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Articles

From Informed Consent to Patient Choice: A New Protected Interest

Marjorie Maguire Shultz†

INTRODUCTION

Judges and legal scholars have long asserted the importance of patient autonomy in medical decisionmaking. Yet autonomy has never been recognized as a legally protectable interest. It has been vindicated only as a by-product of protection for two other interests—bodily security as protected by rules against unconsented contact, and bodily well-being as protected by rules governing professional competence. Neither bodily security nor bodily well-being, however, is an adequate surrogate; they do not coincide with autonomy. Nor is autonomy merely a formal issue. Decisionmaking by competent professionals does not provide an adequate substitute for patient choice. Injuries that arise from invasion of patients' interest in medical choice are both substantial and distinct.

Part I of this Article explains the importance of patient autonomy and describes how existing doctrines protect that value. Part II examines gaps and flaws in that current scheme of protection. Part III analyzes clusters of cases in which greater vindication of patient autonomy has begun to

† Lecturer, Boalt Hall School of Law, University of California, Berkeley. B.A. 1962, College of Wooster; M.A.T. 1964, University of Chicago; J.D. 1976, University of California, Berkeley. I am deeply grateful to William Fletcher, Robert Cole, Meir Dan-Cohen and Jane Staw; each gave invaluable assistance during the development of this Article. I am also much indebted to my research assistants and seminar students: Susan Raffanti, Dena Belinkoff, Catherine Fisk, Tina Stevens, Jon Poland and Allyn Taylor.

emerge, and urges that these developments should be generalized. Part IV recommends the creation of a distinct and independently protected interest in patient autonomy.

I. STARTING POINTS

A. *The Importance of Patient Autonomy*

Individuality and autonomy have long been central values in Anglo-American society and law. In general, the more intense and personal the consequences of a choice and the less direct or significant the impact of that choice upon others, the more compelling the claim to autonomy in the making of a given decision.¹ Under this criterion, the case for respecting patient autonomy in decisions about health and bodily fate is very strong.²

The very fact that health care choices are extremely important, however, generates fear that individuals will make mistakes. The complex and esoteric nature of modern medicine necessitates advice from experts. Needed perspective and emotional support can be provided by family and friends. Given that medical choices affect the quality and even the length of life itself, individuals making such choices may well be urged to seek all the help, in terms of both love and knowledge, that they can find. Ultimately, however, the stake of both experts and loved ones is less intense than that of the patient whose well-being is directly affected.³ Patients' preferences, therefore, ought generally to be controlling.

1. Perhaps the most articulate advocate of this view was John Stuart Mill:

[T]he sole end for which mankind are warranted . . . in interfering with the liberty of action of any of their number, is self-protection. . . . The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

J. MILL, ON LIBERTY 6 (1873).

2. The classic statement of this value in the medical context is that of Judge Cardozo in *Schloendorff v. Society of N.Y. Hosp.*: "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 . . ." 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). A more recent statement of the importance of patient autonomy is found in 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 2-4 (1982) [hereinafter cited as MAKING DECISIONS]. See generally Goldstein, *For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent, and the Plea Bargain*, 84 YALE L.J. 683 (1975) (critiquing inadequate protection of self-determination in three disparate processes, including informed consent to medical intervention).

3. In Western medicine, deference to the patient's interest is rooted in the Hippocratic tradition. See R. VEATCH, A THEORY OF MEDICAL ETHICS 21-25 (1981). In legal terms, the deference to the patient's interest is rooted in the doctor's status as a fiduciary. See *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972). Under these principles, the doctor's interests in income, prestige and convenience, as well as in her own professional opinions and preferences, constitute a less immediate and compelling claim to authority than that which derives from the patient's status as the bearer of consequences. On occasion, however, doctors may have ethical, religious or professional convictions that lead them to wish to refuse some services. See *infra* note 349.

Protecting Patient Choice

B. *Implications for the Doctor-Patient Relationship*

Although the principle of individual autonomy is widely endorsed in theory, its practical implications for the doctor-patient relationship are controversial. Individuals exercise their autonomy in medical decisionmaking by arranging for needed professional services. Presumably, these individuals remain the source of authority and can choose to delegate all or only some of their control to professionals.⁴ Yet, ironically, the most significant threat to patient autonomy comes from the very doctors whom patients hire. Because of their knowledge and traditional role, doctors often preempt patient authority.

Although scholars have proposed various models to describe or prescribe the distribution of power within the doctor-patient relationship,⁵ for a number of years one view dominated professional ideology and customary practice. Under that view, the patient was seen as making only one key decision, to place herself in a given doctor's care, thereby delegating all subsequent authority to the doctor.⁶ Such a model assumed that the patient lacked the technical ability to make medical decisions, and that expertise justified the doctor's making decisions on the patient's behalf.

In the past several decades, however, new developments have strengthened the argument that patient autonomy should receive more than pro forma respect. Advancing medical technology has greatly expanded the options available to the patient. Increased knowledge has heightened

4. Such a right flows from the contractual nature of the doctor-patient relationship. A patient's decision to forego information and consent procedures is typically called a waiver under informed consent doctrine. See Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 453-60 (discussing waiver exception) [hereinafter cited as Meisel, *Exceptions*]. The difficult issue is determining when such a waiver has been made by the patient.

5. See, e.g., R. BURT, *TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS* (1979) (proposing extensive dialogue rather than black and white rules of thumb); Branson, *The Secularization of American Medicine*, HASTINGS CENTER STUD., Nov. 1973, at 17 (advocating that science no longer be regarded as "religion," and that doctors assume more modest, less "priestly" role); Childress, *Metaphors and Models of Medical Relationships*, 8 SOC. RESP.: JOURNALISM, L. MED. 47 (1982) (analyzing various models of medical relationships); May, *Code, Covenant, Contract, or Philanthropy*, HASTINGS CENTER REP., Dec. 1975, at 29 (espousing "covenant" as most inclusive and satisfying model of obligation); Szasz & Hollender, *A Contribution to the Philosophy of Medicine: The Basic Models of the Doctor-Patient Relationship*, in 97 A.M.A. ARCHIVES OF INTERNAL MED. 585 (1956); Veatch, *Models for Ethical Medicine in a Revolutionary Age*, HASTINGS CENTER REP., June 1972, at 5 (pointing out significance of choice of relationship model).

6. See 1 MAKING DECISIONS, *supra* note 2, at 19; Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability By Way of Informed Consent*, 56 NEB. L. REV. 51, 77-80 (1977) (tracing legal requirements imposed upon doctors from early days of minimalism to more demanding contemporary times) [hereinafter cited as Meisel, *Expansion*]. Under earlier models, detailed disclosure to and consent by the patient played a role only insofar as they were thought to be essential to the therapeutic outcome. Pernick, *The Patient's Role in Medical Decisionmaking: A Social History of Informed Consent in Medical Therapy*, in 3 MAKING DECISIONS, *supra* note 2, at 1, 14.

awareness of how much remains unknown.⁷ Debate and conflict within the medical community are widespread and public.⁸ Differences in experts' advice can often be resolved only on the basis of risk and value preferences. This medical uncertainty accentuates the need for professional advice, but it also strengthens the case for ultimate decision by the person whose life is directly involved.

Medical choice increasingly depends on factors that transcend professional training and knowledge. As medicine has become able to extend life, delay and redefine death, harvest and transplant organs, correct abnormality within the womb, enable artificial reproduction, and trace genetic defect, questions about values have come to the fore in medical decisionmaking. Health care choices involve profound questions that are not finally referable to professional expertise.⁹

In the face of value pluralism, factual indeterminacy, and increasing options, patient autonomy has become a central principle of both popular¹⁰ and philosophical¹¹ analysis of medical decisionmaking. Self-care and consumer movements have applied that principle, seeking to shift the balance away from professional dominance and toward individual knowledge and control.¹² Although medical traditions historically have downgraded

7. See J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 183-84 *passim* (1984) (discussing pervasiveness of medical uncertainty).

8. Newspaper articles describing medical differences of opinion are common. See, e.g., Brooks, *New Hope is Offered to Victims of Stroke and Potential Victims*, *Wall St. J.*, July 16, 1984, at 1, col. 1; *Top Surgeon Sees No Future for Artificial Heart*, *N.Y. Times*, Feb. 14, 1984, at D2, col. 3.

9. See Veatch, *Generalization of Expertise*, *HASTINGS CENTER STUD.*, Nov. 1973, at 29.

10. See, e.g., Enright, *What Does Society Really Want from Doctors?: More Disclosure*, *MED. ECON.*, May 29, 1978, at 77 (reporting public preferences for greater information); Peck, *What Does Society Really Want from Doctors?: Greater Accountability*, *MED. ECON.*, May 29, 1978, at 93, 105-11 (discussing growing accountability of doctors to consumers); *Going to Hospital? Stick up for Your Rights*, *U.S. NEWS & WORLD REP.*, Oct. 1, 1984, at 61 (interview with Norma Calhoun, Pres., National Soc'y of Patient Representatives) (advising patients how to gain greater role in decisionmaking); *The Patient Has a Right to Know*, *N.Y. Times*, June 15, 1984, at A26, col. 1 (editorial discussing need for disclosure about health care provider costs and results). The Presidential Commission found that the vast majority of respondents to its survey wanted information and participation in medical decisions. 1 *MAKING DECISIONS*, *supra* note 2, at 17.

11. See, e.g., J. CHILDRESS, *WHO SHOULD DECIDE? PATERNALISM IN HEALTH CARE* (1982) (classifying types of paternalism and analyzing their justification in medical contexts); Dworkin, *Autonomy and Informed Consent*, 3 *BIOETHICS REP.: LITERATURE* 309 (1983) (clarifying special role of autonomy in justifying medical consent norms); Gordon, *The Doctor-Patient Relationship*, 8 *J. MED. & PHIL.* 243 (1983) (from perspective of religious humanist, emphasizing need for physician to respect autonomy of patient).

12. See P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 391-92 (1983) (describing movements exhibiting distrust of professional dominance). A leading theorist of self-care in medicine is Ivan Illich. See I. ILLICH, *MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH* (1976). Both alternative care and self-care have become major influences. See, e.g., BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *THE NEW OUR BODIES, OURSELVES: A BOOK BY AND FOR WOMEN* xiii (1984) (one stated goal of book is "to reach as many women as possible with the tools which will enable them to take greater charge of their own health care").

Protecting Patient Choice

patient autonomy,¹³ doctors, too, have begun to recognize and accept patient demands for more information and control.¹⁴

The law's response to pressures for greater recognition of patient autonomy has been ambivalent.¹⁵ Existing rules repudiate the view that the mere hiring of a doctor transfers all authority from patient to doctor. Yet full vindication of patient autonomy interests would necessitate placing final authority regarding important decisions in the hands of any patient having the capacity and the desire to exercise it.¹⁶ I shall argue that precisely such a model for the allocation of authority is appropriate, but, as Part II will demonstrate, no such guarantee of patient autonomy is currently mandated by the law.

C. Existing Legal Protection of Patient Autonomy

Although the doctor-patient relationship ordinarily arises through contract,¹⁷ courts have deemed patients incapable of bargaining with doctors over the quality of medical services. Doctors' performance has therefore been monitored under standardized tort rules that govern professional

13. Jay Katz traces the history of nondisclosure and failure to share decisions with patients throughout the history of Western medicine. J. KATZ, *supra* note 7, at 1-29. He points out the direct conflict between the medical norm of "custody" and the legal norm of personal liberty. *Id.* at 2.

14. See, e.g., Novack, Plumer, Smith, Ochitill, Morrow & Bennett, *Changes in Physicians' Attitudes Toward Telling the Cancer Patient*, 241 J. A.M.A. 897, 897 (1979) (reporting dramatic reversal in attitude among doctors from 1961 to 1979 over whether to tell patients they have cancer); see also Harris & Associates, *Views of Informed Consent and Decisionmaking: Parallel Surveys of Physicians and the Public*, in 2 MAKING DECISIONS, *supra* note 2, at 17, 18, *passim* (physicians reported positive attitudes toward disclosure).

15. This point is developed particularly by Jay Katz. See J. KATZ, *supra* note 7; Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 138 & nn.1-39 (1977) [hereinafter cited as Katz, *Informed Consent*]. The point is also explored in White, *Informed Consent: Ambiguity in Theory and Practice*, 8 J. HEALTH POL., POL'Y & L. 99 (1983).

16. The province of this discussion is decisionmaking by the autonomous patient who is able to and wants to make her own choices. Traditional exceptions to informed consent doctrine—situations where an emergency exists, where the patient waives the authority to make choices, or where the patient lacks decisionmaking capacity—are not affected by this analysis. Waiver is technically not an exception to respect for autonomy, because it is itself an expression of choice. The other exceptions track the most commonly recognized circumstances under which beneficence, even in the form of paternalism, may justifiably displace autonomy. See Dworkin, *Paternalism*, 56 MONIST 64, 76-84 (1972). The most extensive treatment of exceptions is in Meisel, *Exceptions*, *supra* note 4. Determining patients' decisionmaking capacity can be very problematic. See Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977) (describing five possible standards for determining competency). Moreover, issues may arise regarding temporary or situation-specific incapacity. See, e.g., *In re Yetter*, 62 Pa. D. & C.2d 619 (Northampton County Ct. 1973) (patient's confinement in mental hospital did not mean she lacked capacity to refuse medical treatment); *Nishi v. Hartwell*, 52 Hawaii 188, 473 P.2d 116 (1970) (disclosure of side effect of treatment might have had adverse effect on patient).

17. See, e.g., *Gray v. Grunnagle*, 423 Pa. 144, 166, 223 A.2d 663, 674 (1966) ("[T]he agreement between the physician and his patient is contractual in nature . . ."). The consensual origins of the relationship are especially emphasized in Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. BAR. FOUND. RESEARCH J. 87, 119. Entry into a contract for services is typically, though not always, the basis for imposition of physician duties of care.

malpractice rather than under contractual criteria of individual expectation.¹⁸ Mainly as a derivative matter, the patient's interest in self-determination has also been analyzed under tort theories.¹⁹

1. *Battery*

Patient autonomy was initially identified with and subsumed under an interest in physical security, protected by rules proscribing unconsented touch.²⁰ Medical care often involves touching, and may be considered battery if the touching is unconsented.²¹ By mandating patient consent to specific procedures, battery doctrine counters the implication that doctors acquire authority to make decisions simply by virtue of the contract for professional services. Moreover, professional competence is no defense to a medical battery action.²² Under battery analysis, the patient's wishes take priority over even the fully competent recommendation of a doctor, unless an exception applies.²³ Apart from traditional defenses, the right to be secure against unconsented touching is close to absolute.²⁴ Application of battery doctrine to medical care thus establishes an uncompromising baseline of protection for patients' self-determination.

Despite the capacity of battery doctrine to protect a degree of physical

18. See Epstein, *supra* note 17, at 91-96 (discussing interplay of tort and contract principles in doctor-patient relationship). Under tort law, the same fear about inadequacy of lay judgment—here the judgment of jurors rather than patients—leads courts to concede most regulation of professional competence to the standards of the profession itself. W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER & KEETON ON THE LAW OF TORTS § 32, at 188-89 (5th ed. 1984) [hereinafter cited as PROSSER & KEETON]. Epstein conceives of this as supplying an omitted contract term by incorporating custom of the trade. Epstein, *supra* note 17, at 110.

19. The question of self-determination might be analyzed as a problem of the scope of an agency, to be determined by contract between principal and agent. Some commentators have urged a more contractually oriented analysis of medical relations. See, e.g., Epstein, *supra* note 17.

20. See Pernick, *supra* note 6, at 29-30; see also C. FRIED, MEDICAL EXPERIMENTATION: PERSONAL INTEGRITY AND SOCIAL POLICY 14-18 (1974) (discussing evolution of these doctrines).

21. PROSSER & KEETON, *supra* note 18, § 9, at 39.

22. W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 18, at 104 (4th ed. 1971).

23. Under battery doctrine, the competent patient's choices are largely unfettered. Legal restrictions may arise from the protectable rights of other individuals. The state, for example, may compel vaccination. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905). Public policy restrictions on individual choice are, however, hotly debated. See, e.g., *Bouvia v. County of Riverside*, No. 159780 (Cal. Super. Ct. Dec. 16, 1983) (order denying preliminary injunction against forced feeding). Moreover, constitutional privacy decisions have contracted the scope of permissible intervention in medical choice. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (privacy right to choice concerning abortion); *Andrews v. Ballard*, 498 F. Supp. 1038 (S.D. Tex. 1980) (privacy right of patients to choose form of treatment violated by state restrictions on performance of acupuncture); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (1980) (state interest in preserving life does not override competent but mortally sick patient's right to refuse treatment).

24. C. FRIED, *supra* note 20, at 16. Damages range from symbolic recompense for purely dignitary injury, to compensation of physical or economic injury resulting from unconsented touching (no matter how well intentioned or expertly conducted), to punitive awards for particularly culpable touchings. RESTATEMENT (SECOND) OF TORTS §§ 901, 903, 905, 907, 908 (1979); see also PROSSER & KEETON, *supra* note 18, § 9, at 40-41 ("Since battery is a matter of the worst kind of intentions, it is a tort which frequently justifies punitive damages.").

Protecting Patient Choice

autonomy in patients' relations with doctors, many aspects of the medical care relationship do not fit comfortably within the battery model. Doctors lack the antisocial motivation usually associated with intentional torts such as battery.²⁵ Further, unlike in the typical battery case, the patient usually has given a degree of consent to the doctor's treatment, if only in the broad sense that the patient has sought medical care from the doctor.

Once courts began more thoroughly to examine the subtleties of the doctor-patient relationship, the difficulties inherent in applying battery analysis to problems of medical consent became impossible to ignore. On the one hand, a general consent to treatment given without awareness of risks, prognoses, and options was seen as an insufficient basis upon which to authorize treatment, even medically defensible treatment.²⁶ Yet to hold that such uninformed consent was invalid, thereby subjecting doctors to actions for battery, threatened to yield unacceptably harsh results. Given the absolute nature of battery, the narrowness of its defenses, and the breadth of its remedies, doctors could end up paying significant damages after providing faultless medical treatment, simply because some minor informational aspect of the consent process was questioned.²⁷

25. This point is stressed in many cases, e.g., *Trogon v. Fruchtmann*, 58 Wis. 2d 596, 599, 207 N.W.2d 297, 313 (1973).

26. See *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

27. See, e.g., *Berkey v. Anderson*, 1 Cal. App. 3d 790, 804, 82 Cal. Rptr. 67, 77 (1969) (issue of technical battery raised by failure to disclose risks of myelogram); *Fogal v. Genesee Hospital*, 41 A.D.2d 468, 344 N.Y.S.2d 552, 559 (1973) (failure to disclose risks of using hypothermia blanket cognizable under theory of assault and battery rather than negligence); *Congrove v. Holmes*, 37 Ohio Misc. 95, 308 N.E.2d 765 (C.P. Ross County 1973) (summary judgment for plaintiff for damages for paralysis of vocal cords resulting from thyroidectomy, where physician did not warn of risks); *Cooper v. Roberts*, 220 Pa. Super. 260, 286 A.2d 647 (1971) (assault and battery theory applies where doctor failed to inform patient of collateral risks of perforation of stomach during gastroscopic examination).

