup>

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.  
[Citations omitted.]

Based on this general rule of law, the courts began to develop various principles applicable to actions stemming from the alleged failure of the physician to obtain a valid consent from the patient. The courts were divided, however, on certain important

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4. It shall be a defense to any action for medical malpractice based upon an alleged failure to obtain such an informed consent that:

(a) the risk not disclosed is too commonly known to warrant disclosure;  
or

(b) the patient assured the medical practitioner he would undergo the treatment, procedure or diagnosis regardless of the risk involved, or the patient assured the medical practitioner that he did not want to be informed of the matters to which he would be entitled to be informed; or

(c) consent by or on behalf of the patient was not reasonably possible; or

(d) the medical practitioner, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which such alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such disclosure could reasonably be expected to adversely and substantially affect the patient's condition.

5. *Id.* § 2805-d (1).

6. *Id.* § 2805-d (3).

7. *Id.* § 2805-d (2).

8. *Id.* § 2805-d (4).

9. *Ford v. Ford*, 143 Mass. 577, 578, 10 N.E. 474, 475 (1887) (opinion by Mr. Justice Holmes). See also W. PROSSER, *LAW OF TORTS* § 18 (4th ed. 1971).

10. 211 N.Y. 125, 105 N.E. 92 (1914).

11. *Id.* at 129-30, 105 N.E. at 93.

issues. For example, what risks or alternatives is the physician obligated to disclose in order for a court to find that the consent given was an informed consent?<sup>12</sup> Does the unauthorized touching of the patient's body constitute a battery<sup>13</sup> or is the physician's failure to disclose pertinent information to the patient actionable negligence?<sup>14</sup> Must the plaintiff-patient offer expert testimony concerning the alleged insufficiency of the disclosure or is the jury competent to make such a determination without the aid of an expert?<sup>15</sup> By legislative fiat, section 2805-d ends much of this controversy. This article will examine the principles which had been applied by the courts in attempting to resolve these questions and the manner in which section 2805-d and related provisions of the Malpractice Act will affect the future disposition of cases based on lack of informed consent.

### *Battery or Negligence?*

Often a plaintiff's complaint will allege that prior to treatment the physician failed to obtain an informed consent, thereby leaving it to the court to decide whether such a complaint states a cause of action in battery or negligence. This decision may affect the outcome of the case, since proof of different factual, procedural, and substantive elements may be required, depending upon the theory of liability relied on by the court.

At common law, an intentional unconsented-to touching of

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12. See text accompanying note 47 *infra*.

13. For cases which hold that the action is based on battery see *Bang v. Charles T. Miller Hosp.*, 251 Minn. 427, 88 N.W.2d 186 (1958); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905); *Corn v. French*, 71 Nev. 280, 289 P.2d 173 (1955); *Pearl v. Lesnick*, 19 N.Y.2d 590, 224 N.E.2d 739, 278 N.Y.S.2d 237 (1967); *Fogal v. Genesee Hosp.*, 41 App. Div. 2d 468, 344 N.Y.S.2d 552 (4th Dep't 1973); *Cox v. Stretton*, 77 Misc. 2d 155, 352 N.Y.S.2d 834 (Sup. Ct. St. Lawrence County 1974).

14. For cases holding that the action is based on negligence see *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P.2d 170 (Dist. Ct. App. 1957); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *rehearing denied but decision explained*, 187 Kan. 186, 354 P.2d 670 (1960); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); *Mitchell v. Robinson*, 334 S.W.2d 11 (Mo. 1960); *Abril v. Syntex*, 81 Misc. 2d 112, 364 N.Y.S.2d 281 (Sup. Ct. New York County 1975); *Terry v. Albany Med. Center Hosp.*, 78 Misc. 2d 1035, 359 N.Y.S.2d 235 (Sup. Ct. Albany County 1974); *Watson v. Clutts*, 262 N.C. 153, 136 S.E.2d 617 (1964); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972). For commentary on the negligence-battery question see *McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 423-25 (1957); *Plante, An Analysis of "Informed Consent"*, 36 FORDHAM L. REV. 639 (1968); *Comment, Duty of Doctor to Inform Patient of Risks of Treatment: Battery or Negligence?*, 34 S. CAL. L. REV. 217 (1961). See also *Annot.*, 79 A.L.R.2d 1028 (1961).

15. See text accompanying note 26 *infra*.

another constitutes a battery.<sup>16</sup> The tortfeasor's state of mind need not be hostile, nor need there be an intent to do harm.<sup>17</sup> In a medical malpractice context it is likely that the physician-tortfeasor actually intends to bestow a benefit on the patient. Good intentions notwithstanding, if the physician intends to, and does in fact, touch a patient from whom a valid consent has not been obtained, that physician has committed a battery.

If the consent is invalid because the physician neglected to disclose a particular risk, and if such nondisclosure proximately results in actual injury to the patient, negligence, as well as battery, may be properly alleged. The proposition that a tort may be both intentional (battery) and unintentional (negligent) appears to be a contradiction in terms. Courts have nevertheless recognized both theories of liability where the cause of action is based upon the failure of the physician to obtain a valid, informed consent. In battery, the tort is completed at the moment of the unconsented-to touching<sup>18</sup> whereas in negligence there must be actual injury in order for a plaintiff to make out a *prima facie* case.<sup>19</sup> To illustrate, suppose a patient consents to an operation which has a high risk of resulting in paralysis. If the physician fails to disclose this risk, the consent may be vitiated. Thus, the moment the physician touches the patient's body to perform the operation a battery has been committed. If, but only if, the patient suffers actual injury (paralysis) could the physician be liable for negligence. Thus, if the patient becomes paralyzed the physician could be liable for both battery and negligence.

Courts and commentators have distinguished various fact patterns for the purpose of determining if either of these two liability theories is more appropriate to a particular case. Some courts have reasoned that the battery approach is more appropriate when the physician has obtained no consent whatsoever,<sup>20</sup> or has gone beyond the treatment for which the consent was obtained,<sup>21</sup> whereas a negligence analysis is more properly applied to those situations where the physician has failed to disclose a

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16. See W. PROSSER, *LAW OF TORTS* § 9 (4th ed. 1971).

17. *Id.*

18. *Id.*

19. *Id.* § 30.

20. See, e.g., *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914) (express prohibition).

21. See, e.g., *Corn v. French*, 71 Nev. 280, 289 P.2d 173 (1955) (patient consented to exploratory surgery; surgeon performed a mastectomy).

particular risk of, or alternative to, the proposed treatment. Faced with the latter type of case, the California Supreme Court in *Cobbs v. Grant* observed:<sup>22</sup>

[W]hen the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation, the action should be pleaded in negligence.

This distinction has also been recognized in New York. In *Bruse v. Brickner*,<sup>23</sup> the plaintiff alleged a lack of informed consent. At trial the defendant, relying on the appellate case of *Pearl v. Lesnick*,<sup>24</sup> claimed that the action was barred by the one-year statute of limitations applicable to actions for battery. The *Bruse* court distinguished *Pearl* as a case which<sup>25</sup>

involve[d] no element of failure to adequately inform the plaintiff in obtaining her consent but [was] a case where plaintiff claim[ed] that the defendant doctor performed a radical mastectomy upon her after specifically agreeing not to. As the court held, this would constitute an assault and should quite justly be controlled by the Statute of Limitations governing assaults

. . . .