These results are possible because battery doctrine employs a very simple analysis of causation. See Plant, *An Analysis of "Informed Consent"*, 36 *FORDHAM L. REV.* 639, 666 (1968) [hereinafter cited as Plant, *Analysis*]. Presumably this is because ordinarily a battery defendant's conduct is assumed to be antisocial and not deserving of the protection of more thorough causal analysis. PROSSER & KEETON, *supra* note 18, § 9, at 35, § 43, at 263; Riskin, *Informed Consent: Looking for the Action*, 1975 *U. ILL. L.F.* 580, 583-84. Thus, battery analysis does not inquire whether the patient would have consented if the doctor had acted properly. Battery doctrine treats the consent, if flawed, as completely invalid. See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS*, § 32, at 165 (4th ed. 1971). The likely result would be recovery of all damages, even if the injury was likely to have occurred in any case because the patient would have consented. See Riskin, *supra*, at 583-84, 601; cf. King, *Causation, Valuation and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 *YALE L.J.* 1353 (1981) (critiquing tendency in present tort law to confuse issues of causation and valuation).

If battery doctrine had continued to be applied to medical consent, some more sophisticated (and more fair) fashion of handling causation and damages might have developed. Such a development might parallel earlier decisions in cases of medical battery that allowed a set-off for benefits derived from unauthorized treatment to reduce damages for injury to a dignitary interest. See, e.g., *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905) (taking into account benefits from unauthorized operation on plaintiff's ear); *McCandless v. State*, 3 A.D.2d 600, 162 N.Y.S.2d 570 (1957) (award for unauthorized abortion reduced by offset for improvement in condition), *aff'd*, 4 N.Y.2d 797, 149 N.E.2d 530, 173 N.Y.S.2d 30, (1958). But see D. DOBBS, *LAW OF REMEDIES* 182 (1973) (questioning wisdom of offsetting for benefits received in context of intentional tort). However, the transfer of

Discomfort with treating doctors under a doctrine aimed at antisocial conduct has prompted most jurisdictions to limit the battery action to those relatively unusual situations where a medical procedure has been carried out without *any* consent, rather than where the consent has merely been insufficiently informed.²⁸ The modern allegation of battery typically arises when consent to a particular procedure is given and a different or additional procedure is carried out.²⁹ The relative infrequency with which battery claims arise today should not, however, obscure the fact that battery doctrine retains a critical philosophical and practical function in protecting patient self-determination.

2. *Informed Consent*³⁰

Most litigation about patient autonomy now occurs over doctors' non-disclosure of information, analyzed as an issue of professional negligence.³¹ Doctors' responsibility for professional care of patients' physical

most disclosure issues to analysis under negligence doctrine removed the necessity for such a development.

28. See, e.g., *Cobbs v. Grant*, 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972) ("We agree with the majority trend. The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented."); *Trogun v. Fruchman*, 58 Wis. 2d 596, 598-600, 207 N.W.2d 297, 312-13 (1973) (explaining why battery action is appropriate where operation is unauthorized but not where only issue is nondisclosure). At least one state has abolished any action for medical battery. See ARIZ. REV. STAT. ANN. § 12-562(B) (1982).

29. See, e.g., *Reddington v. Clayman*, 334 Mass. 244, 134 N.E.2d 920 (1956) (question of battery presented where surgeon allegedly removed child's uvula during operation for removal of tonsils and adenoids); *Hively v. Higgs*, 120 Or. 588, 253 P. 363 (1927) (where consent given to operate on septum of nose, removal of tonsils constitutes battery).

The most difficult decisions concern the scope of a consent. See, e.g., *Kinikin v. Heupel*, 305 N.W.2d 589 (Minn. 1981) (upheld jury verdict on battery theory regarding removal of more of breast than patient intended); *Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 663 (1966) (patient's claim that he consented only to exploratory surgery, not to laminectomy, should have gone to jury on battery claim); see also A. ROSOFF, *INFORMED CONSENT: A GUIDE FOR HEALTH CARE PROVIDERS* 8-13 (1981) (discussing factors leading courts to accept or refuse battery theory in disputes over scope of consent).

30. The literature on informed consent is voluminous. Some of the articles that emphasize the importance of patient autonomy include: J. KATZ, *supra* note 7, at 104-64; J. KATZ & A. CAPRON, *CATASTROPHIC DISEASES: WHO DECIDES WHAT?* 82-85 (1975); Epstein, *supra* note 17, at 87, 119; Goldstein, *supra* note 2, at 695 nn.27-29; Katz, *Informed Consent*, *supra* note 15; Meisel, *Exceptions*, *supra* note 4, at 413-22; Riskin, *supra* note 27; White, *supra* note 15. For additional sources on the doctrine, see Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340 (1974); Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 UCLA L. REV. 758 (1970); Meisel, *Expansion*, *supra* note 6; Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407 (1980); Plant, *Analysis*, *supra* note 27; Plant, *The Decline of "Informed Consent"*, 35 WASH. & LEE L. REV. 91 (1978); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1969); Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632 (1974); Note, *Informed Consent in Medical Malpractice*, 55 CAL. L. REV. 1396 (1967); Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L. J. 1533 (1970) [hereinafter cited as Note, *Restructuring*]. For a review and synopsis of the vast array of empirical studies in the area, see Meisel & Roth, *Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265 (1983).

31. PROSSER & KEETON, *supra* note 18, §§ 15, 30, at 106, 165.

Protecting Patient Choice

well-being gives rise to various specific duties, one of which is the provision of sufficient information to allow a patient's decision to be intelligently informed. To recover for nondisclosure under the rules of professional malpractice, the patient must first show a violation of the duty to inform, defined in many states by the standard of expert professionals.³² Second, the nondisclosure must be shown to have caused a harm cognizable under negligence doctrine. Most states have adopted an objective standard of causation in medical informed consent cases.³³ This standard requires the patient to show that the undisclosed information would have induced not just this patient, but a reasonable patient, to withhold consent to the treatment in question.³⁴

3. *The Justifying Prototype*

The shift to negligence analysis made apparent analytic and practical sense.³⁵ Although some critics decried losses to patient autonomy that would result from emerging negligence rules,³⁶ current legal protection of patient autonomy has generally been deemed adequate. That judgment, however, rests upon assumptions that are insufficiently examined and ultimately erroneous.

Assumptions that have implicitly governed the debate over patient autonomy are exposed in a prototypical example of informed consent that is frequently used in discussion and reflected in litigation.³⁷ The doctor pro-

32. For a state by state summary, see 3 MAKING DECISIONS, *supra* note 2, at 206-45. See also J. AREEN, P. KING, S. GOLDBERG & A. CAPRON, LAW, SCIENCE AND MEDICINE 384 n.4 (1984) (interpreting evidence gathered in MAKING DECISIONS as follows: "[A]s of 1982, 26 states that had declared law on informed consent had adopted a professional standard of disclosure, 19 a patient-oriented standard, and 6 had no law on the subject.>").

33. See 3 MAKING DECISIONS, *supra* note 2, at 197, 206-45. Although commentators have urged the subjective standard, e.g., Katz, *Informed Consent*, *supra* note 15, at 163-64, only one state at present seems to have explicitly embraced it, see *Scott v. Bradford*, 606 P.2d 554, 559 (Okla. 1980).

34. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 791 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

35. Protection of patient choice was thought to contribute to the "malpractice crisis" and health care cost escalation. See *Bly v. Rhoads*, 216 Va. 645, 222 S.E.2d 783 (1976); J. LUDLUM, INFORMED CONSENT 41-42 (1978); Adams & Zuckerman, *Variation in the Growth and Incidence of Medical Malpractice Claims*, 9 J. HEALTH POL., POL'Y & L. 475, 485 (1984) (principle of informed consent is significantly associated with higher annual rate of claims after 1972); Miller, *Informed Consent: I*, 244 J. A.M.A. 2100, 2102 (1980).

36. See, e.g., Goldstein, *supra* note 2, at 691; Katz, *Informed Consent*, *supra* note 15, at 139; Meisel, *Expansion*, *supra* note 6, at 112.

37. Not all elements of the prototype are evident in every case or every discussion, but they recur often enough to be a legitimate composite. For instance, surgical cases overwhelmingly dominate the exhaustive list of cases summarized by Rosoff. See A. ROSOFF, *supra* note 29, at 471-520 (case index). A number of the leading and most frequently discussed cases involve such a prototype. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (undisclosed risks of surgery), *cert. denied*, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (same); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P.2d 170 (1957) (same).

poses crucial surgery to a seriously ill patient. The surgery offers the patient's best hope for recovery; no viable alternatives exist. The surgical intervention is competently recommended and competently carried out. The doctor's only failing is nondisclosure of a low-probability risk of complication, such as the possibility of allergic reaction to the anesthetic. The allergic reaction occurs, the patient suffers injury, and the doctor is sued for failure to secure informed consent.

The surgery in the prototype is an invasive touching that requires consent; if there is a conflict between doctor and patient over the advisability of doing the surgery, the competent patient's choice will prevail, as required by battery doctrine. Under modern analysis, the consent, if given, remains valid,³⁸ and issues of nondisclosure will be analyzed under negligence doctrines governing duties to inform. There will be recovery only if the disclosure is one that would have been made by competent doctors, if a reasonable person in the patient's position would have refused the surgery had the disclosure been made, and if the injury is cognizable under standard negligence principles.

In the context of this example, those limitations seem reasonable; the potential for injury appears to be rather slight. As a reasonable person, the patient would presumably have agreed to the surgery even had the omitted disclosure been made. After all, the information that is undisclosed concerns a remote risk, the patient is seriously ill, and the surgery is the only viable treatment. Thus, although individualists will stress that in not disclosing all the facts the doctor has injured the patient's dignity and integrity,³⁹ many—perhaps most—will on these facts construe such an injury to be largely symbolic. Moreover, a patient who would not have consented to the surgery on these facts is aberrational. The idiosyncratic and the symbolic do receive some protection under the rules of battery: Basic, if not fully and exhaustively informed, consent is required in surgical cases. Where other important interests such as fairness to doctor-defendants or medical cost escalation are involved, it may plausibly be argued that such absolute protection need not be extended to the relatively less crucial disclosure of information about remote risks.

On the other hand, the argument continues, in a situation where the doctor's recommendation of surgery was one that a reasonable person would not have accepted had disclosure been made (as might be the case if the illness were minor and the undisclosed risk severe or likely to occur), in all likelihood the recommendation itself was probably "wrong." If the

38. Under earlier analyses, evidence of the nondisclosure regarding a possible allergic reaction would have invalidated the consent, potentially yielding recovery under a battery theory for all consequences of the surgery no matter how faultlessly performed. *See supra* note 27.

39. *See, e.g.,* Goldstein, *supra* note 2.

Protecting Patient Choice

recommendation was wrong, it would presumably be sanctioned under the mainstream rules governing professional competence. Thus, if the informed consent action involved nondisclosures that led to reasonably avoided and significant harms, it would seem to be largely duplicative of an action in professional negligence.

Consequently, although autonomy remains an important value in theory, the prototypical example makes strong protection of patient choice seem largely unnecessary in fact. The patient's interest in autonomy is conceded basic protection under battery rules. Beyond that, under the prototype, the autonomy interest tends to be seen as either mainly symbolic or highly aberrational on the one hand, or as largely redundant to protections under competence-regulating negligence rules on the other. Thus, in the prototypical case, present doctrines may be argued to provide adequate protection for patient autonomy.

But the prototypical case is not representative of the full range of cases in which the autonomy interest is implicated. The conclusion regarding the adequacy of current protection of patient autonomy derives from the prototype's unwarranted assumptions, first, about the respective roles of physical contact and information in medical choice, and second, about the relationship between injuries to autonomy and injuries to physical well-being. As a result, the prototype both underestimates the degree to which professional preemption of patient autonomy can occur and overestimates the degree to which regulation of medical expertise provides an adequate backup for doctrines safeguarding patient choice. Part II challenges these assumptions and demonstrates how they have led to unacceptable flaws in present legal protection for patient autonomy.

II. FLAWS IN EXISTING PROTECTION OF PATIENT AUTONOMY

A. *Choices That Involve No Physical Touching Receive No Protection Under Battery Doctrine*

The doctrinal prototype described above assumes that important medical decisions are implemented through actual physical touching. Defining the scope of an autonomy interest in terms of physical contact with the body has intuitive appeal and offers a certain simplicity of administration. But ultimately, physical contact is too literal a demarcation for what is a much broader, non-tangible interest in patient choice.⁴⁰

40. Just as electronic sophistication made earlier notions of search and seizure insufficient and required the expansion of privacy protection beyond limits on purely physical invasions, *see* *Katz v. United States*, 389 U.S. 347 (1967), modern medical care requires a more flexible, less literal definition of the interest in patient autonomy than can be achieved through analysis based on physical contact.

Health care choices of vast consequence can be made and implemented without such bodily contact as predictably triggers battery analysis. Most notably, this occurs when a doctor makes a decision not to act. For instance, a doctor's judgment that a given level of diagnostic clarity is sufficient, that an acceptable outcome of treatment has been achieved, or that no medical treatment can be administered, each has potentially grave ramifications for the patient. As much as any that involve literal touching, such judgments implicate important autonomy interests; yet under touch-oriented rules they need not receive the patient's consent.

For example, in initial testing to determine the cause of eye problems, the patient in *Gates v. Jensen*⁴¹ showed results consistent with borderline glaucoma. The doctor undertook further diagnostic testing, and ultimately concluded that the patient's problems derived not from glaucoma but from contact lens irritation. He chose not to perform further tests that could with greater certainty have determined the presence or absence of glaucoma. Instead, the doctor prescribed treatment for what he thought to be the problem. After Ms. Gates became legally blind, it was determined that she did have glaucoma, and that it could have been treated and controlled had it been identified earlier.⁴² The doctor's decision not to undertake further diagnostic testing for glaucoma was not expressed as a recommendation to the patient. Rather, the doctor exercised his own judgment unilaterally, on the patient's behalf. Yet, because the doctor's judgment involved no touching of Ms. Gates' body, there was no potential battery: No consent to this "non-action" was required under that doctrine.

The choice of which Ms. Gates was deprived—whether to undergo further testing for glaucoma—was certainly as important as the one she was given—whether to undergo treatment for the contact lens problem. Analyzed in terms of her interest in autonomy rather than her literal physical security, this patient's opportunity to adopt, reject or modify the doctor's unvocalized "recommendation" of inaction should have received as much protection as the choice about the contact lens treatment.

Because the prototypical touching over which the vast bulk of doctor-patient litigation has taken place is surgery,⁴³ not even all *actions* by doctors will trigger battery analysis of patient consent. Where medical proposals involve less discrete or less invasive conduct than surgery, protection for the patient's interest in choice becomes correspondingly attenuated.⁴⁴ For instance, only one court seems to have applied battery

41. 92 Wash. 2d 246, 595 P.2d 919 (1979) (en banc).

42. *Id.* at 250, 595 P.2d at 924.

43. See A. ROSOFF, *supra* note 29, at 471-520 (index of cases litigated, by category).

44. Thus in the survey conducted for the President's Commission by Harris Associates, 53% of doctors indicated that they sought neither written nor oral consent for prescriptions, and 43% sought neither type of consent for blood tests. 2 MAKING DECISIONS, *supra* note 2, at 168. Outside the realm

Protecting Patient Choice

rules to the prescription of medication, and that case involved atypical factors.⁴⁵ Writing a "No-Code" order in a patient's chart, like a choice not to write such an order, will not require patient choice under touch-triggered rules.⁴⁶ Consent requirements also may not be triggered when there is a continuing course of action, even when new information makes new choices available. Thus, when a patient enters a hospital, a consent form for hospitalization, including routine physical touching, is normally signed. If, however, after some period of treatment it becomes clear that a given patient's condition is medically hopeless, the patient may not get a renewed opportunity to consent to the doctor's recommended course of treatment. Where the doctor in effect recommends continued hospitalization by failing to recommend possibilities such as going home to die or going to a hospice, her recommendations may well be imposed by default.

Thus, although courts have explained their concern over patient consent in terms of autonomy values,⁴⁷ by confounding autonomy with control

of surgery or major and invasive diagnostic tests, there is little clarity about when specific consent is required, as has been demonstrated by the empirical research of Meisel and Lidz. *Id.* at 328-35.

45. The aberrant case is *Mink v. University of Chicago*, 460 F. Supp. 713 (N.D. Ill. 1978) (for discussion of case, see *infra* Part III(A)(1)). Most prescriptions are not analyzed as potential battery. See 2 MAKING DECISIONS, *supra* note 2, at 333-34; 3 MAKING DECISIONS, *supra* note 2, at 16-17. Two possible reasons not to apply battery analysis to prescriptions can be suggested. First, although physical consequences may be significant, the doctor does not touch the patient at all. The doctor's behavior in prescribing drugs is essentially judgmental and intellectual. Second, battery analysis may be rejected because patients are deemed to have consented through their voluntary use of the drugs. Such implied consents are often suspect, however. See A. ROSOFF, *supra* note 29, at 5-6. Because courts do not in these instances analyze whether the implied consent is valid, it seems likely that no potential battery is perceived.

Compare the partly analogous problem of patient control over forced feeding. See, e.g., *Bouvia v. County of Riverside*, No. 159780 (Cal. Super. Ct. Dec. 16, 1983) (refusing to restrain hospital from force-feeding a patient who wished to die); see also Dresser, *Feeding the Hunger Artists: Legal Issues in Treating Anorexia Nervosa*, 1984 WIS. L. REV. 297 (analyzing legal grounds for force-feeding anorexics).

46. If mentally competent and sufficiently aware, patients could initiate such decisions. However, it is hard for patients to focus on available options unless someone isolates these options from business as usual and makes them visible. The tendency toward passivity and inertia among the ill is widely acknowledged. See Parsons, *Epilogue to THE DOCTOR-PATIENT RELATIONSHIP IN THE CHANGING HEALTH SCENE* 445-46 (E. Gallagher ed. 1978).

Although some doctors may voluntarily consult with patients, little in their professional training will encourage them to do so. Professor Katz analyzes doctors' disinclination to initiate consultation as "a systematic and intentional omission based upon deeply held professional beliefs that silence is in the patient's best interest." J. KATZ, *supra* note 7, at 58.

The President's Commission for the Study of Ethical Problems in Medicine and Behavioral Research found that only 52% of physicians say they would initiate discussion of resuscitation with a patient in the last stages of a degenerative disease; 38% said they would not do so. 2 MAKING DECISIONS, *supra* note 2, at 226. By contrast, 79% of the public feels that a decision between aggressive and supportive therapy should be made by the patient. Only 12% feel the physician should make the decision unilaterally and 8% think it should be made jointly; 24% believe the patient should control. J. KATZ, *supra* note 7, at 224-25. Professor Katz notes the special difficulties faced in communicating honestly about death. *Id.* at 215-25. See also Comment, *A Structural Analysis of the Physician-Patient Relationship in No-Code Decisionmaking*, 93 YALE L.J. 362 (1983) (patient should control decisions whether or not to resuscitate through system of informed consent).