. . . [W]here there is no element of willful wrongdoing on the part of the doctor but rather a negligent failure to carry out his professional duty to inform his patient . . . the malpractice Statute of Limitations should apply rather than the assault statute.

A court's decision whether the laws of negligence or battery are to govern may determine the necessity of adducing expert testimony. Some commentators have opined that if the court were to accept the battery theory, plaintiff need not offer any expert testimony on the alleged insufficiency of the disclosure.<sup>26</sup>

22. *Cobbs v. Grant*, 8 Cal. 3d 229, 241-42, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972).

23. 78 Misc. 2d 999, 359 N.Y.S.2d 207 (Sup. Ct. Fulton County 1974).

24. 20 App. Div. 2d 761, 247 N.Y.S.2d 561 (1st Dep't 1964), *aff'd*, 19 N.Y.2d 590, 224 N.E.2d 739, 278 N.Y.S.2d 237 (1967).

25. 78 Misc. 2d 999, 999-1000, 359 N.Y.S.2d 207, 208-09 (Sup. Ct. Fulton County 1974).

26. See, e.g., Comment, *Informed Consent: A Malpractice Headache*, 47 CHI.-KENT L. REV. 242, 246 (1971); Comment, *Informed Consent as a Theory of Medical Liability*, 1970 WIS. L. REV. 879, 884.

Expert testimony will not be needed if the issue is simply whether there was any consent given at all, or whether the treatment went beyond the consent. In such cases the testimony of the patient-plaintiff will be sufficient. If the issue is, however, whether an ostensibly valid consent was vitiated by the physician's failure to disclose a certain risk (lack of informed consent), expert testimony may be necessary to determine whether the physician's disclosure was adequate. Should the court measure the standard of disclosure by the prevalent practice within the medical community,<sup>27</sup> expert testimony will be necessary to inform the jury as to what the community standard of disclosure is. On the other hand, if the court determines that the physician must disclose those risks which would be material to an informed decision, expert testimony will not be necessary. Hence, the necessity of expert testimony in lack of informed consent cases depends upon which standard of disclosure is adopted rather than on the theory of liability relied upon by the court.

The court's decision regarding the negligence-battery question may also have an effect on the causation issue. Proximate cause, a necessary element of both intentional and negligent torts, is a judicial method of setting a boundary "to liability for the consequences of any act, upon the basis of some social idea of justice or policy."<sup>28</sup> Courts are therefore willing to expand the sphere of liability in the case of intentional as opposed to negligent torts on the theory that there is something more "punishable" when a tort is intended.<sup>29</sup> Some commentators have even suggested that punitive damages might be awarded on a battery theory of liability,<sup>30</sup> but this is highly unlikely unless there is a showing of intent to harm or at least recklessness.

Resolution of the battery-negligence issue is of particular significance where an affirmative defense based on the statute of limitations may be raised. Before the Malpractice Act, if a New York court determined that medical treatment in the absence of an informed consent was a battery, the one-year battery statute of limitations would be applied,<sup>31</sup> whereas if the failure to obtain an informed consent was held to be medical malpractice (profes-

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27. See note 50 *infra* and accompanying text.

28. W. PROSSER, *LAW OF TORTS* § 41, at 237 (4th ed. 1971).

29. *Id.* § 5.

30. See, e.g., Comment, *Informed Consent As a Theory of Medical Liability*, 1970 WIS. L. REV. 879, 884.

31. N.Y.C.P.L.R. § 215 (3) (McKinney 1972).

sional negligence), the three-year statute of limitations for medical malpractice would be applied.<sup>32</sup> Thus it was not at all uncommon, even in recent years, for a New York court to dismiss a plaintiff's cause of action based on lack of informed consent because the plaintiff failed to sue within one year of the commission of the tort.<sup>33</sup> For example, in *Cox v. Stretton*<sup>34</sup> the plaintiff consulted the defendant-surgeon about a vasectomy. The surgeon failed to advise Mr. Cox that such an operation would not completely eliminate the possibility of conception. A year and one-half after the operation Mrs. Cox became pregnant. The plaintiff sued the surgeon in an action alleging lack of informed consent. The court determined that the cause of action was for battery and therefore had begun to accrue at the time of the unlawful touching. Thus, the one-year battery statute of limitations barred plaintiff's suit. If the court had concluded that the physician's failure to disclose constituted medical malpractice, the three-year statute would have applied and the plaintiff's suit would have been timely.

The question of the appropriate statute of limitations is partially resolved by section 1 (section 2805-d)<sup>35</sup> and section 6<sup>36</sup> of the Malpractice Act. Section 2805-d explicitly recognizes that a physician's failure to disclose certain risks or alternatives constitutes medical malpractice. Section 6 of the Act, which adds section 214-a to the Civil Practice Law and Rules, requires that an action for medical malpractice be commenced within two years and six months of the act, omission, or failure complained of. Thus, where the plaintiff alleges lack of informed consent based upon an undisclosed risk or alternative, as in *Cox v. Stretton*, a court may no longer hold that such an action is a battery and the two and one-half year statute applicable to medical malpractice actions must govern.

The provision in section 214-a that the cause of action begins to accrue at the time of the act, omission, or failure complained

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32. N.Y.C.P.L.R. § 214 (6) (McKinney 1972). This section has been amended by the Malpractice Act, and such actions are now governed by the two and one-half year statute of limitations established by section 6 of the Act. *Id.* § 214-a (McKinney Supp. 1975). See note 36 *infra* and accompanying text.

33. See, e.g., *Murriello v. Crapotta*, 174 N.Y.L.J. 57, Sept. 19, 1975, at 9, col. 3. (Sup. Ct. Queens County).

34. 77 Misc. 2d 155, 352 N.Y.S.2d 834 (Sup. Ct. St. Lawrence County 1974).

35. For the text of this section, see note 4 *supra*.

36. N.Y.C.P.L.R. § 214-a (McKinney Supp. 1975).



of conforms with the general rule, developed by case law, that a malpractice cause of action begins to accrue at the time of the alleged malpractice.<sup>37</sup> A negligence cause of action does not begin to accrue until there is actual injury.<sup>38</sup> The time of actual injury and the time of the act, omission, or failure complained of do not necessarily coincide. For example, in the *Cox* case, the malpractice occurred when the physician failed to disclose a certain risk, but the actual injury did not occur until the plaintiff's wife became pregnant. Under section 214-a, if the undisclosed risk becomes a reality more than two and one-half years after the date of the physician's nondisclosure, the plaintiff's suit is barred by the statute of limitations, regardless of the fact that the plaintiff could not have known of the malpractice before the statute of limitations had expired.

It is unclear whether the two and one-half year statute of limitations will apply to situations where the physician obtained no consent or exceeded the consent (those cases which the *Cobbs* and *Bruse* courts indicated should be classified as battery). It is possible that such cases may continue to be treated as batteries by the New York courts since section 1 of the Malpractice Act is confined to situations where the physician failed to disclose a particular risk, and might not apply to cases where there was no consent or where the consent was exceeded. Thus, New York courts may continue to apply the one-year battery statute to such cases. It is the opinion of the author that the battery theory of liability should be applied, if at all, to those cases where the injury is limited to the unlawful touching. If the unlawful touching results in actual injury, the two and one-half year medical malpractice statute of limitation should be applied. Since section 2805-d (3)<sup>39</sup> requires that the lack of informed consent be established as a proximate cause of the *injury or condition* for which recovery is sought, it is clear that according to the Malpractice Act, actual injury is a necessary element of this cause of action.

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37. See, e.g., *Schwartz v. Heyden Newport Chem. Corp.*, 12 N.Y.2d 212, 188 N.E.2d 142, 237 N.Y.S.2d 714 (1963); *County of Broome v. Smith, Inc.*, 78 Misc. 2d 889, 358 N.Y.S.2d 998 (Sup. Ct. Broome County 1974); *Rokita v. Germaine*, 12 Misc. 2d 84, 176 N.Y.S.2d 34 (Sup. Ct. Queens County), *aff'd*, 8 App. Div. 2d 620, 185 N.Y.S.2d 272 (2d Dep't 1958).

38. See, e.g., *White v. Schnobelen*, 91 N.H. 273, 18 A.2d 185 (1941); *Gile v. Sears, Roebuck & Co.*, 281 App. Div. 95, 120 N.Y.S. 2d 258 (3d Dep't 1952). See generally, W. PROSSER, *LAW OF TORTS* § 30 (4th ed. 1971).

39. N.Y. PUB. HEALTH LAW § 2805-d (3) (McKinney Supp. 1975). For the text of this section, see note 4 *supra*.

Actual injury is the distinctive element of the negligence action whereas the invasion of a protected interest distinguishes trespass (battery). Certainly where there is no consent, or where the consent has been exceeded and an undisclosed risk becomes a reality, there is also a lack of informed consent. Furthermore, under most common law batteries, the plaintiff is immediately aware of the tort and thus a shorter statute of limitations is appropriate. In a medical context, however, the unfortunate results of the treatment may not be manifest until well after the one-year battery statute of limitations has expired; and this is so where there is no consent or where the consent has been exceeded as well as in the traditional lack of informed consent case. Given the legislative intent of protecting the patient's right to consent to treatment, a plaintiff should be allowed two and one-half years to bring suit in all lack of consent cases which result in actual injury.

By establishing that lack of informed consent cases are to be governed by the medical malpractice statute of limitations, the New York State Legislature has settled the battery-negligence controversy in the following manner: the failure of the physician to obtain an informed consent is neither negligence nor battery—it is medical malpractice. Medical malpractice is professional negligence, and the distinctions between professional negligence and ordinary negligence are substantial, particularly where the cause of action is based on lack of informed consent. For example, in a negligence suit the standard of care required of the defendant is measured by the conduct of the reasonable man,<sup>40</sup> whereas a malpractice suit is predicated upon the failure of the physician to exercise the care and skill required of a reasonable medical practitioner under similar circumstances.<sup>41</sup> Thus, section 2805-d (1)<sup>42</sup> provides that in lack of informed consent cases, a reasonable medical practitioner standard is used to measure the sufficiency of the disclosure. Furthermore, a negligence suit may be maintained whenever the negligence of one individual proximately results in injury to another to whom a duty of care is owed.<sup>43</sup> According to section 2805-d (2),<sup>44</sup> however, a cause of ac-

40. W. PROSSER, *LAW OF TORTS* § 32 (4th ed. 1971).

41. *Colvin v. Smith*, 276 App. Div. 9, 92 N.Y.S.2d 794 (3d Dep't 1949); *Fiorentino v. Jaques*, 41 Misc. 2d 972, 246 N.Y.S.2d 421 (Sup. Ct. Nassau County 1964).

42. See text accompanying note 47 *infra*.

43. See W. PROSSER, *LAW OF TORTS* § 30 (4th ed. 1971).

44. N.Y. PUB. HEALTH LAW § 2805-d (2) (McKinney Supp. 1975). For the text of this

tion based on lack of informed consent is limited to cases involving non-emergency treatment or a diagnostic procedure which invades or disrupts the integrity of the body. Section 2805-d (3)<sup>45</sup> requires a plaintiff to establish not only proximate cause (as in negligence) but also to prove that a reasonably prudent patient in the plaintiff's position would not have undergone the treatment or diagnosis if the undisclosed risk had been disclosed. Section 2805-d (4)<sup>46</sup> provides four defenses which in some respects resemble contributory negligence or assumption of the risk, but in other respects are quite unique. Finally, although actual injury is an essential element of both negligence and professional negligence, the general rule is that a cause of action for negligence does not begin to accrue until there is actual injury whereas in a malpractice suit the cause of action begins to accrue at the time of the alleged malpractice.

### *Scope of Disclosure*

According to case law, an uninformed consent is tantamount to no consent at all.<sup>47</sup> True consent, the court in *Canterbury v. Spence* observed, "is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."<sup>48</sup> The problem, however, is in determining when an ostensibly valid consent is vitiated because of the physician's failure to apprise the patient of certain risks inherent in, or the alternatives to, a proposed treatment. The determinative question is whether the risk or alternative which was not disclosed is of sufficient magnitude to nullify the consent.<sup>49</sup> Courts have defined this issue in terms of the "scope of disclosure." Some courts have held that the scope of disclosure should be measured by the prevalent practice in the medical community,<sup>50</sup> while other courts have required the physi-

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section, see note 4 *supra*.

45. See text accompanying note 74 *infra*.

46. See text accompanying notes 86-120 *infra*.

47. *Darrah v. Kite*, 32 App. Div. 2d 208, 301 N.Y.S.2d 286 (3d Dep't 1969); *accord*, *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962); *Birnbaum v. Siegler*, 273 App. Div. 817 (2d Dep't 1948); *Scott v. Wilson*, 396 S.W.2d 532 (Tex. Civ. App. 1965).

48. 464 F.2d 772, 780 (D.C. Cir. 1972).

49. *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972).

50. See, e.g., *DiFilippo v. Preston*, 53 Del. 539, 173 A.2d 333, 339 (1961); *Haggerty v. McCarthy*, 344 Mass. 136, 181 N.E.2d 562, 565-66 (1962); *Roberts v. Young*, 369 Mich. 133, 119 N.W.2d 627, 630 (1963); *Aiken v. Clary*, 396 S.W.2d 668, 675-76 (Mo. 1965); *Petterson v. Lynch*, 59 Misc. 2d 469, 470-71, 299 N.Y.S.2d 244, 245-46 (Sup. Ct. Erie County 1969).

cian to divulge those risks which, "tested by general considerations of reasonable disclosure, under all the circumstances, will materially affect the patient's decision whether to proceed with the treatment."<sup>51</sup>

The medical community standard appears to have evolved from the "locality rule" which was designed to protect unsophisticated country physicians who lacked "that high degree of art and skill possessed by eminent surgeons practicing in larger cities."<sup>52</sup> Critics have questioned the relevance of the rule in light of advances in communication and transportation.<sup>53</sup> One commentator suggests "it is doubtful that a custom of disclosure actually exists in a community of physicians,"<sup>54</sup> while another states that<sup>55</sup>

even if [such a standard] did exist, it would necessarily be so general as to be of little value. . . . [and] must be based on what [the testifying experts] would have done, or on what they believe others should have done, rather than on an application of a standard agreed upon by the profession as a whole.