47. E.g., *Natanson v. Kline*, 186 Kan. 393, 406, 350 P.2d 1093, 1104 (1960) ("Anglo-American

over physical contact they have left significant medical choices insulated from patient control. Although safeguarding the body's physical perimeter is important, medical care is affirmatively sought, and contact with the body is a relatively unexceptional aspect of that care. The maintenance of personal autonomy in a situation of dependence on expert knowledge and skill is both more subtle and more significant. If the key issue is knowledge and choice regarding the fate of one's body, there is no meaningful difference between a decision that will be implemented by touching the body and one that will be implemented without doing so. Physical invasions have symbolic importance, and they constitute one important class of situations in which autonomy interests are involved. To treat that subcategory as co-extensive with the autonomy interest as a whole, however, creates grave deficiencies in the protection of the broader interest.

B. Negligence Doctrine Embeds Protection of Patient Choice Within the Interest in Physical Well-Being

Informed consent is a subcategory of professional negligence doctrine.⁴⁸ Standard negligence analysis protects an interest in physical well-being. The doctrine of informed consent injects into the established framework of negligence a concern with patient choice that would otherwise be absent. It recognizes that one way that actionable physical injury may occur is through the failure to disclose information that would have resulted in non-consent to treatment. The concern with choice does not, however, rise to the level of a fully protected interest under negligence doctrine. Rather, choice remains encapsulated within the dominant interest in physical well-being.

The subordination of choice that results from its submergence within the negligence analysis of physical injury reflects a pervasive fear that plaintiffs making such claims will recover when they have not "really" been injured, or that doctors will be held liable when they have not "really" done anything wrong. Moreover, the tendency to assume that reasonable people choose as their doctors tell them to leads to a conclusion that patients' choices will in any event mimic professionals' competent choices. Any "real" and deserving injuries would then be remedied under standard (i.e. non-choice oriented) professional negligence analyses. The importance of separately protecting patient autonomy would greatly diminish.

The following sections trace the distortion of the interest in choice that

law starts with the premise of thorough-going self-determination."); *Pratt v. Davis*, 118 Ill. App. 161, 166 (1905), *aff'd*, 224 Ill. 300, 79 N.E. 562 (1906) (consent prior to surgery is essential to maintenance of right to inviolability of individual).

48. PROSSER & KEETON, *supra* note 18, § 32, at 189-93.

Protecting Patient Choice

takes place at each stage of the standard negligence analysis and demonstrate that although the chain of assumptions that informs that analysis may be accurate with reference to the prototype, these assumptions are false as applied to nonprototypical cases.

1. *Duty to Disclose: Physical Contact Revisited*

Because informed consent is the doctrinal category that introduces a concern about patient autonomy into the standard negligence analysis, whether or not a case is classified as one of informed consent often determines whether patient autonomy will receive *any* protection. Although many aspects of informed consent have been exhaustively discussed, little attention has been paid to when the doctrine is applied. The physical parameters of battery analysis are definitional and unsurprising. More unexpected is the fact that, as this section will demonstrate, negligence analysis also uses physical contact to determine when to impose a duty to disclose for purposes of securing informed consent. Negligence analysis may employ physical contact as a limiting device on professional duty because habits of thought have been carried over from battery. Or, as discussed above, the limitation may reflect suspicion about the legitimacy of the informed consent action.⁴⁹ Whatever the reason, adoption of physical contact as the triggering concept for negligence duties creates additional gaps in the protection afforded to patient choice.

a. *The Duty to Disclose Will Be Abandoned*

A New York decision, *Karlsons v. Guerinot*,⁵⁰ illustrates how a duty of disclosure may be abandoned where facts do not fit the standard prototype of a proposal to touch. The plaintiff, a thirty-seven-year-old woman, alleged negligent care based on her doctor's failure to perform amniocentesis, a procedure that would have identified Down's Syndrome in her fetus early enough to perform an abortion. She also alleged denial of informed consent based on her doctor's failure to inform her of the existence of the amniocentesis procedure. Allegedly as a result of these failings, she bore a defective child whom she would rather have aborted. She and her husband sought damages for pain and suffering, mental anguish, and for medical and other expenses of rearing the child.⁵¹

In *Karlsons* the court held that, in the absence of any proposed touch-

49. Such an approach would be comparable to special limiting requirements on actions for emotional distress. See RESTATEMENT (SECOND) OF TORTS § 46(2)(b) (1965).

50. 57 A.D.2d 73, 394 N.Y.S.2d 933 (1977).

51. Although several other causes of action are alleged in the case, *id.* at 75, 394 N.Y.S.2d at 934, these are the ones crucial to the analysis here.

ing or invasion of the body, no issue of informed consent could properly be raised.⁵²

Although [our earlier] pronouncement of the scope of the [informed consent] doctrine seems broad on its face, its application has consistently been limited to those situations where the harm suffered arose from some affirmative violation of the patient's physical integrity such as surgical procedures, injections or invasive diagnostic tests.⁵³

Resting its conclusion on both common law and statutory grounds,⁵⁴ the court affirmed the lower court's dismissal of the informed consent cause of action.⁵⁵

How serious a problem was the dismissal of the informed consent count?⁵⁶ In instances of invasive touching, battery doctrine dictates that patients are to make decisions about their own care. A doctor's responsibilities for professionally competent care must then be to know, to advise and recommend, and to implement, but *not* to decide.⁵⁷ I have argued that autonomy interests are as compelling where non-invasive decisions are involved as they are where touching is proposed. However, where no touching is proposed, patient decisionmaking may be ignored not only under

52. Wrongful birth actions have surfaced in the wake of new genetic technology and altered public policy. Although they were originally treated as presenting standard medical malpractice and consent issues, special rules have now emerged in these cases. See generally Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618 (1979) (examining liability for birth of child with condition that if diagnosed early enough would have led parents to avoid such birth); Collins, *An Overview and Analysis: Prenatal Torts, Preconception Torts, Wrongful Life, Wrongful Death and Wrongful Birth: Time for a New Framework*, 22 J. FAM. L. 677, 695 (1983-84) (courts agree parents may state some cause of action based on wrong information, but disagree on proper measure of recovery); Robertson, *Civil Liability Arising from "Wrongful Birth" Following an Unsuccessful Sterilization Operation*, 4 AM. J.L. & MED. 131 (1978) (analyzing actions in both tort and contract for wrongful birth). In Part III, *infra*, I will argue that the need for different rules is not as situation-specific as analysis in these cases has suggested.

53. 57 A.D.2d at 87, 394 N.Y.S.2d at 939 (citations omitted); accord *Malloy v. Shanahan*, 280 Pa. Super. 440, 443, 421 A.2d 803, 804 (1980) ("The doctrine of informed consent has been applied only to suits involving surgical operations or procedure, wherein 'an operation without the patient's consent is a technical assault.'") (quoting trial court, in turn quoting *Gray v. Grunnagle*, 423 Pa. 144, 155, 223 A.2d 663, 669 (1966)).

54. The court acknowledged that the statute it cited was not in effect at the time these facts took place. *Karlsons*, 57 A.D.2d at 82 n.4, 394 N.Y.S.2d at 939 n.4. Nevertheless, the court viewed the statute as providing an indication of legislative inclinations.

55. The *Karlsons* court also rejected the plaintiff's theory that disclosure of the procedure was required under the branch of informed consent dealing with disclosure of alternatives. See *infra* Part II(C).

56. Some patients may know about amniocentesis, unlike other medical information, independently of medical sources. The possibility of independent knowledge, however, should not reduce the scope of the doctor's duty. Rather, it should constitute an affirmative defense, with the doctor bearing the burden of proving the plaintiff's actual knowledge or the applicability of a common knowledge exception.

57. For a discussion of battery rules, see *supra* Part I(C).

Protecting Patient Choice

battery analysis, but also under negligence doctrine. Where choice is not identified as an interest, courts will impose no duty to disclose in order to inform the patient's consent. Yet, in these instances, receiving information from the doctor is the only way a patient can become aware of a pending choice. Nondisclosure here is tantamount to loss of the choice interest itself; only issues of professionally competent care remain.

Karlsons illustrates precisely that outcome. Having denied the existence of any issue of informed consent because of the absence of a proposal to touch, the court observed:

[T]he alleged undisclosed risks did not relate to any affirmative treatment but rather to the condition of pregnancy itself. *Allegations such as these have traditionally formed the basis of actions in medical malpractice and not informed consent.*⁵⁸

Using the framework of malpractice, the court only inquired into whether the treatment that the doctor recommended and actually implemented constituted professionally competent care of physical well-being. Thus, the sole issue regarding amniocentesis that the court allowed to be considered was: Did defendant doctors breach their duty of professional care "by not properly diagnosing the condition of the child"?⁵⁹

The doctor's failure to recommend amniocentesis (and to implement it, thereby discovering those facts that the test would have revealed) might have been argued to be a failure of competent care. However, it is quite likely that what the court formulated as "not properly diagnosing the condition of the child"⁶⁰ would not have constituted professionally incompetent care, particularly in 1973.⁶¹ Amniocentesis involves risks to the fetus. The test was not uniformly used in 1973, and the doctors could competently have held differing opinions about whether such a test should have been recommended.⁶² Moreover, non-medical values about the ultimate issue, abortion, are so disproportionately important in the chain of decisions that the medical risks of amniocentesis pale by comparison. Thus, unless such recommendations are made purely on the basis of such medical matters as risk to the fetus, there is significant danger that a doctor's advice regarding amniocentesis might improperly be influenced by his personal values with regard to the issue of abortion. An expression of such

58. 57 A.D.2d at 82, 394 N.Y.S.2d at 939 (citations omitted and emphasis added).

59. *Id.* at 78, 394 N.Y.S.2d at 936.

60. *Id.*

61. See Capron, *supra* note 52, at 670-71. Professor Capron discusses the difficulty of establishing a standard of practice regarding new fields or procedures like genetic counseling. *Id.* at 620-25. Precisely the same facts that make difference of professional judgment acceptable make the case for disclosure and patient decision more compelling. See *infra* Part III.

62. See discussion of the limits of competence regulation *infra* Part III.

an opinion might be appropriate if the patient requested it, but absent such a request, the doctor might well claim that he properly made no recommendation regarding amniocentesis as a prelude to possible abortion.

For these reasons, it might have been both easy and legitimate for the doctor in *Karlsons* to defeat any allegation that failure to diagnose the fetal abnormality constituted professionally incompetent care.⁶³ Yet there should have been an additional issue derived from the concern with patient choice: Did the defendant doctors breach their duty to protect the patient's autonomy interest by not informing her of the existence of a test, amniocentesis, which could have been used, if the patient so chose, to detect fetal abnormalities? Protection of that interest was lost when the absence of a proposal to touch prompted the court to eliminate issues of disclosure from the case.⁶⁴

Injuries arising from invasion of the interest in choice may be factually similar to injuries arising from failures of competent care. In *Karlsons*, if the doctor's failure to recommend amniocentesis had been judged to constitute professionally incompetent care, the resulting harm would have been the same as if injuries resulted from an invasion of the interest in choice: The parents would have had a child they would not otherwise have had. The possibility of such overlap may easily be construed as meaning that informed consent is nothing but a second, easier bite at the same apple of malpractice recovery.⁶⁵ Yet, although the injuries overlap, the analysis differs, because the interests at stake are different. Liability may legitimately be found under one analytic theory, although there is none under the other. If both concerns are to be vindicated, it is crucial to keep the two issues analytically distinct.

Where *Karlsons* illustrates loss of the choice interest in a pre-care diagnostic setting, *Kelton v. District of Columbia*⁶⁶ reflects an analogous gap in analysis of post-care nondisclosure. Six years after the delivery of her

63. The result would likely be tougher on the doctor if the issue were failure to know of amniocentesis. Such a failure to know of the procedure probably would be found professionally incompetent. Presently, issues of knowledge are often left unexamined because rules do not require inquiry beyond what the doctor recommended or did. The result may be that both incompetence (of knowledge) and inappropriate substitution of judgment go unremedied. For a discussion of the limits of competence regulation, see *infra* Part III. In any case, no such issue of the doctor's knowledge was formulated in *Karlsons*.

64. Professor Capron alludes to this problem but does not pursue it except to suggest that the goals of informed consent are applicable even though there is a lack of touching. Capron, *supra* note 52, at 629-30 n.36.

65. There is a suggestion of such attitudes in Meisel's description of how informed consent functions, Meisel, *Expansion*, *supra* note 6, at 74-77, and in Epstein's critique of the doctrine in which he states that there are "simply no principled limits to a doctrine of informed consent," Epstein, *supra* note 17, at 124.

66. 413 A.2d 919 (D.C. 1980).

Protecting Patient Choice

second child by Caesarian section, the plaintiff underwent exploratory surgery to determine why she had been unable to become pregnant a third time. Her surgeon discovered that there were scars on her fallopian tubes that were consistent with the performance of a tubal ligation or some surgical trauma. The plaintiff sued the doctor who delivered her second child. She alleged that she had not consented to any tubal ligation, nor had she been told of any intentional or accidental surgical intervention affecting her fallopian tubes. Her complaint alleging an unconsented sterilization (battery) was barred by the statute of limitations. However, the plaintiff also claimed that the doctor had breached a separate duty to *tell* her of the damage to her fallopian tubes, and that that claim regarding nondisclosure was timely under negligence limits.

If the plaintiff's allegations were true, she had been injured in several ways. She had been deprived of fertility without her knowledge or consent. The actions that produced this physical harm may have constituted either battery (if intentional) or negligence (if accidental). But the failure to disclose both the physical facts and the doctor's knowledge regarding how the damage came about constituted a different and additional harm. Even after the surgical trauma took place, Ms. Kelton still had a prospective interest in choice. Had she known about the scarring of her tubes, she might have sought surgical repair. At the very least, she would not have had to undergo additional surgery to determine why she was unable to conceive. Disclosure of the scarring would also have allowed her to exercise choice regarding non-medical consequences of the medical facts. Properly informed, Ms. Kelton might have sought to adopt further children, or she might have elected to file suit for the initial injury (the unconsented ligation).⁶⁷

The *Kelton* court, like the *Karlsons* court, allowed a touch-based definition of disclosure requirements to eliminate the patient's interest in these choices. Distinguishing a leading informed consent case, *Canterbury v. Spence*,⁶⁸ as involving a failure to disclose risks of prospective surgery, the *Kelton* court upheld a dismissal under timeliness provisions on the ground that there was no cause of action other than battery.⁶⁹ The court

67. Loss of opportunity to file the battery action may not have been attributable to the doctor's failure to disclose the injury that had occurred. The plaintiff did not file a timely battery action when she did later discover the injury. It is not necessarily the case, however, that a similar delay would have occurred had she been informed earlier. In any event, the other injuries to her interest in choice could not be so easily dismissed.

68. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

69. The court may have seen the disclosure cause of action as a subterfuge to get around the statute of limitations in the "real" battery action. If the court was hostile to the disclosure action for this reason, it underscores the tendency to "see" choice-based disclosure issues within a narrow, pre-cut pattern. For discussion of the duty to disclose malpractice, see Vogel & Delgado, *To Tell the Truth: Physicians' Duty to Disclose Medical Mistakes*, 28 UCLA L. REV. 52 (1980) and *infra* Part

stated: "Thus a breach of duty to disclose [lack of consent] is not actionable in negligence unless it induces a patient's uninformed consent to a risky operation from which damages actually result."⁷⁰ The court's statement implies the following: Consent and consent-oriented disclosure duties arise only in surgery cases and only in advance of a proposed intervention, and such duties extend only to disclosure of the risks posed by the proposed intervention itself. This formulation of the rule ignores various types of disclosure essential to protection of patient autonomy.⁷¹ Thus, while the court recognized that the patient's choice interest may have been violated if a tubal ligation was intentionally performed without the patient's consent, it failed to understand that a choice interest was also implicated in the nondisclosure of the facts after the intervention had occurred. As in *Karlsons*, analysis of disclosures essential to the protection of autonomy was foreclosed because the issue arose outside the touch-based parameters of the informed consent prototype.

b. *The Duty to Disclose Will Be Transposed*

Where a case does not involve physical touching, the issue of disclosure may not wholly disappear, as it did in *Karlsons* and *Kelton*. Instead, a duty to disclose may be considered, but analysis of that duty will shift when a case is not identified as one of informed consent. Where nothing signals the involvement of patient autonomy, duties to disclose will be transposed into issues about professional care of physical well-being. *Roark v. Allen*,⁷² a 1982 case decided by the Texas Supreme Court, illustrates this pattern.

The plaintiffs were the parents of a baby allegedly injured during a breech birth. After the delivery, the defendant doctors noticed forceps indentations on the infant's head. They considered the possibility that the indentations might indicate a fractured skull, but after further examination decided that there was no fracture. No one informed the parents of the possibility of a skull fracture, nor were x-rays, which would have revealed the fracture, ordered. Weeks later, bilateral fractures of the infant's skull were detected and the problem was then corrected. The parents sued the obstetrician for negligent use of forceps and their family doctor for

III.

70. 413 A.2d at 922.

71. The court's statement also ignores the fact that failure to disclose information may in some situations actually be a failure to provide competent care. See, e.g., *Crosby v. Grandview Nursing Home*, 290 A.2d 375 (Me. 1972) (failure of physician to advise regarding care of injured foot). The court probably makes this error because it assumes a usage whereby verbal communication necessary to competent care of physical well-being is called "instruction" or "advice."

72. 633 S.W.2d 804 (Tex. 1982), *affg in part, rev'g in part*, 625 S.W.2d 411 (Tex. Ct. App. 1981).

Protecting Patient Choice

failure to inform them of the possibility of skull fracture. The jury found for the plaintiffs against both doctors.⁷³

The failure of the family doctor to inform the parents of the possibility of skull fracture is the primary concern here. The Texas Supreme Court objected to the lower court's use of informed consent theories to analyze this issue. According to the court, informed consent applies "only to medical procedures which have yet to be performed and . . . it is inapplicable . . . where the patient has already undergone the proposed treatment and been injured."⁷⁴ Characterizing this type of nondisclosure as "a totally different cause of action" from informed consent,⁷⁵ the court analyzed it as a problem of ordinary negligence and reversed the trial court's judgment for the plaintiff. The *Roark* court's method of arriving at that decision betrays the transposition of interests that occurs when informed consent analysis is deemed inapplicable.