One of the necessary evils of the community standard is the "battle between medical witnesses of the opposing parties."<sup>56</sup> A jury cannot know whether a physician's disclosure conformed to the community standard unless it is aided by an expert witness who can testify as to what that standard is. Thus, the plaintiff has the burden of producing an expert who will testify that the reasonable medical practitioner within the community would have disclosed the risk which the defendant-physician failed to disclose. The defendant may attempt to rebut this allegation by adducing expert testimony that it is not the customary practice within the medical community to disclose the particular risk. This time-consuming, costly, and confusing battle between ex-

51. *Fogal v. Genesee Hosp.*, 41 App. Div. 2d 468, 473, 344 N.Y.S.2d 552, 559 (4th Dep't 1973). See also *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Zelesnik v. Jewish Chronic Disease Hosp.*, 47 App. Div. 2d 199, 366 N.Y.S.2d 163 (2d Dep't 1975).

52. *Small v. Howard*, 128 Mass. 131, 136, 35 Am. Rep. 363, 365 (1880).

53. See, e.g., Nations & Sargent, *Medical Malpractice and the Locality Rule*, 14 S. TEXAS L.J. 129 (1973); Comment, *Medical Malpractice—"The Locality Rule" and the "Conspiracy of Silence,"* 22 S.C. L. REV. 810 (1970); Note, 6 TEXAS TECH. L. REV. 279 (1974). But see King & Coe, *The Wisdom of the Strict Locality Rule*, 3 U. BALT. L. REV. 221 (1974).

54. Note, *Failure to Inform as Medical Malpractice*, 23 VAND. L. REV. 754, 768 (1970).

55. Note, 75 HARV. L. REV. 1445, 1447 (1962).

56. *Zelesnik v. Jewish Chronic Disease Hosp.*, 47 App. Div. 2d 199, 206, 366 N.Y.S.2d 163, 171 (2d Dep't 1975).

pert witnesses has, in recent years, prompted the New York courts to reject the questionably relevant community standard.<sup>57</sup> For instance, in *Zelevnik v. Jewish Chronic Disease Hospital* the court stated:<sup>58</sup>

The distractions of a battle between medical witnesses of the opposing parties as to an alleged community standard of disclosed risks have no place in a rational attempt to learn which risks, tested by general considerations of reasonable disclosure under all the circumstances, should have been disclosed as materially affecting the patient's decision whether to proceed with the treatment.

Once a court concludes that the physician's duty is to disclose those risks which may have a material effect on the patient's decision, the need for expert testimony on this issue is obviated since the jury is capable of making such a determination without the aid of an expert. Courts of other jurisdictions have also rejected the medical community standard.<sup>59</sup> In *Canterbury v. Spence*<sup>60</sup> the court found "no basis for operation of the special medical standard where the physician's activity does not bring his medical knowledge and skills peculiarly into play."<sup>61</sup> The court therefore concluded:<sup>62</sup>

The decision to unveil the patient's condition and the chances as to remediation . . . is oft-times a non-medical judgment and, if so, is a decision outside the ambit of the special standard. Where that is the situation, professional custom hardly furnishes the legal criterion for measuring the physician's responsibility to reasonably inform his patient of the options and the hazards as to treatment.

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57. *Zelevnik v. Jewish Chronic Disease Hosp.*, 47 App. Div. 2d 199, 366 N.Y.S.2d 163 (2d Dep't 1975); *Garone v. Roberts' Technical & Trade School, Inc.*, 47 App. Div. 2d 306, 366 N.Y.S.2d 129 (1st Dep't 1975); *Fogal v. Genesee Hosp.*, 41 App. Div. 2d 468, 344 N.Y.S.2d 552 (4th Dep't 1973); *Barnette v. Potenza*, 79 Misc. 2d 51, 359 N.Y.S.2d 432 (Sup. Ct. Nassau County 1974).

58. *Zelevnik v. Jewish Chronic Disease Hosp.*, 47 App. Div. 2d 199, 206, 366 N.Y.S.2d 163, 171 (2d Dep't 1975).

59. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972).

60. 464 F.2d 772 (D.C. Cir. 1972).

61. *Id.* at 785.

62. *Id.* The use of the word "ofttimes" in the quoted passage presumably is a recognition of the "emergency" and "therapeutic privilege" doctrines which the court refers to later in the opinion as exceptions to the general rule of disclosure. When these two exceptions are invoked the decision to unveil the patient's condition must be tempered by medical judgment. See notes 107 & 112 *infra* and accompanying text.

. . . And surely in nondisclosure cases the factfinder is not invariably functioning in an area of such technical complexity that it must be bound to medical custom as an inexorable application of the community standard of reasonable care.

. . . We hold that the standard measuring performance [of the physician's duty to disclose] is conduct which is reasonable under the circumstances.

The reasonableness of a physician's conduct is ordinarily a matter beyond the scope of the jury. For example, without the aid of an expert, would a jury know whether it is reasonable to permit tightly packed Surgicel to remain in the body<sup>63</sup> or whether reasonable medical practice requires that an X-ray be taken of a fractured bone which had been successfully united seven years before?<sup>64</sup> Expert testimony is unquestionably needed to resolve such matters and its admissibility is governed by the rule of necessity.<sup>65</sup>

The "material risk" standard, however, eliminates the need for expert testimony. Courts adopting this standard are, in effect, concluding that medical considerations play no part in the decision to reveal the risks of a proposed treatment. In rejecting the material risk standard, one court observed that to require the physician to disclose risks which may have a material effect on the patient's decision is to require the physician to second-guess the patient.<sup>66</sup>

The standard of disclosure established by the Medical Malpractice Insurance Act appears to lie somewhere between the physician-oriented community standard and the patient-oriented material risk standard. Section 2805-d (1) defines lack of informed consent to be<sup>67</sup>

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

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63. *Brannon v. Wood*, 251 Ore. 348, 444 P.2d 558 (1968).

64. *Boyce v. Brown*, 51 Ariz. 416, 77 P.2d 455 (1938).

65. See E. FISCHE, *NEW YORK EVIDENCE* § 412 (10th ed. Prince 1973); *UNIFORM RULES OF EVIDENCE* rules 56-61 (1953). See also Ordoover, *Expert Testimony: A Proposal for New York*, 19 N.Y.L. FORUM 809 (1974).

66. *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972).

67. N.Y. PUB. HEALTH LAW § 2805-d (1) (McKinney Supp. 1975).

The benefits to be expected from, the risks inherent in, and the alternatives to a proposed treatment are medical facts which the physician is expected to know. The decision to disclose these facts to the patient, however, is a nonmedical judgment, and depends on which medical facts the physician believes the patient is entitled to know. Since this decision is ultimately a nonmedical judgment, the reasonableness of it may be determined by the jury without the aid of expert testimony. Without the aid of expert testimony, however, the jury could not know the benefits, risks, or alternatives involved in the proposed treatment. Hence, section 9 of the Malpractice Act<sup>68</sup> requires the court to grant a defendant's motion at the end of the plaintiff's case if the plaintiff has failed to adduce any expert testimony in support of the alleged insufficiency of the consent. The consent is insufficient if the disclosure fails to satisfy the standard established by section 2805-d (1). Thus, the plaintiff must produce an expert who will testify about the particular medical treatment, specifically the benefits and risks involved as well as any alternatives thereto. The jury must then decide, in light of these medical facts, whether the physician was acting reasonably in failing to disclose whatever medical facts the plaintiff alleges should have been disclosed. In order to make this determination, the jury should appreciate the purpose and policy behind the doctrine of informed consent—that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."<sup>69</sup> and that "[u]nlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected."<sup>70</sup>

Section 2805-d (1), it should be noted, is qualified by the phrase, "in a manner permitting the patient to make a knowledgeable evaluation."<sup>71</sup> The primary function of this qualification is to require the physician to make the disclosure in plain and

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68. N.Y.C.P.L.R. § 4401-a (McKinney Supp. 1975). This section provides:

A motion for judgment at the end of the plaintiff's case must be granted as to any cause of action for medical malpractice based solely on lack of informed consent if the plaintiff has failed to adduce expert medical testimony in support of the alleged qualitative insufficiency of the consent.

69. *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

70. *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972).

71. N.Y. PUB. HEALTH LAW § 2805-d (1) (McKinney Supp. 1975).

simple language in order that the ordinary patient, unversed in technical medical terminology, will be able to comprehend fully the risks and benefits of the proposed treatment.<sup>72</sup> The explicit legislative intent is, nevertheless, to protect the patient's right to make a knowledgeable evaluation, and the plaintiff is entitled to have the jury so instructed. Considering the fiduciary nature of the physician-patient relationship,<sup>73</sup> and assuming that the risk, benefit, or alternative has been established through expert testimony as reasonably foreseeable, the jury should conclude that the physician was not acting as a reasonable medical practitioner under similar circumstances would have acted if the nondisclosure abrogated the patient's right to make a knowledgeable evaluation.

### *Causation*

Elementary tort law dictates that a breach of duty will not result in liability unless the breach is causally related to the plaintiff's injury.<sup>74</sup> The causation issue in lack of informed consent cases is often quite subtle and elusive since the inquiry must perforce analyze the effect of certain words (or the absence of them) on the human mind. The problem which the courts have attempted to resolve is whether the plaintiff establishes proximate cause by testifying that had the risk been disclosed, he or she would not have undergone the treatment. Such testimony is bound to be unreliable. Once the undisclosed risk has become a reality, even an honest plaintiff will find it difficult to testify objectively regarding the effect disclosure would have had, and most will vigorously assert that they would not have undergone the treatment had the risk been disclosed. In *Zelesnik v. Jewish Chronic Disease Hospital*,<sup>75</sup> one of the issues on appeal was the trial judge's instruction to the jury that resolution of the proximate cause issue depended upon whether the plaintiff would not have submitted to the treatment had he been fully informed. In reversing a judgment for the plaintiff, the appellate division held

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72. In *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972), the court noted that "the patient's interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required . . ." *Id.* at 244, 502 P.2d at 11, 104 Cal. Rptr. at 515. See also Shartsis, *Informed Consent: Some Problems Revisited*, 51 NEB. L. REV. 527, 548-50 (1972).

73. See note 86 *infra* and accompanying text.

74. See generally, W. PROSSER, LAW OF TORTS § 30 (4th ed. 1971).

75. 47 App. Div. 2d 199, 366 N.Y.S.2d 163 (2d Dep't 1975).



that the correct test of proximate cause was whether a reasonably prudent patient in the plaintiff's position would not have undergone the treatment had the risk been disclosed.<sup>76</sup> To hold otherwise, the court observed, would place the physician<sup>77</sup>

at the mercy of the patient's hindsight. Honest though he may be, the disastrous results of the therapy necessarily affects the patient's guess as to whether the risks, if divulged, would have been acceptable.

The court concluded that the plaintiff's testimony is relevant, though not conclusive, in determining the effect that disclosure of the risk would have had on the "reasonably prudent patient."

In order to determine whether the physician should be legally responsible for failing to meet the standard of disclosure established in section 2805-d (1), the plaintiff must satisfy the two causation requirements set forth in section 2805-d (3).<sup>78</sup> According to section 2805-d (3), the plaintiff must establish that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis had he been fully informed, and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought.

As indicated by the *Zelevnik* court, the purpose of the "reasonably prudent patient" standard is to protect the physician. In order to do this, however, it becomes necessary to sacrifice the rights of certain patients. For example, suppose two patients, A and B, are suffering from the same disease which, if untreated, will inevitably result in death. If treated there is a risk of blindness which is always disclosed by the reasonable medical practitioner under similar circumstances. A and B consult a physician who does not disclose this risk. Both submit to the treatment and both go blind. Assume A would have undergone the treatment had the risk been disclosed, but B would not have undergone the treatment had the risk been disclosed. A jury would most probably find that the reasonably prudent patient in A or B's position would undergo the treatment even if the risk was disclosed because it is unreasonable not to risk blindness if death is the inevitable result of foregoing the treatment. At their trials, both A and

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76. *Id.* at 207, 366 N.Y.S.2d at 171. See also Comment, *Failure to Inform as Medical Malpractice*, 23 VAND. L. REV. 754 (1970).

77. 47 App. Div. 2d 199, 207, 366 N.Y.S.2d 163, 171 (2d Dep't 1975).

78. N.Y. PUB. HEALTH LAW § 2805-d (3) (McKinney Supp. 1975). For the text of this section, see note 4 *supra*.

B testify that they would not have consented to the treatment had the risk of blindness been disclosed, but A is testifying falsely whereas B is telling the truth. Neither A nor B can recover, according to section 2805-d (3), if the jury determines that the reasonably prudent patient would have undergone the treatment even if the risk of blindness had been disclosed. In order to prevent A from recovering, B's right to be unreasonable has been sacrificed.

Assuming the plaintiff is able to surmount the "reasonably prudent patient" hurdle, section 2805-d (3) also requires that the lack of informed consent be established as a proximate cause of the injury or condition for which recovery is sought. Before it can be determined that the defendant's failure to obtain an informed consent is a proximate cause, such conduct must be established as a "cause-in-fact" of the injury or condition for which recovery is sought.<sup>79</sup> Proof of causation-in-fact is offered when the plaintiff testifies that but for the physician's failure to disclose, consent would not have been given.<sup>80</sup> Causation-in-fact, however, does not establish liability. For example, suppose that but for the physician's failure to disclose a certain risk the plaintiff would not have consented to an operation. Suppose further that during the operation a fire occurred in the hospital and the plaintiff was badly burned. The physician's failure to obtain an informed consent is a cause-in-fact of the injury—but for the physician's failure to disclose, the plaintiff would not have been burned. It is not, however, a legal (proximate) cause of the injury.

According to Dean Prosser, proximate cause is a method of limiting legal responsibility<sup>81</sup>

to those causes which are so closely connected with the result and of such significance that the law is justified in imposing liability. Some boundary must be set to liability for the consequences of any act, upon the basis of some social idea of justice or policy.

Considerations of duty and foreseeability are necessary to determine whether a cause-in-fact will be viewed as a proximate cause.<sup>82</sup> For instance, in the hypothetical presented in the

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79. W. PROSSER, *LAW OF TORTS* § 41, at 236 (4th ed. 1971).

80. *Id.* This is known as the "but for" or "sine qua non" rule.

81. *Id.* at 237.