The plaintiffs and the lower courts had posed this nondisclosure as a breach of a duty to protect the parents' interest in choice; they called it an action for lack of informed consent. Once the supreme court decided that informed consent doctrine did not apply, it abandoned the interest in choice and analyzed disclosure in light of the traditional negligence interest in professionally competent care of physical well-being. The court observed that expert testimony was essential to evaluate the duty because "diagnosis of skull fractures is not within the experience of the ordinary layman."⁷⁶ This characterization shifted the issue from one of informing about possible courses of action to one of diagnosing skull fractures. The

73. *Id.* at 807-08. The Texas Supreme Court affirmed the court of appeals' reversal of the verdict against the obstetrician, albeit on a different ground (that although he was negligent in his use of the forceps, the causal connection between this negligence and the baby's injuries was not sufficiently established). *Id.* at 811. *Roark* illustrates that, even where there is a finding of incompetent care that produces a harm factually similar to the harm resulting from invasion of autonomy, analysis of the autonomy interest would not be redundant.

74. *Id.* at 808. The court seems unwilling to acknowledge that the distinction between pre-care and post-care is largely semantic. This case could be described as one involving a need for further diagnosis and care as a result of birth injuries. Indeed the trial court used just such a phrasing. *Id.*

75. *Id.*

76. *Id.* at 809. At the time the facts occurred, Texas also required expert testimony to establish the standard of care in informed consent actions. *See Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967). The way the issues are posed in these two actions, however, differs. In an informed consent action, the law itself establishes that there is a choice to be made by the patient; only then does it require medical evidence regarding what a competent doctor would have disclosed to the patient making that choice. Thus *Wilson*, the leading Texas informed consent case, states: "Physicians . . . have a duty to make a reasonable disclosure to a patient . . . based upon the patient's right . . . to exercise an informed consent . . . [That duty is measured by what a reasonable doctor] would have disclosed to his patient about the risks incident to a proposed diagnosis or treatment . . ." *Id.* at 301-02. If the law had required the patient's consent (here to a recommendation that the indentations need not be x-rayed), some disclosure, at least of the existence of a choice to be made, would have been necessary. By contrast, where no issue of informed consent is recognized, unless expert testimony is offered regarding the need to disclose, there may be no information given about the very existence of a choice to be made.

defendant's own testimony had been used to establish the standard of care. Asked whether the correct medical procedure would be to advise of the possibility that such a fracture existed, he replied, "Yes, if the fracture was assumed to be there."⁷⁷ The supreme court reversed a jury verdict for the plaintiffs, saying there was *no evidence* to support it because "the evidence is uncontroverted that Dr. Allen assumed a fracture did not exist."⁷⁸ What began as a question of informing patient choice ended as an issue of the doctor's diagnostic accuracy.⁷⁹

Similarly, in *Sinkey v. Surgical Associates*,⁸⁰ the court began with an alleged duty to inform the parents of a child patient (regarding the opinions of a consulting radiologist) and transposed it into a different issue: Was the reading of the x-ray professionally competent? Again, the information was unconnected to any prototypical proposal to touch; the case was not identified as one of informed consent. Yet an interest in choice was probably the basis on which the plaintiff parents alleged that the information should have been communicated to them.⁸¹ The Iowa Supreme Court affirmed a directed verdict for the defendant, saying:

The second allegation of negligence is based on an asserted duty to advise the patient that the x-ray finding was consistent with appendicitis and that the radiologist's impression was appendicitis. . . .

*We find no evidence to support the allegation of an incorrect interpretation of the x-ray [by the attending doctor who diagnosed tonsillitis] and hold that under these circumstances the doctor had no duty to advise the patient of the fact that the condition shown in the x-ray was also consistent with appendicitis.*⁸²

If the allegation were that the doctor should have diagnosed the appendicitis, the competence of the x-ray reading would be critical. Where patient knowledge and choice are the concern, however, the competence of the reading is not the issue.

77. *Allen v. Roark*, 625 S.W.2d 411, 415 (Tex. Ct. App. 1981), *aff'd in part, rev'd in part*, 633 S.W.2d 804 (Tex. 1982).

78. *Allen v. Roark*, 633 S.W.2d at 809.

79. This decision may have been technically acceptable. The court, however, could easily have taken the "yes" part of the defendant's answer as sufficient, particularly where it reversed the decision under a "no evidence" standard. Even if failure to make such a recommendation was not shown to be incompetent, as the court concluded here, the issue of disclosure for choice should still have remained live. As between the doctor and the parents, it ought to have been the parents' choice whether to incur risks and costs in order to determine with greater accuracy whether or not fractures were present.

80. 186 N.W.2d 658 (Iowa 1971).

81. Where professionally competent care is the interest which requires verbal communication, that communication tends to be denominated "diagnosis," "advice," or "recommendation." Where the term "disclosure" is used, it ordinarily conveys a concern about patient autonomy.

82. 186 N.W.2d at 661 (emphasis added).

Protecting Patient Choice

Policies for evaluating the competence of doctors' diagnoses differ significantly from those involved in patient choice. The uncertainty of medical judgment legitimately excuses a failure to diagnose correctly, if the judgment was carefully and reasonably made. Such uncertainty should not, however, excuse a failure to disclose information that would have permitted a patient to exercise a different choice. Indeed, the more uncertain the medical judgment involved, the more reason there is to excuse a wrong diagnosis. But, the more uncertain the medical judgment, the less acceptable is the doctor's substitution of her judgment for the patient's. The courts in *Roark* and *Sinkey* applied notions of uncertainty appropriate to analysis of competent care rather than to analysis of disclosure to protect choice. Had the absence of a prototypical proposal to touch not prevented these issues from being recognized as questions of informed consent, the courts would, I think, have been less likely to make this mistake.⁸³

2. *Duty To Disclose—Physical Contact Transcended?*

A requirement to disclose alternatives is sometimes mentioned in informed consent cases.⁸⁴ If broadly applied and interpreted, such a requirement could close some of the identified gaps in protection of choice, but the requirement to disclose alternatives is itself constricted by concepts centered on touching. Many jurisdictions impose no such disclosure requirements.⁸⁵ When they do, the mandate is typically to disclose only al-

83. The central tenet of classical informed consent doctrine is disclosure of risks, i.e., possible but uncertain occurrences. *Roark* is a relatively pure type under which the interest in choice is wholly abandoned. Sometimes when a case not falling within the prototypical boundaries of informed consent is treated as an instance of ordinary negligence, it is unclear whether the court analyzes disclosure as a duty derived from an interest in choice or from one in professionally competent care. *Stills v. Gratton*, 55 Cal. App. 3d 698, 127 Cal. Rptr. 652 (1976), provides an interesting example. The court's selection and discussion of facts, duty, standard of care, and damages reflect alternating and somewhat inconsistent concerns first with choice and then with competent care. Although, as a case treating disclosure under ordinary negligence doctrine, *Stills* provided a greater than average degree of protection for patient choice, that result was shaped by several atypical factors. The case involved the completeness of an abortion, a subject about which sensitivity to choice has been heightened. See *infra* Part III. Further, because two different doctors were involved, disclosure was factually separated from professional care. The same result might not be forthcoming in other circumstances.

84. E.g., *Scott v. Bradford*, 606 P.2d 554, 557 (Okla. 1979); *Siegel v. Mount Sinai Hosp.*, 62 Ohio App. 2d 12, 21, 403 N.E.2d 202, 209 (1978); *Natanson v. Kline*, 186 Kan. 393, 410, 350 P.2d 1093, 1106 (1960).

85. According to Andrews, only 10 of 23 statutes governing informed consent specifically require that the doctor disclose alternatives to treatment. Andrews, *Informed Consent Statutes and the Decisionmaking Process*, 5 J. LEGAL MED. 163, 197 (1984). Only a few cases squarely hold a doctor liable for failure to disclose alternatives. One such case is *Archer v. Galbraith*, 18 Wash. App. 369, 379, 567 P.2d 1155, 1161 (1977). *But cf.* *Dunham v. Wright*, 423 F.2d 940, 946 (3d Cir. 1970) (disclosure of alternatives not actionable when doctor determines patient has "no alternative"). Even when the issue is raised, courts often leave it to the jury, making no requirement as a matter of law. See, e.g., *Masquat v. Maguire*, 638 P.2d 1105 (Okla. 1981) (for discussion of case, see *infra* note 133).

ternative treatments, not alternative diagnostic data, theories of the case, or courses for case management.⁸⁶ Disclosure requirements are rarely applied to situations of aftermath disclosure,⁸⁷ to situations in which no change in continuing treatment is proposed, or to situations where either no treatment is possible or none is proposed. Thus, the alternatives rule does not extend far enough to encompass many situations identified here as gaps in autonomy protection.

Developments in two states suggest potentially broader changes in the limitations that derive from negligence requirements for physical contact. In *Gates v. Jensen*,⁸⁸ the Washington Supreme Court selected the doctor's possession of knowledge, rather than his proposal to touch, as the occasion for a duty to inform the patient's choice. The court held that an ophthalmologist had an obligation to inform the patient of test results showing possible glaucoma even though he did not propose either to test further for that condition, or to treat it.

The jury found for the doctor on the plaintiff's claim that the ophthalmologist's failure to diagnose her glaucoma was professionally incompetent. Yet the doctor's failure to tell the patient that her tests showed borderline symptoms of the disease, and that further testing for it was

Andrews notes that only 14 percent of physicians surveyed by the President's Commission considered information about alternatives to be integral to informed consent. Andrews, *supra*, at 197. The enactment of statutes specifying exactly what alternatives are to be disclosed in particularly controversial circumstances provides further evidence of the inadequacy of general statutory or common law requirements. E.g., CAL. HEALTH & SAFETY CODE § 1704.5 (West Supp. 1985) (failure to disclose alternative treatments of breast cancer constitutes unprofessional conduct). For a further discussion of the inadequacy of the present alternatives rules, see *infra* Part II(C).

86. For example, in one Washington case, *Thornton v. Annett*, 19 Wash. App. 174, 574 P.2d 1199 (1978), the defendant doctor performed a hysterectomy during exploratory surgery on the plaintiff, who had severe pelvic inflammatory disease. The plaintiff appealed a jury verdict for the defendant on the ground that the doctor's total failure to disclose alternatives should have entitled her to a partial directed verdict on the issue of informed consent. Concluding that the plaintiff's alleged alternatives were alternative methods of diagnosing rather than alternative treatments, the court upheld denial of the directed verdict. It stated that "[o]nly feasible and available treatment must be disclosed." *Id.* at 179, 574 P.2d at 1203. Under the court's analysis, no disclosure of alternative approaches to diagnosis is required, at least as a matter of law. As in *Karlsons*, when disclosure disappeared from the analysis, only the interest in professionally competent care remained. The court held that the jury might legitimately have concluded that the defendant had complied with the proper standard of care "in performing the exploratory surgery as a method of diagnosing plaintiff's symptoms." *Id.* at 180, 574 P.2d at 1203 (emphasis added).

Many cases discussed in this article (*Karlsons*, *Roark*, *Sinke*, *Keogan*) involve disclosure about alternative diagnostic theories; others could be so characterized if artificial pre/post-care distinctions were abandoned (*Kelton*). In these cases the notion of disclosing alternatives did not convince the courts to accept an informed consent theory of the case. In *Karlsons*, disclosure under an alternatives theory was expressly rejected.

87. Judgments made by a doctor in the aftermath of medical intervention could be described as being the diagnostic process for a potential next stage of decision. Thus diagnosis could, at its most expansive, mean "alternative knowings." As this Article shows, however, courts have tended to freeze concepts like "diagnosis" and "consent" into narrow and literal meanings. Some more flexible and generic concept would be necessary to trigger adequate disclosure.

88. 92 Wash. 2d 246, 595 P.2d 919 (1979), *rev'g* 20 Wash. App. 81, 579 P.2d 374 (1979).

Protecting Patient Choice

possible, deprived her of the choice whether to consent to his recommendation that no further investigation of glaucoma be undertaken. Under the traditional approaches discussed above, the interest in that choice might well have been ignored.

No battery action would lie in *Gates* because there was no unconsented touch. Nor, under the interpretation employed by cases like *Karlsons*,⁸⁹ *Kelton*⁹⁰ or *Roark*,⁹¹ would there be an obligation to disclose under informed consent doctrine. In accord with such interpretations, the defendant in *Gates* claimed that because he was still engaged in diagnostic assessment and had not yet recommended treatment, no duty to disclose had arisen.⁹² But unlike courts in the cases discussed above, the Washington court did not allow the absence of a proposal to touch to eliminate the patient's interest in disclosure and choice.⁹³

Although it purported only to apply existing informed consent law, the Washington court articulated what might have become a significant new standard: It ordered that a doctor should disclose whenever he has knowledge of a potentially dangerous abnormality in the patient's body.⁹⁴ Under this test, the occasion for disclosure would not be a proposed act of touching, but the doctor's possession of significant knowledge about the medical condition of the patient. The *Gates* standard, if allowed to develop, could have superceded touch-based boundaries that limit protection of patient choice interests to particular stages of treatment or to types of proposed intervention.

89. 57 A.D.2d 73, 394 N.Y.S.2d 933 (1977). See *supra* text accompanying notes 50-65 (discussing *Karlsons*).

90. 413 A.2d 919 (D.C. 1980). See *supra* text accompanying notes 66-71 (discussing *Kelton*).

91. 633 S.W.2d 804 (Tex. 1982). See *supra* text accompanying notes 72-79 (discussing *Roark*).

92. The intermediate court explicitly adopted this view in affirming the trial court's refusal to give informed consent instructions. 20 Wash. App. at 87, 579 P.2d at 377. Timeline factors *per se* continue to be suggested by some authors as appropriate considerations in creating duties of disclosure. See Comment, *Informed Consent in Washington: Expanded Scope of Material Facts that the Physician Must Disclose to His Patient*, 55 WASH. L. REV. 655, 667-70 (1980).

93. Unlike the court in *Thornton*, 19 Wash. App. 174, 574 P.2d 1199 (1978) (for discussion of case, see *supra* note 86), the court in *Gates* also refused to distinguish between diagnostic theories and proposals to treat for purposes of triggering a patient's interest in disclosure. *Gates*, 92 Wash. 2d at 250, 595 P.2d at 922.

94. In its summary of the facts, the court mentions that Ms. Gates asked about the result of the doctor's tests and was told that everything was all right, but the court does not characterize the problem as misrepresentation. The court phrased its broadened concept of an affirmative duty as follows: "The existence of an abnormal condition in one's body, the presence of a high risk of disease, and the existence of alternative diagnostic procedures to conclusively determine the presence or absence of that disease are all facts which a patient must know in order to make an informed decision on the *course which future medical care will take*." 92 Wash. 2d at 251, 595 P.2d at 923 (emphasis added). Although an improvement on a touch-based trigger, this formulation is still not optimal. It might not, for instance, encompass disclosure of the availability of amniocentesis.

Although the *Gates* court purported only to apply the rule of *Miller v. Kennedy*, 11 Wash. App. 272, 522 P.2d 852 (1974), *aff'd*, 85 Wash. 2d 151, 530 P.2d 334 (1975), *aff'd en banc*, 91 Wash. 2d 155, 588 P.2d 734 (1978), it is *Gates* which created a new standard not dependent on touching.

Gates was decided in a context of intense conflict over the adequacy of standards of professional negligence.⁹⁵ As a by-product of its dissatisfaction with the limitations of traditional competence regulation, the court seems to have become particularly sensitive to the unfairness entailed in relying on the judgment of professionals instead of patients.⁹⁶ However, faced with new medical facts, the same court, in *Keogan v. Holy Family Hospital*,⁹⁷ sharply limited the potential of *Gates*. In circumstances analytically similar to *Gates*,⁹⁸ five justices refused in *Keogan* to impose a duty of disclosure based on possession of knowledge.⁹⁹ Instead, like the court in *Karlsons*, they reverted to the assumption that, apart from instances involving touching, regulation of the doctor's competence was the only important issue.¹⁰⁰

Gates has been criticized as interfering with proper professional judgment, indulging in the fantasy that a patient can "correct the reasonable errors of his physician."¹⁰¹ Yet *Gates* glimpsed what *Keogan* lost sight of: Although the patient is not more competent in making judgments assessing the likelihood of a particular disease, she is more competent in deciding whether she wishes to undergo more tests and spend more money in order to be more certain about the diagnosis in her case.

95. In *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974), the court had held that reasonable prudence may require a standard of care higher than the prevailing professional standard. The state legislature responded by enacting WASH. REV. CODE ANN. § 4.24.290 (West Supp. 1986), requiring a plaintiff to demonstrate that the practitioner "failed to exercise that degree of skill, care, and learning possessed at that time by other persons in the same profession . . ." The *Gates* court, however, interpreted the statute in a fashion that allowed it to continue to apply the doctrine of *Helling*. See 92 Wash. 2d at 253-54, 595 P.2d at 924.

96. Because doctors are incompetent only when they fail to act as other doctors would, there is no external referent by which to judge what are, essentially, questions of utility, e.g., how much certainty about the presence of glaucoma is adequate. The patient could provide a determinate referent by deciding the personal value of additional tests or procedures. Another source for such evaluations would be social decisions allocating collective resources through collective cost-benefit analyses. In *Gates* the court used both tools. It expanded a doctor's obligation to respect patient choice, and it permitted a societal cost-benefit analysis of the adequacy of care by allowing a jury to decide that reliance on the prevailing professional standard was insufficient.

97. 95 Wash. 2d 306, 622 P.2d 1246 (1980).

98. A doctor had obtained results suggesting but not confirming that heart disease was a possible cause of plaintiff's chest pains. As in *Gates*, the doctor concluded that problems other than heart disease lay at the root of the patient's symptoms, and made no disclosure of the possibility of heart disease or of the test results. The patient later died from a heart attack. *Id.* at 307-08, 622 P.2d at 1249.

99. *Id.* at 330-31, 622 P.2d at 1261. The precedential effect of the opinion is uncertain. Justice Horowitz's opinion, purporting to be the opinion of the court, was joined by two other justices on the matter of disclosure under *Gates*. The dissent, refusing to apply *Gates*, however, was signed by five justices. A rehearing was granted, but the case was settled before the rehearing was held. Thus *Keogan* did not directly reverse *Gates*, but it did undermine the holding.

100. Five justices signed an opinion stating that, "[i]f Dr. Snyder was negligent because he should have discovered Keogan's diseased heart and failed to do so, that is what should be alleged and proved This court with its benefit of hindsight should not now enter the fray . . . with rulings as a matter of law as to what the doctor should have told the patient." *Id.*

101. Comment, *supra* note 92, at 673.

Protecting Patient Choice

Several recent California cases have also taken steps away from physical contact as the definitive occasion for choice-oriented disclosure. In *Truman v. Thomas*,¹⁰² a thirty-year-old woman several times declined to have a Pap Smear that her gynecologist recommended, sometimes saying she could not afford it, sometimes saying simply that she did not feel like it. She eventually died of cervical cancer, and a wrongful death suit was filed alleging the doctor's negligent failure to inform her of the risks of refusing the test. The majority concluded that the case was controlled by *Cobbs v. Grant*,¹⁰³ the leading California case on informed consent. It held that instructions should have been given allowing the jury to consider whether the doctor had breached a duty by failing to inform the patient of the risks of refusing the recommended test.¹⁰⁴

Although the majority appropriately rested its holding on *Cobbs*, the facts in *Truman* differed from the traditional informed consent facts to which *Cobbs* is typically applied. The fact that the patient decided not to have the test meant that the doctor would not touch her. Both the court of appeal majority and the supreme court dissenters stressed that requiring disclosure in such a situation would be a serious and undesirable expansion of the basic doctrine.¹⁰⁵ In their view, apart from traditional requirements for consent to physical contact, people should do as their competent doctors tell them,¹⁰⁶ and protection against incompetent care is therefore

102. 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980), *rev'g* 155 Cal. Rptr. 752 (Ct. App. 1979).

103. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

104. *Truman*, 27 Cal. 3d at 294-95, 611 P.2d at 307-08, 165 Cal. Rptr. at 313-14. A Pap Smear involves physical touching and would therefore require both consent and information about risks. However, no disclosure of remote or minor risks is required. A Pap Smear is virtually risk-free. The risks attach primarily to *refusal* to undergo the recommended test. It is therefore, technically, the alternatives branch of informed consent doctrine that actually requires disclosure. Refusal is a self-evident alternative, but the risks of not having a Pap Smear might not be common knowledge and, therefore, ought to be disclosed.

105. 155 Cal. Rptr. at 757-59; 27 Cal. 3d at 297-301, 611 P.2d at 909-11, 165 Cal. Rptr. at 315-17.

106. According to the court of appeal majority, "[i]t does not follow that the doctor should be required to protect his patient from the patient's lack of judgment." 155 Cal. Rptr. at 757. Furthermore, "[i]t is nonsensical to claim that [a patient] goes to the doctor for advice he will not thereafter follow . . ." *Id.* at 759. Similarly, according to Judge Clark, writing for the supreme court dissenters, "[w]hen a patient chooses a physician, he or she obviously has confidence in the doctor and intends to accept proffered medical advice [, and it is] reasonable to assume that a patient who refuses advice is aware of potential risk." 27 Cal. 3d at 299, 611 P.2d at 910, 165 Cal. Rptr. at 316.

The supreme court dissenters raise one legitimate issue. There seems a danger here that doctors will be held liable if they fail to get patients' consent, or if a "bad" outcome results from honoring the patient's choice. The *Truman* majority forestalled that problem by holding that if the plaintiff would have refused the test even if fully informed, no liability should result. 27 Cal. 3d at 294, 611 P.2d at 907, 165 Cal. Rptr. at 313. Thus, although it ordinarily uses a reasonable person standard of causation in informed consent cases, the court adopted a subjective person standard here. That decision handled the immediate problem but failed to address the analogous unfairness created by the use of the reasonable person causation standard in the more usual informed consent case. *See also infra* text accompanying notes 127-31, 212-13, 294-309.

all that should be required. The closeness of the outcome in *Truman*,¹⁰⁷ decided in a jurisdiction where concern for patient autonomy has traditionally been vigorous, suggests that the perception of an essential nexus between physical contact and choice is still very strong.

On its facts, *Truman* created a rather modest extension of duty. However, a subsequent California case, *Jamison v. Lindsay*,¹⁰⁸ described a potentially broader obligation to disclose. The plaintiff sued a pathologist for failing to inform either the surgeon or herself of the presence of immature tissue in a tumor removed from her body or of a controversy among pathologists over whether or not such tissue increases the odds of later malignancy. Again, because there was no proposed physical contact, the court of appeal upheld the trial court's refusal to give informed consent instructions, and affirmed a jury verdict for the defendant doctors.¹⁰⁹ Unlike other courts,¹¹⁰ however, the *Jamison* court did not allow its conclusion that informed consent did not apply to eliminate disclosure as a duty imposed to protect patient autonomy. It observed that, pursuant to the broadened duties of disclosure suggested by *Truman*, an instruction regarding a duty to disclose information necessary for informed decision-making regarding *whether to seek additional treatment* following surgery would have been appropriate.¹¹¹ Such a duty would necessarily make possession of information rather than proposed physical contact the occasion for disclosure.¹¹² Despite the breadth of its theories, *Jamison's* rather stringent procedural rulings¹¹³ barred any actual implementation of those

107. The intermediate court's 2-1 decision that no duty was appropriate, 155 Cal. Rptr. 752, was reversed by a bare 4-3 majority of the supreme court, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308.

108. 108 Cal. App. 3d 223, 166 Cal. Rptr. 443 (1980).

109. "[N]o treatment or tests had been proposed by respondents. The informed consent theory and appellant's proposed instructions on the duty of a physician to disclose . . . 'regarding the proposed . . . postoperative treatment' were inapposite [because] . . . [a]fter the surgery, respondents did not propose any therapy as to which appellant would have been entitled to make an informed decision." *Id.* at 230; 166 Cal. Rptr. at 446.

110. *See supra* Section B(1).

111. 108 Cal. App. 3d at 231, 166 Cal. Rptr. at 447. Despite this observation, the court held that because the trial court had no responsibility to edit proposed instructions, no reversible error resulted. *Id.*

112. Using that new standard, *Jamison* would require post-intervention disclosure in much the same way that *Gates* extended pre-intervention disclosure.

113. For example, the plaintiff argued on appeal that the nondisclosure should have been analyzed under the reasonable person rather than the expert standard of care. Although agreeing that the broadened duty of disclosure as judged by the lay standard could legitimately have been alleged under ordinary negligence law rather than informed consent doctrine, the appellate court nevertheless held that the plaintiff herself invited the error by requesting an instruction incorporating the expert standard of care. 108 Cal. App. 3d at 232, 166 Cal. Rptr. at 448. Yet, presumably, the plaintiff's lawyer, having characterized the issue as one of informed consent, would have assumed that the lay standard regarding disclosure would have been invoked under that theory, and therefore would have seen no need to request such instructions with reference to the ordinary negligence aspect of the case. The assumption that informed consent doctrine would apply does not seem unwarranted. The appellate court itself cited *Truman* and *Cobbs* (both labeled as informed consent cases), and indicated its recog-

Protecting Patient Choice

theories in the case.¹¹⁴ It thus remains uncertain whether future plaintiffs can use *Jamison* to achieve broader protection for patient autonomy.

These cases strain to transcend the traditional, touch-based limits on disclosure duties protecting patient autonomy. The standards they suggest would require more disclosure of a different genre of information. A *Gates* or *Truman* standard would require that doctors disclose the process and reasons by which they arrive at their recommendations, rather than simply provide boilerplate warnings about recommendations that are to be accepted as foregone conclusions. It would also require that, even if a doctor deems care satisfactorily completed, and thus recommends no further treatment, she would have to disclose what she *knows* about the patient's condition and prospects as a result of earlier interventions.

Such information could produce a different kind of patient participation than has resulted from disclosure requirements under traditional informed consent.¹¹⁵ Rather than being a yes/no gatekeeper regarding a single preselected option,¹¹⁶ the patient could act on broader information that would provide the basis for meaningful participation in medical decision-making. These cases envision a patient actually making choices, including choices that differ from what the doctor deems "reasonable."¹¹⁷

dition that the disclosure issue was essentially one involving patient choice. Yet the court refused either to flex its interpretation of the scope of informed consent doctrine or to allow the plaintiff instructions appropriate to a choice theory of the case, however labeled. When the court transferred the disclosure analysis from informed consent to ordinary negligence, the parallel request for an appropriate standard of care instruction should have been deemed similarly transferred.

The plaintiff also challenged the trial judge's instruction, which stated that the pathologist had a right to make a professionally competent judgment between alternative medical procedures. The pathologist, the plaintiff argued, was choosing between beliefs or conclusions that should have been disclosed. The court agreed that the alternative methods instruction was inappropriate. But because the plaintiff did not properly raise this argument at trial, the court refused to consider it on appeal. *Id.* at 233, 166 Cal. Rptr. at 448.

114. In another substantive ruling that prevented broadened disclosure, the court refused to apply the principles of express warranty to the doctor's assertions about the plaintiff's condition, even though he did not disclose known controversy regarding those assertions. *Id.* at 234, 166 Cal. Rptr. at 449. Although the court's conclusion probably reflected traditional resistance to the use of contract principles in medical cases, it was explained on premises linked to a touch-oriented model. The court said the statement came *after* the surgery, and no consent to treatment was based on it. However, from the vantage point of choice, the inaction that was based on the statement was just as significant.

115. Some commentators seem to have given up on the law's ability to create more than a pro forma role for patients. The President's Commission, describing informed consent as having created only a "duty to warn," 1 MAKING DECISIONS, *supra* note 2, at 20, seems to have adopted a rather pessimistic view of the law's role, and has turned its attention to medical education and public opinion to create the "shared decisionmaking" it envisions.

116. *See id.* at 24, 29 (litigation process forces examination of disclosure of risks concerning particular procedure rather than evaluation of entire doctor-patient relationship).

117. Thus in *Truman* the patient made her "unreasonable" choice at least partly for economic reasons. The Pap Smear seemed of less value to her than it seemed to the doctor and she rejected his advice. 27 Cal. 3d at 290, 611 P.2d at 904, 165 Cal. Rptr. at 310. In some sense the case is like that of a Jehovah's Witness whose refusal of a blood transfusion is honored. *See, e.g., In re Melideo*, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976). But our willingness to give public recognition to the conflicts of value in the two cases may differ. Although religious conviction is a palatable as well as a constitutionally protected reason for being "unreasonable," we are less sure about lack of funds, a

Although the expansions of duty undertaken in *Gates*, *Truman* and *Jamison* could be significant, the potential impact of these three cases is questionable. Although not directly overruled, *Gates* was emasculated by *Keogan*. *Truman* requires disclosure about a course of inaction, but its informed refusal stance is unusual and renders it vulnerable to a narrow, touch-oriented interpretation. The relevant parts of *Jamison* are dicta, expounded by an intermediate court, and the case has not been followed or much discussed. There is little indication of these approaches being adopted in other jurisdictions. If the duty suggested in these cases were actually to take root and develop, it would increase protection for patient autonomy. Whether even such an expanded protection would be adequate to ensure patient choice, however, is the subject of the next section.

3. *Other Elements of the Analysis Which Distort Patient Choice*

Although the *Gates-Truman* approach could bring some instances of patient choice not involving physical contact within the ambit of negligence duties, adoption of this approach would not affect the distortion of choice that occurs at other stages of the informed consent analysis. Informed consent doctrines remain embedded within the different, and often inconsistent, interest in physical well-being. Although various of the specific doctrinal rules of informed consent have been extensively criticized,¹¹⁸ the role played by interest definition in diluting the vindication of autonomy has not been adequately challenged.

a. *Standard of Care*

Advocates of autonomy have argued that the standard for disclosure in informed consent cases should be what a reasonable patient would want to know rather than what the average competent doctor would actually disclose.¹¹⁹ Because doctors are trained to take active responsibility and are

vastly more frequent factor influencing patient choice. Increased protection of individual choice will highlight potentially unpleasant realities about the correlation of wealth and access to health care under our system. But the difficulty of those issues is no excuse for abandoning analytic clarity concerning the relevant interests. See *infra* Part IV(C).

118. Autonomy-oriented critics have objected to two principal aspects of the doctrine of informed consent: the standards of care and of causation. See, e.g., J. KATZ, *supra* note 7, at 48-84 (criticizing professional standard of care and noting that causation requirements conflict with dignity of individual and right to self-determination); Katz, *Informed Consent*, *supra* note 15, at 169 (standard of care with respect to disclosure confuses need for medical knowledge to establish risks of proposed procedures with need for medical judgment to establish limits of disclosure); Note, *Restructuring*, *supra* note 30, at 1555-59 (criticizing professional standard of disclosure). These rules have survived partly because they are logical outgrowths of the way interests are defined under current doctrine.

119. See, e.g., J. KATZ, *supra* note 7 (advocating disclosure based on patient self-determination rather than medical expertise); J. KATZ & A. CAPRON, *supra* note 30, at 114 (goal of full and frank partnership between physician and patient); Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1407 (1967) (proposing full disclosure of all known risks); Note, *Restructur-*

Protecting Patient Choice

concerned first and foremost with *outcomes*, historically they have been reluctant to disclose risks and share decisionmaking.¹²⁰ If doctors evaluate the adequacy of disclosure, even when it is designed to protect choice, they will naturally respond in terms of these traditions.¹²¹

Professional expertise, therefore, is not the appropriate determinant of how much disclosure is desirable or adequate for purposes of patient choice. Where the ultimate issue is defined as protection from physical injury, however, absent a painstaking parsing of the sub-issues, professional expertise will seem both central and sufficient to measure duties of care. A substantial minority of states, responding to the identification of the subsidiary choice interest, have adopted a reasonable patient standard to measure the content and adequacy of disclosure.¹²² But most states, responding to physical well-being as the protected interest, have chosen professionalized standards of care as both natural and justified.¹²³ The difference of rules reflects the internal conflict within the hybrid doctrine; the dominance of the professional standard reflects the dominance of physical well-being as the ultimately protected interest. If choice were an independently protected interest, the role of medical expertise could more appropriately be delimited.

b. *Causation*

Medical cases potentially impose enormous liability. Fearing that patients' testimony would be self-serving and biased by hindsight,¹²⁴ courts have felt it necessary to subject hypothetical reconstructions of individual choice to standardized criteria.¹²⁵ In informed consent cases, plaintiffs

ing, supra note 30, at 1559–66 (urging adoption of “reasonable patient standard”). Perhaps the best known objection to the professional standard was expressed by Judge Robinson in *Canterbury v. Spence*: “Nor can we ignore the fact that to bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone.” 464 F.2d 772, 784 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

To some degree, the conflict over the standard for disclosure reflects the difference between contractual and tort norms. Causes of action in contract look to the reasonable expectations of the promisee; professional negligence actions in tort look to the specialized competencies and practices of the professional group.

120. This fact is thoroughly documented by J. KATZ, *supra* note 7, at 1–29.

121. For example, in *Dunham v. Wright*, 423 F.2d 940 (3d Cir. 1970), a case involving death as a result of thyroid surgery, the court affirmed the trial court's refusal to grant a judgment n.o.v. on the issue of informed consent after a jury verdict for the doctor. The plaintiff claimed that the doctor's failure to disclose alternative methods of treatment rendered the patient's consent defective. The court, however, quoted with apparent approval the doctor's assertion that the patient had had no alternatives. *Id.* at 946. It seemed completely unaware that the doctor may have simply characterized his expert recommendation in a fashion that justified the foreclosure of the patient's interest in choice.

122. J. AREEN, P. KING, S. GOLDBERG & A. CAPRON, *supra* note 32, at 384 n.4.

123. *Id.* (twenty-six states use professional standard of care).

124. See, e.g., *Canterbury v. Spence*, 464 F.2d at 790–91 (subjective standard “places the physician in jeopardy of the patient's hindsight and bitterness”).

125. *Id.* at 791. But see *Scott v. Bradford*, 606 P.2d 554, 559 (Okla. 1980) (refusing to jeopardize

must show that, had the contested disclosure been made, a reasonable person would not have consented to the treatment.¹²⁶

Such a standard invites both juries and doctors to make the too easy and superficial assumption that reasonable people do what their competent doctors tell them to do.¹²⁷ Moreover, as commentators have argued, the choices made by reasonable others are not an appropriate screening criterion where the value at issue is personal autonomy.¹²⁸ Yet where physical well-being is the protected interest, choice is placed in the role of factual cause, linking breaches of duty to the occurrence of harm. Analyzed in this way, what began as a concern for individual autonomy almost necessarily comes to be subjected to standardizing and oversimplifying criteria that are alien to individuality.

"right to know" by imposition of "reasonable man" standard). In some unusual instances an objective standard of causation will work to disadvantage doctors. In such instances even jurisdictions that ordinarily employ an objective standard may switch to a subjective one. Of course, the problem of self-serving testimony is removed in these instances, but the substantive illegitimacy of the objective standard in the ordinary case is also indirectly acknowledged by these decisions. *See, e.g.,* Truman v. Thomas, 27 Cal. 3d 285, 294, 611 P.2d 902, 907, 165 Cal. Rptr. 308, 313, (1980) (satisfying "prudent person test" necessary but not sufficient for recovery by plaintiff); *see also* Guebard v. Jabaay, 117 Ill. App. 3d 1, 10, 452 N.E.2d 751, 757-58 (1983) (upholding jury verdict for defendant/physician because, given plaintiff's active sports life, she would have been *less* likely than reasonable person to choose undisclosed alternative to doctor's suggested treatment).

126. Almost all jurisdictions have adopted the objective standard. 3 MAKING DECISIONS, *supra* note 2, at 197. In tort law generally, decisions about how to handle causal questions regarding what would have happened had greater information been provided have not always paralleled the treatment of the issue in medical informed consent cases. Thus, for example, in products liability cases involving failure to warn, courts have not asked whether a warning, if one had been given, would have been heeded. These cases consequently never reach the question of whether that judgment should be assessed in individual or in reasonable person terms. *See, e.g.,* McCormack v. Hanksraft Co., 278 Minn. 322, 154 N.W.2d 488 (1967) (in reversing judgment n.o.v. for defendant, court found evidence sufficient to uphold jury verdict in favor of child injured by boiling water in vaporizer where manufacturer failed to warn despite lack of evidence regarding effectiveness of hypothetical warning). *But see* Cunningham v. Charles Pfizer & Co., 532 P.2d 1377 (Okla. 1975) (failure to warn of statistically small risk of paralysis rendered consent defective; case remanded for new trial with plaintiff entitled to rebuttable presumption that warning would have been heeded with ultimate test being objective one). For a discussion of failure to warn in products liability cases, see Keeton, *Products Liability—Inadequacy of Information*, 48 TEX. L. REV. 398 (1970). Manufacturers and doctors may differ in their ability to absorb the costs of accidents, but doctors can probably prevent invasions of patients' choice more easily than manufacturers can prevent injuries from products. The comparatively personalized setting of the doctor-patient relationship should make discussion and evaluation of warning information more useful than written product warnings. The different treatment of the issue in products liability cases at least suggests that it is not essential to employ the causation analysis currently used by the courts in informed consent. *See also infra* text accompanying notes 212-13, 294-308.

127. *See, e.g., supra* note 106.

128. *See* Meisel, *Expansion, supra* note 6, at 112. Judge Burger made the point forcefully when discussing an opinion by Justice Brandeis. He observed that:

Nothing in this utterance [by Brandeis] suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, reasonable emotions, or *well-founded* sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risks.

Application of the President & Directors of Georgetown College, 331 F.2d 1010, 1017 (D.C. Cir. 1964) (Burger, J., dissenting) (emphasis in original).

Protecting Patient Choice

In many tort actions, factual cause is relatively clear. Even in those actions where actual causation is less certain, an all-or-nothing resolution may yet be justified on grounds that, under a balance of probabilities test, the injury either was or was not causally connected to the negligent act.¹²⁹ Invasions of autonomy, however, involve an especially complex and probabilistic analysis. There are multiple issues: Did the doctor's nondisclosure materially invade the patient's interest in choice? What would the patient have chosen had her choice been protected? What would have happened, medically, had the alternate choice been made? Such complexities are unmanageable within the yes/no framework of factual cause; compressed into a single question, they become oversimplified.