82. See, e.g., *Stanton v. State*, 29 App. Div. 2d 612, 285 N.Y.S.2d 964 (3d Dep't 1967), *aff'd*, 26 N.Y.2d 990, 259 N.E.2d 494, 311 N.Y.S.2d 28 (1970); *Jansen v. State*, 60 Misc.

preceding paragraph, the defendant's conduct is not the proximate cause of the injury because it was not the physician's duty to protect the plaintiff from the unforeseeable risk of fire. Suppose, however, that during the operation an anesthesiologist's negligence results in an injury which is unrelated to the undisclosed risk. This negligence may be viewed as a foreseeable intervening cause, and thus the original tortfeasor's failure to disclose may be considered to be a proximate cause of the injury.<sup>83</sup> If the undisclosed risk is the same risk which later materializes or is a reasonably foreseeable consequence of the physician's failure to disclose, a court should hold that the defendant's conduct in failing to obtain an informed consent is a proximate cause of the injury or condition for which recovery is sought.

In attempting to resolve the issue of proximate cause in lack of informed consent cases, courts have applied either the "reasonably prudent patient" test,<sup>84</sup> *i.e.*, would a reasonably prudent patient in the plaintiff's position have undergone the treatment had the risk been disclosed, or the "actual plaintiff" test,<sup>85</sup> *i.e.*, would the actual plaintiff have undergone the treatment had the risk been disclosed. The former test has recently gained favor as courts have concluded that the "actual plaintiff" test is unfair to the defendant due to the self-serving nature of the plaintiff's testimony. In apparent agreement, the New York State Legislature has rejected the "actual plaintiff" test by incorporating the "reasonably prudent patient" test into section 2805-d (3). The requirement of proximate cause does not impose any additional burden on the plaintiff since proximate cause was a necessary element of the plaintiff's case before the Act was passed. The plaintiff must, however, establish that the defendant's conduct is a proximate cause of the *injury* or *condition* for which recovery is

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2d 36, 301 N.Y.S.2d 811 (Ct. Cl. 1968), *aff'd*, 32 App. Div. 2d 889, 302 N.Y.S.2d 1016 (4th Dep't 1969).

83. For cases which hold that a physician's intervening negligent treatment does not relieve the original tortfeasor of liability see *Jess Edwards, Inc. v. Goergen*, 256 F.2d 542 (10th Cir. 1958); *City of Covington v. Keal*, 280 Ky. 237, 133 S.W.2d 49 (1939); *Thompson v. Fox*, 326 Pa. 209, 192 A. 107 (1937) and cases collected in Annot., 100 A.L.R.2d 808 (1965).

84. See, *e.g.*, *Canterbury v. Spence*, 464 F.2d 772, 783-88 (D.C. Cir. 1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 242-43, 502 P.2d 1, 9-10, 104 Cal. Rptr. 505, 513-14 (1972); *Zelevnik v. Jewish Chronic Disease Hosp.*, 47 App. Div. 2d 199, 207, 366 N.Y.S.2d 163, 171-72 (2d Dep't 1975); *Fogal v. Genesee Hosp.*, 41 App. Div. 2d 468, 473, 344 N.Y.S.2d 552, 559 (4th Dep't 1973).

85. See, *e.g.*, *Shetter v. Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (1965); *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965); *Sharpe v. Pugh*, 270 N.C. 598, 155 S.E.2d 108 (1967).

sought. Thus, unlike battery, actual injury must have occurred as a result of the defendant's failure to disclose in order for a plaintiff to make out a prima facie case. In all cases, therefore, where the injury or condition for which recovery is sought is a reasonably foreseeable consequence of the physician's nondisclosure, the plaintiff's testimony that he or she would not have consented to the treatment had the risk been disclosed should be sufficient to satisfy the proximate cause requirement. It should then be for the jury to decide whether the plaintiff would have been acting as a reasonably prudent patient in not consenting, and if the jury answers this question affirmatively, the two causation requirements of section 2805-d (3) have been satisfied.

### *Defenses*

The duty of the doctor to inform the patient is a fiduciary duty.<sup>86</sup> Both the legal and medical professions recognize that due to the fiduciary nature of the relationship, certain situations arise wherein the physician may proceed to treat the patient without first obtaining an informed consent, yet not be liable for negligence, malpractice, or battery. The duty to disclose is a means to an end—protecting the welfare of the patient. If sound medical judgment dictates that less than full disclosure is necessary to protect the patient's welfare, the physician should be allowed to proceed without obtaining an informed consent, provided that the justification for the nondisclosure is "reasonable." "[T]he validity of a defense," one court remarked, "is considered from the standpoint of concern for the well-being of the patient."<sup>87</sup> According to the Medical Malpractice Insurance Act, where a patient alleges that the physician failed to disclose a risk which ought to have been disclosed, the physician may attempt to justify the nondisclosure by raising one of the four defenses established by section 2805-d (4).<sup>88</sup>

#### *Section 2805-d (4)(a)—Risk too commonly known to warrant disclosure*

If the patient is able to establish through expert testimony

86. *Hunter v. Brown*, 4 Wash. App. 899, 484 P.2d 1162, 1166 (1971), *aff'd*, 81 Wash. 2d 465, 502 P.2d 1194 (1972); *Mason v. Ellsworth*, 3 Wash. App. 342, 474 P.2d 909, 916 (1970).

87. *Miller v. Kennedy*, 11 Wash. App. 272, 522 P.2d 852, 864 (1974).

88. N.Y. PUB. HEALTH LAW § 2805-d (4) (McKinney Supp. 1975). For the text of this section see note 4 *supra*.

that the reasonable medical practitioner under similar circumstances would have revealed a particular risk which the defendant failed to disclose, the defendant might testify that the risk was not disclosed because it is too commonly known to warrant disclosure.<sup>89</sup> In order to assert this defense, the physician must have reasonably believed that the patient knew of the risk and was willing to assume it. "In its simplest and primary sense," Dean Prosser writes,<sup>90</sup>

assumption of risk means that the plaintiff, in advance, has given his consent to relieve the defendant of an obligation of conduct toward him, and to take his chances of injury from a known risk arising from what the defendant is to do or leave undone. The situation is then the same as where the plaintiff consents to the infliction of what would otherwise be an intentional tort.

. . . .  
. . . [T]he plaintiff may be acting quite reasonably, because the advantages of his conduct outweigh the risk.

Consent is now generally recognized as the basis of assumption of the risk.<sup>91</sup> As one court observed, however, "[k]nowledge of the risk is the watchword of the defense of assumption of risk."<sup>92</sup> If knowledge is indeed the watchword, the following statement by the *Canterbury* court may be difficult to reconcile with the "commonly known risk" defense:<sup>93</sup>

The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. . . .

. . . His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject.

As dependent as they may be, most patients are aware that certain medical procedures are inherently risky. Even the *Canterbury* court, aware of the ignorance and helplessness of the patient, recognized that "[s]ome dangers—infection, for exam-

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89. N.Y. PUB. HEALTH LAW § 2805-d (4)(a) (McKinney Supp. 1975). For the text of this subsection see note 4 *supra*.

90. W. PROSSER, LAW OF TORTS § 68, at 440 (4th ed. 1971).

91. *Id.*

92. *Cincinnati, N.O. & T.P. Ry. v. Thompson*, 236 F. 1, 9 (6th Cir. 1916).

93. *Canterbury v. Spence*, 464 F.2d 772, 780-82 (D.C. Cir. 1972).

ple —are inherent in any operation; there is no obligation to communicate those [risks] of which persons of average sophistication are aware.”<sup>94</sup>

The difficulty with the defense is in determining what kind of risks are contemplated by the phrase “commonly known.” *Canterbury* adopts an objective “persons of average sophistication” standard. Subsection (a) of section 2805-d (4) is silent, however, as to any standard by which to judge whether a risk is commonly known. Should the standard be nondisclosure of those risks which persons of average sophistication are aware (objective), or should the physician be required to prove he or she was justified in believing that the actual plaintiff was aware of the risk (subjective)?

A subjective standard is usually preferred in an assumption of the risk defense.<sup>95</sup> Accordingly, in a negligence suit the defendant must establish that the actual plaintiff knew of the risk and voluntarily elected to encounter it.<sup>96</sup> A cause of action based on lack of informed consent, however, is an action for malpractice, not ordinary negligence, and arguably a different standard might apply. Under the subjective standard the jury must find that the defendant-physician reasonably believed disclosure of the particular risk was unnecessary because the patient was already aware of it, whereas under an objective standard the physician would attempt to prove that a patient of average sophistication would have been aware of the risk. The language of the statute offers no guidance since it fails to state to whom the risk must be commonly known in order for the defense to succeed. It is submitted, however, that the subjective standard is more consistent with the fiduciary nature of the patient-physician relationship. It is also more consistent with the other three defenses established by section 2805-d (4). If this subjective standard is not read into subsection 2805-d (4)(a), it will be the only defense which focuses on the risk and scope of disclosure rather than on the extenuating circumstances of the particular patient’s situation.

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94. *Id.* at 788.

95. W. PROSSER, *LAW OF TORTS* § 68 (4th ed. 1971); see, e.g., *Vierra v. Fifth Avenue Rental Serv.*, 60 Cal. 2d 266, 383 P.2d 777, 32 Cal. Rptr. 193 (1963); *Aldes v. St. Paul Baseball Club*, 251 Minn. 440, 88 N.W.2d 94 (1958).

96. *Id.*

### Section 2805-d (4)(b)—Waiver

Section 2805-d (4)(b)<sup>97</sup> allows for waiver of the right to be fully informed and is clearly focused on the particular plaintiff. This defense may be raised if the patient assures the physician that he or she intends to undergo the treatment regardless of the risks or does not want the risks disclosed. In both cases the assurances of the patient operate as a waiver thereby relieving the physician of the duty to disclose.

The use of the word "assured" in this section is significant. As originally enacted the second clause of the subsection read:<sup>98</sup>

[or] *indicated* to the medical practitioner that he did not want to be informed of the matters to which he would be entitled to be informed.

This was later amended by substituting "assured" for "indicated to."<sup>99</sup> In order for the waiver to be a valid defense, more than a mere indication is necessary. The patient's assurance should be explicit and unambiguous.

### Section 2805-d (4)(c)—Consent Not Reasonably Possible—Emergency Doctrine

In *Schloendorff v. Society of New York Hospital*<sup>100</sup> Mr. Justice Cardozo established the general rule that a physician who performs an operation without his patient's consent commits an assault.<sup>101</sup> The court recognized, however, that an exception applies "in case of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained."<sup>102</sup>

The sound policy considerations which give rise to the exception are well stated in *Sullivan v. Montgomery*:<sup>103</sup>

To hold that a physician or surgeon must wait until perhaps he may be able to secure the consent of the parents, who may not be available, before administering an anaesthetic or giving to the person injured the benefit of his skill and learning, to the

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97. N.Y. PUB. HEALTH LAW § 2805-d (4)(b) (McKinney Supp. 1975). For the text of this subsection see note 4 *supra*.

98. Ch. 109, § 1, [1975] McKinney's Laws of N.Y. 134.

99. Ch. 476, § 1, [1975] McKinney's Laws of N.Y. 715.

100. 211 N.Y. 125, 105 N.E. 92 (1914).

101. *Id.* at 129-30, 105 N.E. at 93.

102. *Id.* at 130, 105 N.E. at 93.

103. 155 Misc. 448, 449-50, 279 N.Y.S. 575, 577 (City Ct. Bronx County 1935).

end that pain and suffering may be alleviated, may result in the loss of many lives and pain and suffering which might otherwise be prevented.

Emergency situations frequently arise in which a valid consent cannot immediately be obtained. For example, an unconscious, severely injured patient urgently in need of medical attention may be brought to the physician's office,<sup>104</sup> or the patient may be conscious, but incapable of giving a valid consent due to minority.<sup>105</sup> A surgeon operating on an anesthetized patient from whom a valid consent has been obtained may discover a serious condition unrelated to the problem for which the consent was originally obtained but which can be corrected by immediate surgery.<sup>106</sup> The question in all such cases and as required by section 2805-d (4)(c)<sup>107</sup> is whether consent by or on behalf of the patient is reasonably possible. Resolution of this issue depends upon the facts of each case, but the general test of reasonableness in an emergency situation is whether the harm threatened by delaying in order to obtain a valid, informed consent is greater than the harm threatened by the emergency treatment.<sup>108</sup> If the harm threatened by delay is greater, the physician is not only justified in administering treatment, but has a duty to do so,<sup>109</sup> and the consent of the patient will be implied.<sup>110</sup>

#### *Section 2805-d (4)(d)—Therapeutic Privilege*

Implicit in all four defenses established by section 2805-d

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104. See, e.g., *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912). In New York, if a physician renders first aid or emergency treatment at the scene of an accident, section 6527 (2) of the Education Law provides that unless gross negligence can be established, the physician will not be liable for injuries which result by reason of an act or omission which allegedly occurred while such aid was being rendered. N.Y. EDUC. LAW § 6527 (2) (McKinney 1972).

105. See, e.g., *Wells v. McGehee*, 39 So. 2d 196 (La. Ct. App. 1949).

106. See, e.g., *Stone v. Goodman*, 241 App. Div. 290, 271 N.Y.S. 500 (1st Dep't 1934). See also cases collected in Annot., 56 A.L.R.2d 695 (1957).

107. N.Y. PUB. HEALTH LAW § 2805-d (4)(c) (McKinney Supp. 1975). For the text of this subsection see note 4 *supra*.

108. *Canterbury v. Spence*, 464 F.2d 772, 783-89 (D.C. Cir. 1972).

109. *Wheeler v. Barker*, 92 Cal. App. 2d 776, 208 P.2d 68 (Dist. Ct. App. 1949); *Jackovach v. Yocom*, 212 Iowa 914, 237 N.W. 444 (1931).

110. This is not a true "implied consent" situation, according to Dean Prosser, since no conduct by the patient indicates any willingness to consent. Therefore, it is more accurate to say that "the [physician] is privileged because he is reasonably entitled to assume that, if the patient were competent and understood the situation, he would consent, and therefore [the physician may] act as if it has been given." W. PROSSER, *LAW OF TORTS* § 18, at 103 (4th ed. 1971).