Under such a simplified analysis, if individual criteria were used, the very existence of any injury would seem to turn solely on the rather shaky reed of the plaintiff's hindsight testimony. It is not surprising that courts faced with such a compacted ultimate issue moved to adopt objective standards of reasonableness to address the question.¹³⁰ If, on the other hand, choice were an independently protected interest, the factual cause issue would be narrower and simpler—whether the patient's right to choose had been encroached upon as a result of a doctor's failure to disclose.¹³¹

To be sure, difficult problems of uncertainty, prediction and credibility would remain regarding what would have happened had the patient been given the choice. However, with choice as the protected interest, these problems would be assessed as questions of the valuation of an injury that was acknowledged to have taken place. The framework of valuation is better adapted to the resolution of such probabilistic issues than is the traditional analysis of factual cause. Moreover, questions regarding what redress should be available to remedy the invasion of choice would then be analyzed, appropriately, as issues of sanctioning policy rather than of the factual existence of harm.

c. *Categories of Compensable Harm*

Where battery was preoccupied with physical touch, negligence vindicates physical well-being.¹³² Many invasions of patient autonomy do re-

129. For example, even if the defendants were negligent, if their negligence was, more probably than not, *not* a substantial factor in plaintiff's injury, no liability is warranted. See J. FLEMING, AN INTRODUCTION TO THE LAW OF TORTS 109-11 (1967). And where the question of factual cause is complicated by the presence of two tortious factors, if either could, more probably than not, have produced the injurious result, liability is warranted. *Id.*

130. See King, *supra* note 27 (criticizing courts' frequent conflation of issues of causation and valuation).

131. Some standard of materiality would be needed. See *infra* text accompanying note 285.

132. While physical injury is the central theme of negligence doctrine, other types of injury may be cognizable. For example, damages for emotional distress may be recovered in conjunction with infringement of other interests, see RESTATEMENT (SECOND) OF TORTS § 905(b) (1977), or in their

sult in physical injury as it is traditionally defined. Although such injuries would seem to fit standard negligence definitions of harm, they often go unredressed because, as demonstrated above, the analysis of duty, breach, or cause differs where the protected interest is physical well-being rather than choice. In addition, preemption of patients' authority by doctors may also give rise to injuries that are real but intangible, or to physical outcomes that are arguably not "injurious" except from the individual's vantage point. These outcomes may be excluded from negligence doctrine's definitions of harm. Thus, a patient not told about a method of sterilization that is more reversible than the one performed may have difficulty convincing a court that nonreversibility is a cognizable physical injury.¹³³ A patient who alleges that, properly informed, she would have chosen a lumpectomy rather than a radical mastectomy might find it hard, under existing negligence rules, to characterize the successful operation that removed her breast and eradicated her cancer as having "injured" her.¹³⁴ Similarly, the patient with a desire to go home or to a hospice to die, who is instead maintained alive by hospital machinery, might have difficulty establishing "injury" under definitions of an interest in physical well-being rather than choice.¹³⁵ And, at least when such cases were first liti-

own right, under rules governing the interest in freedom from emotional distress, *see id.* at § 46.

133. *See, e.g.,* Masquat v. Maguire, 638 P.2d 1105 (Okla. 1981). The doctor admitted he did not inform Ms. Masquat of alternative procedures or of their differing degrees of reversibility. The court held that the doctor's nondisclosure would not support either a battery or an informed consent action because of the absence of "causal linkage between some unrevealed risk and the injuries complained of." *Id.* at 1107.

Intangibility of injury might also play a role in barring redress in cases where doctors' nondisclosure arguably deprived patients of a chance to obtain a preferable outcome. If more sophisticated concepts of measurement were used to value a chance, these "ordinary" physical injuries might arguably be analyzed as injuries attributable to a lapse of professionally competent care. If the chance is lost because the doctor's conduct fell below professional standards, that would be appropriate. Many deprivation of a chance cases, however, are better characterized as injuries to choice. The uncertainty of medicine dictates that doctors should not be accountable for perfect outcomes. Precise measurement of lost chances might suggest such accountability. Competence standards can and should require a substantial threshold of knowledge, judgment, and action. Yet beyond demanding conformity to professional standards, the law should leave the weighing of which chances are worth taking to the judgment of the individual affected. *See infra* text accompanying notes 217-31.

134. Despite the controversial nature of the surgery, no case has been discovered dealing with deprivation of choice regarding lumpectomy as opposed to mastectomy, which suggests that such a cause of action would not presently be cognizable. *Cf.* Hanks v. Doctors Ranson, Swan & Burch, Ltd., 359 So. 2d 1089, 1093 (La. Ct. App.) (for discussion of case, *see infra* text accompanying notes 147-49), *cert. denied*, 360 So. 2d 1178 (La. 1978).

135. The "right to die" examples, although anecdotally familiar, do not seem to have reached the courts—at least as disputes between individuals. *But see Court Hears Dead Man's Arguments in Right-to-Die Case*, San Francisco Chron., Nov. 9, 1984, at 10, col.1 (family filed \$10 million civil damage suit against hospital for not respecting family member's wish to be disconnected from respirator). The paucity of such litigation in the literature suggests lacunae in the cause of action as presently conceived. In addition, the societal interest in such decisions is still being litigated. *See generally* J. AREEN, P. KING, S. GOLDBERG & A. CAPRON, *supra* note 32, at 1077-1147 (presenting interdisciplinary viewpoints on legal, social, and ethical issues in regulation of death decisions); PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983) (re-examining way decisions are and

Protecting Patient Choice

gated, the patient who gives birth to an unwanted child because of a doctor's failure to provide choice-protecting information may have difficulty showing harm.¹³⁶

Conclusions about the reality of injury and about whether conduct is deserving of sanction ultimately depend both on how the underlying interest is defined and on how accurately the consequences of its invasion have been traced. In both respects, existing analysis that vindicates patient autonomy only in an indirect fashion has produced a pattern of protection for that interest that is flawed in critical ways.

C. *The Insufficiency of Negligence Protection*

The preceding sections document how choice is subordinated and distorted at every stage of the negligence analysis. Under the prototype identified at the outset, this weak form of protection offered by informed consent doctrine governs only comparatively peripheral questions. Thus, where the doctor proposes surgical intervention, the occurrence of that intervention will necessarily be within the patient's awareness, and, hence, to some degree, control. Furthermore, medical custom has accepted a need for at least some basic consent in such circumstances.¹³⁷ Finally, most states retain some legal requirement under battery doctrine that the patient's consent be sought.¹³⁸ Under modern views, that requirement does not demand that the patient's consent be highly informed. However, because courts often treat blanket consents as being of questionable validity,¹³⁹ the basic consent requirement for battery in fact necessitates *some* disclosure regarding the specific proposal. Under the prototype, what is

ought to be made about whether to forego life-sustaining treatment). Once the parameters of patient autonomy in regard to death decisions are more clearly established, litigation over infringement of those rights by private parties such as doctors and hospitals will likely begin in earnest, as was the case when resolution of constitutional disputes over abortion gave rise to large numbers of private law actions concerning wrongful birth, life, conception, etc.

136. Wrongful birth cases will be discussed in Part III as examples of the emergence of an interest in choice similar to the one suggested here.

137. 2 MAKING DECISIONS, *supra* note 2, at 81. Virtually all doctors report obtaining consent for inpatient surgery.

138. 1 MAKING DECISIONS, *supra* note 2, at 22; *see also supra* text accompanying notes 28–29.

139. *See, e.g.*, *Rogers v. Lumbermens Mutual Casualty Co.*, 119 So. 2d 649 (La. Ct. App. 1960) (operation for removal of reproductive organs tortious when plaintiff only consented to removal of appendix); *Gray v. Grunnagle*, 423 Pa. 144, 167, 223 A.2d 663, 674 (1966) (general consent signed upon admission to hospital may be found inadequate). *But see Kennedy v. Parrott*, 243 N.C. 355, 362, 90 S.E.2d 754, 759 (1956) (absent proof to contrary, consent to major operation will be construed as general in nature and surgeon may extend operation to remedy any condition in area of original incision). *See generally* 23 OHIO REV. CODE ANN. § 2317.54 (Page 1981) (example of statute requiring consent forms to be particular and specific); 1 MAKING DECISIONS, *supra* note 2, at 106 (Joint Commission on Accreditation of Hospitals requiring separate consent forms be signed for any procedure or treatment "for which it is appropriate"); A. ROSOFF, *supra* note 29, at 283 (warning doctors that blanket consent forms are often legally defective).

left to be litigated under a negligence/informed consent theory is mainly nondisclosure concerning collateral risks.¹⁴⁰

Disclosure of collateral risks tends to be additive and elaborative, comparatively unimportant,¹⁴¹ particularly if only one course of action is under discussion.¹⁴² As between doing nothing and accepting the recommendation, a patient's decision is driven by the pains and problems of the disease or illness that brought her to the doctor in the first place. Subjecting the patient's interest in receiving such information to professional standards of care and reasonable patient standards of causation seems relatively unobjectionable.

In nonprototypical situations, the contrast is stark. Where the doctor in effect recommends inaction (or continuing action or non-touching action), that recommendation can be implemented without the patient's awareness. Such decisions cannot be physically "sensed" by the patient. As a matter of medical custom, they are viewed as issues of professional competence rather than patient choice.¹⁴³ Existing touch-oriented legal doctrines inappropriately reinforce that conclusion.

Yet in these instances, information does not merely elaborate collateral risks but is itself the *sine qua non* of choice, the sole means by which the patient can become aware of highly consequential courses of medical management. Information in these cases is far more important than is most collateral risk information; without disclosure, self-executing judgments will be made by the doctor. The problem is illustrated by *Hanks v. Ranson*.¹⁴⁴ In *Hanks*, the plaintiff's healthy breast was amputated after a competently administered but mistaken diagnostic test. The plaintiff complained that the doctor had not told her of a more diagnostically accurate two-step procedure that would have separated surgery from the diagnostic biopsy. No protection regarding such an alternate choice will be forthcoming under battery doctrine. Consent was given to the very procedure per-

140. Under negligence analysis the predominant issue is disclosure of risks of the proposed procedure. See 3 MAKING DECISIONS, *supra* note 2, at 195; Andrews, *supra* note 85, at 195.

141. Current doctrines are preoccupied most with that information which is least important. This may explain why the doctrine itself is commonly perceived to be rather insignificant. Thus Katz calls it a "Fairy Tale." Katz, *Informed Consent*, *supra* note 15; see also Meisel, *Expansion*, *supra* note 6, at 90 (calling informed consent in 1960's a "paper tiger"). Doctors frequently perceive the legal doctrine to be an albatross. See, e.g., Katz, *Informed Consent: Is It Bad Medicine?* 126 WESTERN J. MED. 426 (1977) (anesthesiologist argues that "informed consent" is useless legal doctrine and that patients complain of being told "too much"). Seventy-nine percent of the public feels that the primary purpose of consent forms is to protect doctors from lawsuits. See 2 MAKING DECISIONS, *supra* note 2, at 160.

142. Given the weakness of present rules regarding disclosure of alternatives, this will typically be the situation. See *supra* text accompanying notes 84-87.

143. As the intervention becomes less like the prototypical surgery, there is a rapid fall-off in perceived need to seek consent. See 2 MAKING DECISIONS, *supra* note 2, at 168, 335. This is true even though medication decisions, for example, may involve greater risks than surgery. See *id.* at 335.

144. 359 So. 2d 1089 (La. Ct. App.), *cert. denied*, 360 So. 2d 1178 (La. 1978).

Protecting Patient Choice

formed; no consent is presently required for the doctor's decision *not* to use the two-step alternative because that decision involved no physical contact. Moreover, despite acknowledged non-disclosure of the alternative,¹⁴⁵ the court upheld a verdict for the defendant even though jury instructions on informed consent made no reference to disclosure of alternatives. Recharacterizing the issue as one of risk, the court held that the risk of a wrong diagnostic outcome was "remote," and thus need not be disclosed.¹⁴⁶

Information about alternative courses of action is different than information about collateral risks. Though remote side effect risks of a single option may be comparatively unimportant, even a slightly greater risk, for example, of unnecessary amputation may be sufficient to cause the patient to choose an alternative. Under current informed consent doctrine, however, protection of the opportunity to choose an alternative may either wholly disappear, as in *Hanks*, or be eroded by the distortions that flow from the negligence interest definition.¹⁴⁷ Thus, even had the court in *Hanks* required disclosure of alternatives, vindication of a breast cancer patient's interest in making the choice between one- and two-step procedures should not depend upon whether doctors typically disclose that information, upon whether reasonable patients would make the same choice as the patient, or upon standardized definitions of physical injury. Yet with regard to nonprototypical choices, that will be the result if only current negligence analysis is employed.

Current doctrine perceives nearly all informational issues to be problems of professional knowledge and duty; negligence has become the ordinary category for analysis of nondisclosure.¹⁴⁸ Thus, when informa-

145. *Id.* at 1091. Even if disclosure is required, some fact patterns involving alternatives may not be characterized as "injury" where the protected interest is physical well-being. See *Masquat v. Maguire*, 638 P.2d 1105, 1106-07 (Okla. 1981).

146. 359 So. 2d at 1093.

147. Cf. *Masquat*, 638 P.2d 1105 (for discussion of case, see *supra* note 133); *Thornton v. Anest*, 19 Wash. App. 174, 574 P.2d 1199 (1978) (for discussion of case, see *supra* note 86). In part, these cases reflect appellate deference to jury verdicts on the basis of norms regarding the judge-jury function. But they also make clear the inadequacy of current legal protection of patient autonomy under existing doctrines.

148. One authority did not succumb to this perception. Professor Plant suggested that nondisclosure of information about the "nature and character" of proposed treatment should trigger a claim for battery, while information about collateral risks could be adequately treated under negligence. Plant, *Analysis*, *supra* note 27, at 648-50 (correlating different types of nondisclosure with different legal actions). The suggestion, however, has not been widely followed. Professor Plant himself later observed that "[u]ltimately almost all informed consent cases came to be treated as falling in the negligence area." Plant, *Decline*, *supra* note 30, at 92. An occasional court picked up the distinction, see, e.g., *Hales v. Pittman*, 118 Ariz. 305, 309, 576 P.2d 493, 497 (1978); *Gaston v. Hunter*, 121 Ariz. 33, 57, 588 P.2d 326, 350 (Ct. App. 1978), but their efforts have had little effect. Indeed, it is not likely coincidental that the jurisdiction whose courts incorporated this approach became the first to adopt a statute abolishing actions for medical battery. See ARIZ. REV. STAT. ANN. § 12-562 (Supp. 1979).

Moreover, Plant's approach still assumes that important choices will involve physical touching. The

tional gaps in the protection accorded to choice have been perceived at all, they have been "corrected" by expanding the scope of the duty to secure informed consent.¹⁴⁹ The narrow disclosure-of-alternative-treatments approach or the broader *Gates*-type extension of informed consent¹⁵⁰ would bring more information concerning such decisions to the attention of the patient than do other formulations of the duty to secure informed consent. But the solution is less than adequate. The protection offered to patient autonomy under the informed consent doctrine is weak, distorted by an analysis rooted in the standard negligence interest definition. Although such analysis arguably provides adequate vindication for choice interests regarding collateral risk information, it is difficult to justify when it constitutes the sole protection accorded to patient choices regarding entire courses of action (or inaction). Yet that will be the result where battery/consent requirements are not triggered because no touching is proposed.

Only a few states have even extended the doctrine of informed consent to impose any duty of disclosure in circumstances that involve no physical contact.¹⁵¹ Others have actually moved in the opposite direction: They have abolished all actions for medical-care battery, leaving only a negligence action to protect all aspects of patient choice.¹⁵² Such a policy does nothing to correct existing weaknesses of negligence doctrine; at the same time, it deprives even those instances of choice that do involve physical contact of any vindication other than that available under negligence doctrines. The move to abolish battery seems to be an outgrowth of legitimate frustration with certain aspects of the intentional tort analysis. Yet it may also derive from an uncritical assumption that if negligence/informed consent analysis seems to be doing an adequate job with some aspects of patient choice protection, it may legitimately be applied to all aspects. Such a conclusion is seriously mistaken. If that mistake is not corrected, and some better approach to the problem put forth, the move to abolish medical battery actions might expand, further undermining the limited protection the law currently accords to patient autonomy.

types of information under discussion here are not easily characterized as being about the "nature and character" of a proposed intervention.

149. This is the result, for example, of an expansion to cover prescription of drugs, to require disclosure of alternative treatments, or more broadly, to require disclosure of important information, as the Washington court did in *Gates*.

150. See *Gates v. Jensen*, 92 Wash. 2d 246, 595 P.2d 919 (1979) (en banc). For further discussion of this case, see *supra* text accompanying notes 88-101.

151. See *supra* Part II(B)(1)(b).

152. See, e.g., ARIZ. REV. STAT. ANN. § 12-562 (Supp. 1979).

III. TOWARD GREATER PROTECTION OF PATIENT CHOICE

A. *Factors Strengthening Patient Choice*

In the case law, two factors seem to strengthen patient claims to information and choice. When there is a relatively crystallized conflict of interest, or when there is a recognizably heightened electiveness, the protection accorded to patient autonomy is likely to be stronger than it would otherwise be. Although neither factor has been clearly articulated or consistently applied, each can be discerned as an emerging influence.

1. *Conflict of Interest: Disqualifying the Doctor*

The principal conflict of interest within the doctor-patient relationship derives from the fact that doctors' incomes rise when patients consume health care services that those same doctors recommend and provide.¹⁵³ While that issue is frequently implicit in conflicts about care, it is rarely raised in litigation, presumably because most patients have only an indirect economic stake in the health care they receive.¹⁵⁴ In a few areas, however, litigation raising clear problems of conflict of interest does arise.

a. *Expansion of Battery Doctrine*

Only one court has accepted a battery theory as applicable to the prescription of drugs.¹⁵⁵ Although the holding in *Mink v. University of Chi-*

153. Although the incentive to over-service is somewhat reduced because many doctors are paid according to time expended rather than procedures performed, this is not true of some specialists. For example, surgeons are paid mainly when patients accept their recommendations. This relatively direct conflict of interest may partly explain why patient choice is most aggressively protected under battery's consent requirements in surgical cases. Moreover, the potential pharmaceutical, hospital, or laboratory profits that are available to doctors greatly undermine the effectiveness of the payment-for-time concept in offsetting the conflict of interest. See Relman, *Dealing With Conflicts of Interest*, 313 NEW ENG. J. MED. 749 (1985) (expressing concern that doctors' entrepreneurial profit-making desires weaken both professional ethics and public trust). The concept also does not remove doctors' economic incentives to recommend time-use itself.

154. Despite their indirect stake in, for example, insurance premiums, patients are not the most obvious financial losers when excess care is provided. Few patients file suit alleging only that they were given more care than they needed, i.e. that they paid for unnecessary care. See *Salis v. United States*, 522 F. Supp. 989, 994-96 (M.D. Pa. 1981). The main objectors to such care would be third-party payors. These organizations tend to pursue political and market methods of cost control. See Blumstein & Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849, 856-59, 863-64 (1981); Havighurst, *Competition in Health Services: Overview, Issues and Answers*, 34 VAND. L. REV. 1117, 1123 (1981). Moreover, since the main conceptual structure of physician accountability is professional competence rather than patient (or indirectly, payor) choice, over-care will rarely be negligent, though it may constitute a violation of patient choice.

155. Several courts have applied negligence theories of informed consent to drug prescription. See, e.g., *Hamilton v. Hardy*, 37 Colo. App. 375, 549 P.2d 1099, 1104-05 (1976); *Trogun v. Fruchtmann*, 58 Wis. 2d 596, 592-604, 207 N.W.2d 297, 307-15 (1973). At least one case holds drug prescription to be strictly a therapeutic decision, requiring no disclosure to or consent by the patient. See *Malloy v. Shanahan*, 280 Pa. Super. 440, 421 A.2d 803 (1980).

*icago*¹⁵⁶ was unusual, the federal district court apparently decided that only battery, from among existing doctrinal tools, provided sufficient protection to these patients' autonomy in the face of their doctors' conflict of interest.

During their prenatal care, the *Mink* plaintiffs were administered DES pursuant to a research experiment evaluating the effectiveness of the drug. Suing under both battery and negligence theories, plaintiffs claimed injuries from the increased risk of cancer to their daughters and from personal emotional distress arising from this threat to their children.

As noted in Part II, the application of battery analysis to these facts would ordinarily have been questionable on several grounds.¹⁵⁷ Although pills may have serious physical consequences, prescribing them does not involve the kind of touching traditionally associated with battery. Moreover, the plaintiffs had consented to prenatal care. Under prevailing standards,¹⁵⁸ miscarriage prevention would seem to fall within the ordinary scope of prenatal care; the fact that patients voluntarily ingested the pills would also typically have constituted consent.¹⁵⁹ Yet when the plaintiffs' claim was characterized as one alleging professional negligence, it failed. Even if nondisclosure were found to violate medical community standards, a questionable matter at best, the plaintiffs alleged no injury cognizable under negligence doctrine.¹⁶⁰

Thus under existing medical consent law, the plaintiffs in *Mink* were trapped between the absence of unconsented touch on the one hand and the lack of injury to physical well-being on the other. Yet the court sensed an injury to patient choice that it was unwilling to ignore; it accepted a

156. 460 F. Supp. 713 (N.D. Ill. 1978).

157. See *supra* note 45.

158. The court itself stated the Illinois standard for battery to be a "total lack of consent by the patient." 460 F. Supp. at 717 (footnote omitted).

159. Exactly what the patients were told is a matter of some uncertainty. According to Mark Debofsky, of the office of the plaintiffs' attorney, various plaintiffs testified that doctors told them, "I want you to take these pills to help you through your pregnancy," "I want you to take these vitamins." Mr. Debofsky did not feel that the court's acceptance of the battery claim was premised on affirmative misrepresentation. Telephone interview with Mark Debofsky (Oct. 1984).

160. 460 F. Supp. at 720. Cf. *Rogers v. Okin*, 478 F. Supp. 1342, 1388 (D. Mass.) (no injury under negligence/informed consent because patients have not yet developed tardive dyskinesia, the primary risk/side-effect of medications they were forced to take), *aff'd in part, rev'd in part on other grounds*, 634 F.2d 650 (1st Cir. 1979). The inability to recover under negligence concepts of harm is a common thread in *Mink* and *Rogers*. The *Rogers* court's award of injunctive relief against forced medication based on constitutional grounds is analogous to the acceptance of a battery characterization in *Mink*: Each provided vindication for the patients' interests in choice independent of the definitions and standards of professional negligence. Given the *Rogers* court's constitutional holding, in which it explicitly stated that the competence of the professional recommendation was not sufficient to overcome or satisfy the patients' privacy right to refuse forced medication, it is theoretically though not pragmatically surprising that the court rejected a battery action and held that, although an informed consent action might be appropriate, it would be judged by standards of professional practice. *Id.* at 1387.

Protecting Patient Choice

battery characterization of the nondisclosure in *Mink* rather than allow that injury to go unredressed. The court set aside the absence of physical contact, stating that “[t]he gravamen of a battery action is the plaintiff’s lack of consent, not the form of touching.”¹⁶¹ It also determined that the issue regarding consent was sufficient to go to the jury under a battery theory.

In explaining its decision, the court referred to performance of “substantially different acts.”¹⁶² The description seems inapposite, however, for it is not the *acts* that were different. Rather, the essential complaint in *Mink* was that the patients were not given crucial information before consenting. Although nondisclosure about medication is typically analyzed, if at all, as an issue of professional negligence,¹⁶³ the particular nature of this undisclosed information caused the *Mink* court to deviate from that pattern. What the doctors did not disclose was their research purposes.¹⁶⁴ Although the court does not use the term “conflict of interest,” that seems the essential framework from which its decision derives.

A doctor’s specialized knowledge and powerful role make her a fiduciary to those who depend on her. Consequently, the doctor owes undivided loyalty to her patients.¹⁶⁵ This duty of loyalty constrains and legitimates whatever power the doctor has to advise or act on behalf of the patient. In *Mink*, however, the doctors’ judgments were potentially influenced by research motivations. This violation of the doctor’s fiduciary obligation of loyalty increased the court’s concern that the dependent patient have the opportunity to control decisions.¹⁶⁶ Typically, where conflict of interest is

161. 460 F. Supp. at 717 n.4. The court observed that if the medicine had been administered by injection, touching would have been present. *Id.* at 718.

162. *Id.* (emphasis added).

163. See *supra* note 155. Certainly omitting to tell patients the content of a drug is common, see 2 MAKING DECISIONS, *supra* note 2, at 334, and such omission is not perceived as subjecting a doctor to liability. Failure to disclose side effect risks is treated as an issue of professional negligence.

164. Thus it is not the nature of the doctors’ medical intervention that is at issue but their *motivation* for intervening.

165. RESTATEMENT (SECOND) OF AGENCY § 387 (1957).

166. See RESTATEMENT (SECOND) OF AGENCY § 390 comment a (1957). *But see* *Burton v. Brooklyn Doctors Hosp.*, 88 A.D.2d 217, 452 N.Y.S.2d 875 (1982), which held that researching doctors were negligent in subjecting a premature baby to an experiment involving usage of high quantities of oxygen that eventually blinded the baby. Incompetent care, together with occurrence of injury cognizable under negligence analysis, rescued *Burton* from the problem faced by the court in *Mink*; there was no discussion of battery here. The court’s analysis of disclosure, however, was seriously flawed. The court reversed a jury verdict of negligence against the treating doctor for not disclosing the experimentation by his colleagues, about which he knew, to the baby’s parents. In so doing, it stated that the doctor did nothing wrong. It concluded that because “no evidence was offered of any continuing obligation on his part to obtain informed consent once his order was countermanded by a superior, the verdict against him based on failure to obtain informed consent cannot stand.” *Id.* at 227, 452 N.Y.S.2d at 881–82. Although it is correct to say there was no incompetent *care* by this doctor, dismissal of the disclosure issue seems wrong. The court’s “no evidence” characterization is puzzling, because it stated that the hospital imposed on the treating doctor the duty of informing parents, and that he testified that he could not remember informing them. *Id.* Although here the loss

involved, even a showing of competence is insufficient to immunize a fiduciary from liability.¹⁶⁷ A fiduciary must not only justify the substantive adequacy (the competence) of the transaction, but must also disclose it and seek the agreement of the client.¹⁶⁸ The *Mink* court's acceptance of a battery characterization is what prevented either the presence of professional competence or the absence of an injury to physical well-being from immunizing the conduct of the doctors.

The *Mink* decision demonstrates circumstances that call for stronger vindication of patient choice. It suggests the needed transition from physical parameters of consent toward a more intangible notion of medical choice. Furthermore, it transcends the dichotomy that places basic consent under battery doctrine while assigning issues of disclosure to negligence theory. Finally, it reveals that guaranteeing professionally competent care of physical well-being does not sufficiently safeguard patient autonomy.

b. *Application of General Fiduciary Principles*

When medical intervention leads to harm, the doctor who may be guilty of malpractice and does not wish to disclose pertinent facts has interests that directly conflict with those of the patient.¹⁶⁹ Such situations do not lend themselves to a *Mink*-type battery analysis. Some courts, sensing the underlying conflict, have achieved a similar result by analyzing these issues of disclosure under general principles of fiduciary duty. The duty to disclose for purposes of informed consent is a specific instance of such a fiduciary duty,¹⁷⁰ yet, for several reasons, a generic fiduciary duty to dis-

could be laid on other more culpable defendants, the court's analysis of nondisclosure leaves much to be desired. Again, the inadequacy stems in part from a refusal to examine disclosure in non-prototypical situations.

167. See RESTATEMENT (SECOND) OF AGENCY § 381 comment d (1957). A conflict of interest might, of course, cause the doctors to provide a level of care that falls below the professional standard of competence. If so, they would be liable for the results of that incompetence. There was no contention in *Mink* that the doctors had provided incompetent care at the time the drugs were administered. At the time, DES (a man-made estrogen) was widely prescribed as a miscarriage preventive. Note, *DES and a Proposed Theory of Enterprise Liability*, 46 FORDHAM L. REV. 963, 964 & n.4 (1978). The FDA did not withdraw DES from the market until 1971. *Sindell v. Abbott Laboratories*, 26 Cal. 3d 588, 594, 607 P.2d 924, 925, 163 Cal. Rptr. 132, 133, cert. denied, 449 U.S. 912 (1980).

168. Where an agent, even with the knowledge of the principal, acts on the agent's own account in a transaction, that agent "has a duty to deal fairly . . . and to disclose . . . all facts which the agent knows or should know would reasonably affect the principal's judgment, unless the principal has manifested that . . . he does not care to know them." RESTATEMENT (SECOND) OF AGENCY § 390 (1957). The limitation implied here by the qualifier "reasonably" is not nearly so restrictive as the reasonable person causation standard employed in informed consent cases: The actual individual client remains the decisionmaker, and the "unless" clause clearly tilts the requirement in favor of disclosure. Another analogy may be drawn from lawyer-client relations. See MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.7(b) (1982) (requires both adequate representation and disclosure/consent).

169. See Delgado & Vogel, *supra* note 69, at 52 (proposing duty on all members of medical team to disclose any malpractice they have witnessed).

170. *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972),

Protecting Patient Choice

close sometimes more effectively vindicates patient interests in autonomy than do the narrower duties that have crystallized under ordinary rules of medical consent.

Fiduciary responsibilities are imposed in order to regulate relationships marked by dependency and disparity of power.¹⁷¹ Although technical expertise is the main reason a power inequity exists, such expertise is not the sole measure of the fiduciary's responsibility. Where the possibility of conflict of interest exists, the fiduciary's accountability for disclosure and accountability for competence are separate and cumulative, not alternative. Thus, analysis under general fiduciary principles is less likely than analysis under informed consent doctrines to narrow the obligation of disclosure or to confuse the issues of patient choice with those of professional competence.¹⁷²

For example, where there is failure to disclose in the aftermath of a medical intervention, no proposal to touch or treat is made, and thus battery doctrine will not protect patient autonomy. The absence of proposed physical contact could also mean that no disclosure would be required under rules of informed consent.¹⁷³ Yet conflict of interest may trigger analysis under general fiduciary principles, requiring disclosure of all information that might be material to the patient.¹⁷⁴ Unlike the duties specified under battery or informed consent doctrines, such a duty has no limitation based on time or stage of treatment. It is triggered not by physical contact, but by the more flexible and general criterion of possession of relevant information.¹⁷⁵ Thus, under fiduciary principles, where malpractice has likely occurred, nondisclosure of the relevant facts may be remediable in an independent cause of action,¹⁷⁶ or may provide plaintiff a reason to toll the statute of limitations in a malpractice action that would otherwise be barred.¹⁷⁷

draws on this earlier and broader concept of fiduciary duty to impose the specific informed consent duty.

171. See Frankel, *Fiduciary Law*, 71 CALIF. L. REV. 795 (1983) (emphasizing control of discretionary and unequal power as common theme in fiduciary law).

172. But see Delgado & Vogel, *supra* note 69, at 67 (noting that, although doctors are frequently characterized as fiduciaries, duties of disclosure imposed on them have been less extensive than those imposed on other fiduciaries). Outside of conflict of interest, fiduciary law, too, exhibits some ambivalence about the role of professional standards. See *infra* note 187.

173. See, e.g., cases cited *supra* Part II(B)(1); see also Delgado & Vogel, *supra* note 69, at 69-71 (noting limited scope of informed consent duties).

174. See *Nixdorf v. Hicken*, 612 P.2d 348, 354 (Utah 1980) (duty to disclose applies to material information).

175. Such a standard is like the one developed in *Gates v. Jensen*, 92 Wash. 2d 246, 595 P.2d 919 (1979) (for discussion of case, see *supra* Part II(B)(2)).

176. See, e.g., *Nixdorf*, 612 P.2d at 352 n.7.

177. Some courts impose an affirmative duty under which mere silence is tantamount to concealment. See, e.g., *Stafford v. Shultz*, 42 Cal. 2d 767, 270 P.2d 1 (1954). Other courts require active misrepresentation or silence regarding a known certainty before tolling the statute. See, e.g., *Nardone v. Reynolds*, 333 So. 2d 25, 34-40 (Fla. 1976).

Moreover, once a duty of disclosure is imposed under general fiduciary principles, there may be less tendency at other stages of the analysis to confuse the patient's interest in the information with issues of competent physical care.¹⁷⁸ Thus, expert testimony may be less likely to be required to establish the standard of care,¹⁷⁹ and defenses might be more narrowly drawn.¹⁸⁰ As in battery analysis, factual cause will tend to be presumed; no inquiry will likely be made regarding what a reasonable person would have done had the disclosure been made.¹⁸¹ Remedy for a breach of fiduciary duty in circumstances involving conflict of interest may also be broader than if the action were one in ordinary negligence.¹⁸²

Despite their tendency to broaden liability and remedy, however, several factors limit the capacity of general fiduciary duties to resolve problems identified here. First, a relatively crystallized conflict of interest may be necessary before courts decide that such principles should apply. If even the conflict of interest inherent in situations of alleged malpractice

178. *But see Nardone*, 333 So. 2d 25. The plaintiffs urged that doctors' nondisclosure of a possible cause of their son's deteriorated condition after brain surgery should toll the statute of limitations in their action for malpractice. The plaintiffs knew of the boy's condition but not why he had suddenly become worse. They were informed only that "these things happen." *Id.* at 29. The court held that the doctors had no affirmative duty to disclose their speculations as distinct from their certainties regarding causes. *Id.* at 39. Given the prevalence of uncertainty in medical knowledge, this distinction places severe constraints on the affirmative duty to disclose. *See also infra* text accompanying notes 215-31. *Nardone* illustrates that even the taint of fiduciary conflict of interest will not always be sufficient to cause a court to strengthen the protection it gives to patient autonomy.

179. Where disclosure of possible malpractice is at issue, the physical injury arises because of allegedly incompetent care, but the legal problem regarding *disclosure* of the harm has nothing to do with professional expertise. This may be more easily recognized in these cases because, intuitively, outcome disclosure is less likely than pretreatment disclosure to be characterized as a question of professional competence. *But see Lopez v. Swyer*, 115 N.J. Super. 237, 251, 279 A.2d 116, 124 (1971) (employing medical community standard of disclosure despite issue of possible malpractice).

The issues of standard of care here may simply parallel the debate over the standard of care in informed consent cases. States that use a reasonable person standard to decide issues of informed consent are likely to use the same criterion under general fiduciary analysis. Yet the influence probably flows the other way. Awareness of the breadth of fiduciary responsibilities may make a court more likely to choose the lay standard of disclosure even where the context is proposed treatment.

180. For instance, the defense of therapeutic privilege may not apply. Utah's informed consent statute, for example, has such a privilege, UTAH CODE ANN. § 78-14-5(2) (1977), which would presumably not apply where a court invoked the broad duty derived from fiduciary principles in *Nixdorf*, 612 P.2d 348.

181. *See, e.g., Nixdorf*, 612 P.2d 348; *Stafford*, 42 Cal. 2d 767, 270 P.2d 1; *Lopez*, 115 N.J. Super. 237, 279 A.2d 116.

182. *E.g.*, had the court imposed a duty to disclose facts to the plaintiff in *Kelton*, 413 A.2d 919, she might have recovered damages flowing from deprivation of her interest in making decisions not only about possible medical intervention, but also about litigation, possible adoption, etc. *See supra* text accompanying notes 66-71.

Delgado and Vogel discuss injuries that may result from nondisclosure of malpractice that are different from those arising from the malpractice itself. Economic harm in particular may be more easily recognized where the conceptual framework is one of general fiduciary responsibility rather than disclosure in the context of treatment per se. Delgado & Vogel, *supra* note 69, at 89; *see also Hart v. Browne*, 103 Cal. App. 3d 947, 163 Cal. Rptr. 356 (1980) (lost opportunity to file malpractice action because of negligence of doctor advising about whether another physician was guilty of malpractice).

Protecting Patient Choice

does not always trigger a duty to disclose,¹⁸³ general fiduciary principles would probably be ineffective to generate more aftermath disclosure where malpractice is unlikely.¹⁸⁴ Yet even where no malpractice judgment would be likely, doctors possess information that could be vital to their patients.

Second, decisions involving broad fiduciary principles of disclosure have most frequently arisen in the context of requests to toll the statute of limitations. In such cases, the duty to disclose is imposed for the limited purpose of removing a technical defense to malpractice. The underlying protected interest is still in some sense the same as that in professionally competent physical care.¹⁸⁵ It is less clear whether such a fiduciary duty of disclosure would be recognized as an independent action—i.e., as protecting an interest in patient knowledge and choice rather than as a reason to remove barriers to redress of injuries resulting from a violation of professional care.¹⁸⁶

Thus, general fiduciary principles can ameliorate limitations on protection of patient choice under existing medical consent doctrines, but such principles are, at present, likely to be invoked only in limited circumstances for limited purposes. A more general fiduciary principle might yet emerge with sufficient coherence and force to solve the problems identified in this Article.¹⁸⁷ In the meantime, principles governing fiduciary conflict of interest have important implications for the protection of patient choice.

183. See *Kelton v. District of Columbia*, 413 A.2d 919 (D.C. 1980) (no duty to disclose scarring of fallopian tubes that occurred during caesarian birth); *Nardone*, 333 So. 2d at 39 (no duty to disclose conjecture about cause of relapse).

184. See, e.g., *Roark v. Allen*, 633 S.W.2d 804 (Tex. 1982) (no duty to disclose factual condition about which doctors made competent but mistaken judgment). But see *Tresemmer v. Barke*, 86 Cal. App. 3d 656, 150 Cal. Rptr. 384 (1978) (duty to warn former patient when later learned of dangers of IUD).