(4) is a recognition of the flexibility which must be accorded physicians if they are to continue to function effectively. As one commentator observed, "a surgeon cannot operate if one hand holds *Gray's Anatomy* and the other holds *Corpus Juris*."<sup>111</sup> The physician does not sell medical services in an arm's length transaction with the patient, and rules which govern their relationship cannot be enforced like a commercial code. Thus, subsection (d) of section 2805-d (4)<sup>112</sup> allows the physician a privilege to withhold certain information which ordinarily would be divulged if the physician reasonably believes that such disclosure could adversely and substantially affect the patient's condition. "The critical inquiry," the court observed in *Canterbury v. Spence*, "is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well-being."<sup>113</sup>

An example of a case where the therapeutic privilege clearly applied was *Nishi v. Hartwell*.<sup>114</sup> The plaintiff had been suffering from hypertension (high blood pressure) and chest pains. The defendant-doctor gave the following testimony:<sup>115</sup>

I mentioned he had high blood pressure, he had pain in his chest which we were trying to find an answer to, and if I had sat down with [the plaintiff] and said, 'We are about to inject something into you which has a remote chance of causing you to be paralyzed, you may get an immediate reaction which will cost you your life,' if I had said these things to [the plaintiff], I think it would have been a terrible mistake.

Where the patient suffers from a physiological condition which might be aggravated by a psychological shock, the therapeutic privilege to withhold information applies because disclosure may reasonably be expected to have a direct negative effect on the patient's condition.

Some courts and commentators have indicated that the privilege may be applied to situations in which the effect of disclosure would not directly affect the condition.<sup>116</sup> For example, in *Roberts*

111. Levin, *Consent to Medical Procedures*, 1963 *Ins. L.J.* 711.

112. N.Y. PUB. HEALTH LAW § 2805-d (4)(d) (McKinney Supp. 1975). For the text of this section see note 4 *supra*.

113. 464 F.2d 772, 789 (D.C. Cir. 1972).

114. 52 Hawaii 188, 473 P.2d 116 (1970).

115. 473 P.2d at 120.

116. *Cobbs v. Grant*, 8 Cal. 3d 229, 246, 502 P.2d 1, 12, 104 Cal. Rptr. 505, 516 (1972) (privilege might apply where disclosure would be so upsetting that "the patient would not

*v. Wood*,<sup>117</sup> the plaintiff was suffering from a toxic goiter, and it was determined that an operation to remove part of her thyroid gland was necessary. The physician failed to disclose that damage to the vocal cords is an inherent risk of a thyroidectomy, and as a result of the operation the plaintiff's right vocal cord became paralyzed, reducing her speaking ability to a mere whisper. The court, holding that the disclosure was sufficient, reasoned that "[n]ot only is much of the risk of a technical nature beyond the patient's understanding, but the anxiety, apprehension, and fear generated by a full disclosure thereof may have a very detrimental effect on some patients."<sup>118</sup>

The distinctive feature of *Nishi v. Hartwell* is the presence of a plaintiff whose physical condition could be directly worsened by the psychological shock of full disclosure, whereas in *Roberts v. Wood*, full disclosure could not directly worsen the condition of the goiter. Indirectly, however, if the patient decides to forego a necessary operation due to an irrational fear, the condition may eventually worsen. On this point, the court in *Canterbury v. Spence* offered the following caveat:<sup>119</sup>

The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed . . . for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent because divulgence might prompt the patient to forego therapy the physician feels the patient really needs.

The therapeutic privilege is "carefully circumscribed" by the language of subsection (d) of section 2805-d (4) in the thrice-repeated requirement of reasonableness, and the phrase "adversely and substantially affect the patient's condition." It is submitted that these rather stringent requirements indicate a

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be able to dispassionately weigh the risks of refusing to undergo the recommended treatment"); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *clarified and reh. denied*, 187 Kan. 186, 354 P.2d 670 (1960) (in dicta the court suggested a privilege to withhold where disclosure of some dread disease would jeopardize the chances of recovery); *Watson v. Clutts*, 262 N.C. 153, 136 S.E.2d 617 (1964) (patient needed thyroid removed—court recognized undesirability of sending a patient who was nervous from fright to the operating room). See also *Lund, The Doctor, the Patient, and the Truth*, 19 TENN. L. REV. 344 (1946); *Smith, Therapeutic Privilege to Withhold Specific Diagnosis from Patient Sick With Serious or Fatal Illness*, 19 TENN. L. REV. 349 (1946); Note, 75 HARV. L. REV. 1445 (1962).

117. 206 F. Supp. 579 (S.D. Ala. 1962).

118. *Id.* at 583.

119. *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972).

legislative intent to allow the privilege under only the most extreme circumstances, as were present in *Nishi v. Hartwell*. The question is not whether the physician actually believed nondisclosure would have a substantially adverse effect but whether such a belief was reasonable from a medical point of view.

The defenses present issues of fact which must be resolved by the jury. Although the burden of proof is on the defendant, expert testimony could be offered by either party to demonstrate whether the physician's judgment was medically reasonable where either the "emergency doctrine" or "therapeutic privilege" defenses are raised.<sup>120</sup> Expert testimony would not be necessary where the defense is based on "waiver" since the only issue is whether the patient waived the right to be informed of the risks. Neither would such testimony be appropriate to a "commonly known risk" defense since it is highly unlikely that an expert is qualified to testify with respect to what risks are commonly known.

### *Conclusion*

According to Governor Carey's accompanying memorandum, the Medical Malpractice Insurance Act is intended to "deal comprehensively with the critical threat to the health and welfare of the State as a result of the lack of adequate medical malpractice insurance at reasonable rates."<sup>121</sup> Thus, certain provisions of the Act are designed to limit the physician's malpractice liability in order to reduce the cost of insurance premiums.

One such provision is section 6, which reduces the statute of limitations in a medical malpractice action from three years to two years and six months. Ironically, in a lack of informed consent case, this provision may have the effect of increasing the statute of limitations from one year to two and one-half, since prior to the Act some courts were applying the one-year battery statute to such actions. Under the Act, lack of informed consent is recognized as medical malpractice, and thus the two and one-half year malpractice statute must be applied.

The Malpractice Act also attempts to limit a physician's liability by adopting the "reasonable medical practitioner" standard of disclosure. The legislature's acceptance of this standard represents a rejection of the physician-oriented community stan-

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120. See note 65 *supra* and accompanying text.

121. [1975] McKinney's Laws of N.Y. 1739.

dard and the patient-oriented material risk standard. As a practical matter, the effect of the adoption of the standard established by section 2805-d (1) is to require the plaintiff to adduce expert testimony concerning the alleged insufficiency of the consent. Since expert testimony can usually be obtained, this may amount to no more than an inconvenience. On the other hand, some plaintiffs may be more willing to settle out of court knowing that expert testimony may in certain cases be difficult to obtain and that the expert witness' fees will be deducted from the recovery if the case has to go to trial.

In contrast to the legislature's rejection of the "material risk" and "community" standards, the Act's incorporation of the "reasonably prudent patient" test of causation is consistent with modern judicial trends. In effect, this test requires the jury to make a factual determination that the plaintiff would have been acting as a reasonably prudent person by not undergoing the treatment had the risk been disclosed. The requirement of proximate cause places no additional burden on the plaintiff since proximate causation was a necessary element of the plaintiff's prima facie case even before the Act was passed.

The four defenses established by the Act may provide the physician with a substantial coat of armor; hopefully, courts will not allow these defenses to be abused. The protection of the patient's best interests, the fiduciary nature of the physician-patient relationship, and the advantages of allowing the physician flexibility in exercising medical and human judgment should serve as guiding considerations in determining the validity of a defense.

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