185. Damages in the delayed malpractice action may not be identical to what they would have been had the problem been disclosed at the outset. See *Delgado and Vogel*, *supra* note 69, at 89.

186. One court has recognized an independent action. *Nixdorf*, 612 P.2d 348. Another, without clearly addressing the relevant issues, declined to recognize any independent duty of aftermath disclosure. *Kelton*, 413 A.2d at 922.

187. LeBlang & King, *Tort Liability for Nondisclosure: The Physician's Legal Obligations to Disclose Patient Illness and Injury*, 89 DICK. L. REV. 1, 24–26 (1984), suggest that a broad fiduciary duty of disclosure is already emerging. However, many of the cases they annotate could be grounded on other analyses, such as the duty to provide competent care. Thus, the extent to which such cases really rest on and protect patients' autonomy interests, as the authors claim, is questionable.

Moreover, although a broad fiduciary duty surmounts some problems identified here, it is not immune to others. An agent's duty to "act on behalf of the principal," see *RESTATEMENT (SECOND) OF AGENCY* § 13 comment a (1957), may conflict with his accountability to the control of the principal. *Id.* at §§ 13, 14. In most agency relationships, this tension is resolved by contractual allocation of authority. See *id.* at § 376. But in professional relationships, contract is a weak and rarely used tool. In its absence, achieving adequate control by the principal (in professional settings, the client) is further complicated by incorporation of professional standards of conduct into agency rules. *Id.* at § 379 comment c (discussing obligations of professional agent in traditional agency terms). To the extent that professional standards provide a basis for measuring competent performance, they constitute no problem. To the extent that they become a substitute for control by the client, they present the same difficulties that are inherent in the rules now governing medical consent.

2. *Heightened Electiveness: Empowering the Patient*

Just as conflict of interest sometimes prompts courts to require special choice-protecting disclosure, so a factor that might be called "heightened electiveness" seems to produce more aggressive and independent protection of patient choice. I use the term "heightened electiveness" to denote cases where the special role of personal values or preferences causes a court to have greater than ordinary concern about patient choice. Two types of fact patterns seem presently to be perceived as possessing this characteristic: (1) those involving elective, especially cosmetic surgery; and (2) those involving procreation, including sterilization, pregnancy, and birth. Both cosmetic surgery and birth/procreational procedures are, to a significant degree, optional. No progressive and threatening disease drives the patient to undergo medical treatment. The patient seeks some affirmative outcome instead of warding off an encroaching evil. Furthermore, both types of decisions are recognized as highly personal, involving either the uniqueness of personal appearance or the deep personal values and consequences inherent in procreation and parenting.¹⁸⁸ Where heightened electiveness is present, courts sometimes analyze a case in terms of doctrines other than professional negligence, or alternatively, they may use the framework of professional negligence but adapt it in some fashion that increases the protection afforded to choice.

a. *Analysis Under Contract Principles*

A court may strengthen protection of patient choice by classifying the problem as one of contractual obligation, but few medical cases are analyzed under contractual theories. Those that are so analyzed emphasize the definiteness of the doctor's promise.¹⁸⁹ Although that factor may play a role, it is probably not generally dispositive. The certainty of the doctor's promises in such cases is not markedly greater than that in disputes where contractual analysis is denied.¹⁹⁰

188. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (right to abortion based on constitutional right to privacy); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (access to birth control information protected by constitutional right of privacy). Procreation cases have to a considerable degree been analyzed as situation-specific, and they are indeed unique. However, these cases also illustrate unresolved issues that are generally present in current doctrines protecting choice.

189. See *Depenbrok v. Kaiser Found. Health Plan*, 79 Cal. App. 3d 167, 144 Cal. Rptr. 724 (1978) (patient may recover for breach of contract if doctor clearly promised a particular result); *Guilmet v. Campbell*, 385 Mich. 57, 188 N.W.2d 601 (1971) (allegation of specific, clear, and express promise sufficient to go to jury on contract theory). The critical problem is to distinguish between therapeutic reassurance and binding commitment in a setting of inherent uncertainty. As one annotator has aptly commented, "Despite the statement of some courts that [therapeutic reassurance and contractual promise] are quite distinct, there appears to be a 'gray area' . . ." Annot., 43 A.L.R.3d 1221, 1226 (1972).

190. Thus promises such as "to cure him of bladder trouble," *Marty v. Somers*, 35 Cal. App.

Protecting Patient Choice

The more important factor leading courts to apply contractual doctrines is the electiveness of the medical intervention. A striking number of the cases employing contractual analysis involve cosmetic surgery or procreative choice.¹⁹¹ The choice in these cases is often whether to have medical treatment at all, rather than simply what kind of treatment to choose for a condition that requires some treatment. Although courts ordinarily interpret doctors' positive descriptions of potential outcomes as harmless therapeutic reassurance, they are more willing in cases of elective treatment to believe that the doctor induced the treatment,¹⁹² and accordingly more willing to hold the doctor accountable for her promised results rather than solely for the competence of her efforts.

Under tort law, the patient's interest in choice is analyzed under the rules of battery and informed consent; vindication of choice is often diluted. By contrast, contract vindicates patient choice directly. Injury to expectation is judged from the perspective of the actual patient and encompasses, but is not confined to, physical injury; physical contact is irrelevant; professional competence is not dispositive of duty.

b. *Analysis Under Battery Principles*

Battery doctrine, too, provides greater protection for choice than does negligence analysis. Battery applies where there has been no consent at all.¹⁹³ Decisions about whether a battery theory may be invoked are most difficult where the finding of no consent rests on whether a treatment is deemed to exceed a consent given to some different or lesser procedure. Although fact patterns vary considerably, cosmetic surgery or procreation

182, 182, 169 P. 411, 412 (1917), and that a doctor "could and would cure" an osteopathic problem, *Kershaw v. Tilbury*, 214 Cal. 679, 689, 8 P.2d 109, 113 (1932), have been held not to state a cause of action in contract. A promise to make the patient's hand "100% good," *Wilson v. Blair*, 65 Mont. 155, 177-78, 211 P. 289, 297 (1922) (Farr, J., dissenting), *overruled on other grounds*, *Klemens & Son v. Reber Plumbing & Heating Co.*, 139 Mont. 115, 360 P.2d 1005 (1961), was unenforceable because it was not given for separate consideration, an approach that is merely a different way to defeat a contract characterization. *See also Herrera v. Roessing*, 533 P.2d 60 (Colo. Ct. App. 1975) (doctor's statement that patient would not get pregnant after tubal ligation mere opinion, not contractual guarantee). According to Lane and Hirsh, "Courts will look for 'buzz' words such as 'I guarantee' or 'I promise you,'" before upholding a cause of action in contract. Lane & Hirsh, *The Broken Promise: Physician's Breach of Warranty*, 89 CASE & COM., Sept.-Oct. 1984, at 3, 8.

191. *See, e.g.*, *Depenbrok v. Kaiser Found. Health Plan*, 79 Cal. App. 3d 167, 144 Cal. Rptr. 724 (1978) (promise that tubal ligation would prevent pregnancy); *Sullivan v. O'Connor*, 363 Mass. 579, 296 N.E.2d 183 (1973) (plastic surgery on nose); *Stewart v. Rudner*, 349 Mich. 459, 84 N.W.2d 816 (1957) (promise to perform Caesarian section); *Hawkins v. McGee*, 84 N.H. 114, 146 A. 641 (1929) (plastic surgery on hand). *But see Herrera v. Roessing*, 533 P.2d 60 (Colo. Ct. App. 1975) (statements about tubal ligation did not create contract).

192. *See, e.g., Hawkins*, 84 N.H. 114, 146 A. 641 (relying on repeated solicitations of doctor to uphold contract claim).

193. *See Cobbs v. Grant*, 8 Cal. 3d 229, 240, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972).

cases also stand out among those that allow the battery characterization in such circumstances.¹⁹⁴

c. *Negligence Analysis Under Altered Interest Definition*

Heightened electiveness sometimes causes courts to adapt standard negligence doctrines in ways that strengthen protection of patient choice. Such adaptations are particularly likely to occur in cases involving procreation.

Actions for wrongful birth have encountered multiple analytic difficulties under standard negligence doctrines. When these cases first emerged, courts were extremely reluctant to define the birth of a child,¹⁹⁵ particularly a healthy child,¹⁹⁶ as an injury. When constitutional protection of procreation deflected public policy objections to birth-as-injury,¹⁹⁷ analytic problems came to the fore. The birth of a child, especially a normal child, was difficult to encompass within a definition of protected interest as avoidance of physical injury.¹⁹⁸ If the unwanted child was physically defective, the absence of physical harm might seemingly be finessed, but new

194. In his exhaustive analysis of informed consent cases, Professor Rosoff discusses the circumstances under which a limited consent may be used to validate a more extensive operation. *See* A. ROSOFF, *supra* note 29, at 8-13. As cited by Rosoff, the cases refusing to extend consent include a sterilization, *Wells v. Van Nort*, 100 Ohio St. 101, 125 N.E. 910 (1919), a cosmetic addition to surgery, *Lloyd v. Kull*, 329 F.2d 168 (7th Cir. 1964), and a hip prosthesis, *Cathemer v. Hunter*, 27 Ariz. App. 780, 558 P.2d 975 (1976). By contrast, the cases accepting an extension of consent as valid involved the reduction of a fracture, *McGuire v. Rix*, 118 Neb. 434, 225 N.W. 120 (1929), and an appendectomy and rupture of cysts, *Kennedy v. Parrott*, 243 N.C. 355, 90 S.E.2d 54 (1956). Rosoff specifically mentions that where medical intervention affects reproductive capacity, ordinary rules about extension of consent may not apply. A. ROSOFF, *supra* note 29, at 8-12. For other decisions upholding battery claims for surgery, see *Meretsky v. Ellenby*, 370 So. 2d 1222, 1224 (Fla. Dist. Ct. App. 1979) (tip of nose alteration presents battery claim despite statute deeming written consent sufficient to relieve doctor of liability); *Kinikin v. Heupel*, 305 N.W.2d 589 (Minn. 1981) (breast reduction beyond patient consent constitutes battery); *Bang v. Charles T. Miller Hosp.*, 251 Minn. 427, 88 N.W.2d 186 (1958) (consent to prostate resection does not bar claim of battery where possible severance of sperm cords not disclosed).

195. *Gleitman v. Cosgrove*, 49 N.J. 22, 31, 227 A.2d 689, 693 (1967).

196. *See, e.g.*, *Shaheen v. Knight*, 6 Lyc. Rptr. 19, 11 Pa. D. & C.2d 41 (Lycoming County Ct. 1957); Comment, *Wrongful Pregnancy: Recovery for Raising a Healthy Child*, 10 N. KY. L. REV. 341 (1983).

197. *See* *Boone v. Mullendore*, 416 So. 2d 718 (Ala. 1982); *Cockrum v. Baumgartner*, 95 Ill. 2d 193, 447 N.E.2d 385, *cert. denied*, 464 U.S. 846 (1983); *Christensen v. Thornby*, 192 Minn. 123, 255 N.W. 620 (1934); *Gleitman v. Cosgrove*, 49 N.J. 22, 227 A.2d 689 (1967); *Collins, supra* note 52, at 691-93.

198. *See, e.g.*, *Howard v. Lecher*, 42 N.Y.2d 109, 112, 366 N.E.2d 64, 66, 397 N.Y.S.2d 363, 365 (1977) (parents "were made to bear no physical or mental injury, other than the anguish of observing their child suffer"); *Hickman v. Myers*, 632 S.W.2d 869, 870 (Tex. Ct. App. 1982) ("A parent cannot be said to have been damaged by the birth and rearing of a normal, healthy child."). In significant part this concern is discussed as a problem of damages—their intangibility, their uncertainty, and the difficulty of balancing benefits and burdens. *See, e.g.*, *Public Health Trust v. Brown*, 388 So. 2d 1084, 1085-86 (Fla. Dist. Ct. App. 1980) ("[T]he intangible but all-important, incalculable but invaluable 'benefits' of parenthood far outweigh any of the mere monetary burdens involved."); *Rieck v. Medical Protective Co.*, 64 Wis. 2d 514, 518, 219 N.W.2d 242, 244 (1974) ("Every child's smile, every bond of love and affection, every reason for parental pride . . . [T]hese are intangible benefits, but they are nonetheless real.").

Protecting Patient Choice

analytic problems arose. It was hard to view the child's physical defect as a harm to the parent,¹⁹⁹ yet parents often brought suit on their own behalf, alleging breach of duties owed to them.²⁰⁰

Delineations of duty also derive from definition of interest. It was easier to tolerate the unusual nature of the injury involved in these cases if the breach was of a duty that was familiar to negligence doctrine. Such a duty might be an ordinary one of competent care, breached, for instance, by a botched procedure or misdiagnosis.²⁰¹ Or it might be a duty of disclosure stemming from the subsidiary choice interest under informed consent, breached for instance, by a failure to disclose risks.²⁰² Where, however, not only the injury but the duty as well was unusual, it was doubly difficult for a court to recognize this cause of action.²⁰³

One court solved these analytic problems in a procreation case by redefining the protected interest from physical well-being to an intangible concept of choice. *Berman v. Allen*²⁰⁴ spoke of the plaintiff's injury as one of being "deprived of the option of making a meaningful decision as to whether to abort the fetus."²⁰⁵ There is little difficulty in recognizing the birth of either a healthy or a defective child as an injurious consequence if the protected interest is choice. Further, such a formulation easily recognizes parents as plaintiffs in their own right. The redefinition of protected interest also allowed *Berman* to impose a rather unusual duty. In circumstances similar to those in which the court in *Karlsons* found no such duty,²⁰⁶ the *Berman* court recognized an obligation to preserve the parents' choice by informing them about the availability of amniocentesis

199. See *Howard v. Lecher*, 42 N.Y.2d 109, 112, 366 N.E.2d 64, 66, 397 N.Y.S.2d 363, 365 (1977). Capron, *supra* note 52, at 642, effectively critiqued the treatment of parents as bystanders.

200. For a list of cases, see Collins, *supra* note 52, at 693-95 nn.81-84.

201. One of the first cases to allow recovery for the birth of a healthy child was *Custodio v. Bauer*, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967), in which a negligent surgical sterilization failed to prevent pregnancy. See *Troppi v. Scarf*, 31 Mich. App. 240, 187 N.W.2d 511 (1971) (negligent filling of birth control pill prescription resulted in unwanted pregnancy); *Dumer v. St. Michael's Hosp.*, 69 Wis. 2d 766, 233 N.W.2d 372 (1975) (wrongful birth derived from negligent failure to diagnose rubella).

202. See *Harbeson v. Parke-Davis, Inc.*, 98 Wash. 2d 460, 472, 656 P.2d 483, 491 (1983) (health care providers have duty "to impart to their patients material information as to the likelihood of future children's [sic] being born defective").

203. Although in *Karlsons v. Guerinot*, 57 A.D.2d 73, 394 N.Y.S.2d 933 (1977), the court did recognize the parents as appropriate plaintiffs, the only duty the court recognized was that of providing competent physical care. See *supra* text accompanying notes 50-65.

204. 80 N.J. 421, 404 A.2d 8 (1979).

205. *Id.* at 430-31, 404 A.2d at 13. *Harbeson*, 98 Wash. 2d at 478, 656 P.2d at 494, involving a more typical breach of duty—the failure to inform a woman plaintiff of risks involved in becoming pregnant while taking epilepsy medication—uses similar language: "Mrs. Harbeson ought to have been informed in order to intelligently exercise her judgment whether to have further children."

206. Like the plaintiff in *Karlsons*, 57 A.D.2d 73, 394 N.Y.S.2d 933, the plaintiff in *Berman* was in her late thirties at the time of the pregnancy. Both women claimed their doctors had a duty to inform them about amniocentesis in order to determine possible fetal abnormality. In both cases the babies were born with Down's Syndrome.

even though no analysis of informed consent would ordinarily be triggered.²⁰⁷ With choice as the directly protected interest, such a duty of disclosure was both more obvious and more legitimate. The touch-based boundaries of disclosure under informed consent doctrine could be discarded.

Despite its imposition of an unusual duty, *Berman* did not follow its redefinition of interest with an altered standard of care.²⁰⁸ Other courts, however, have altered the standard of care in cases of heightened electiveness. The Iowa Supreme Court, for instance, although acknowledging that it usually employed a medical community standard in cases of informed consent, adopted a reasonable person standard in a case involving a vasectomy.²⁰⁹ It explicitly rested that decision on the elective and personal nature of the medical treatment involved.²¹⁰

Berman's redefinition of protected interest did alter its analysis in another crucial way. Although choice is routinely assessed by an objective standard in informed consent actions where it provides the causal link to physical injury,²¹¹ the *Berman* court used a subjective, individualized standard, asking only what these particular parents would have done.²¹² This individualized approach emerges naturally where choice itself becomes the protected interest.²¹³

Finally, with reference to analysis of damages, *Berman* asserted that because the doctors neither caused nor could have ameliorated the baby's defects, a comprehensive award of tort damages would be out of proportion to defendants' culpability. The court held that the parents could recover damages for emotional distress, but could not recover for the costs of

207. See *supra* Part II(B)(1).

208. It adopted the medical community standard. The court accepted without discussion the plaintiffs' characterization of the issue as one to be measured by "accepted medical standards." 80 N.J. at 424, 404 A.2d at 10.

209. *Cowman v. Hornaday*, 329 N.W.2d 422 (Iowa 1983); *cf.* *Cross v. Trapp*, 294 S.E.2d 446 (W. Va. 1982) (adopting reasonable person standard in case involving male impotence as result of prostate resection). West Virginia previously had no case law or statute governing informed consent.

210. *Cowman*, 329 N.W.2d at 427. In jurisdictions that routinely employ the lay standard in informed consent cases any special impact of the procreation fact pattern is obscured. See, e.g., *Harbeson*, 98 Wash. 2d 460, 656 P.2d 483.

211. See 3 MAKING DECISIONS, *supra* note 2, at 197 (virtually all states employ objective standard of causation).

212. *Berman*, 80 N.J. at 431-32, 404 A.2d at 14. New Jersey apparently has no case or statutory law on causation apart from *Berman*. *Cf.* *Harbeson*, 98 Wash. 2d 460, 656 P.2d 483, which also adopts without comment a subjective analysis of causation in a procreation case. *Id.* at 482-83, 656 P.2d at 494. Washington clearly employs an objective standard of causation in other informed consent cases, making this decision unique to the procreation context. *Cf.* *Steele v. St. Paul Fire & Marine Ins. Co.*, 371 So. 2d 843, 851 (La. Ct. App.), *cert. denied*, 374 So. 2d 658 (La. 1979) (in hysterectomy case involving young woman, court applied objective person standard but used "in the circumstances" provision of the standard to particularize it to an unusual degree to individual plaintiff).

213. The court did not comment on its divergence from the norm of objective causation. It may simply have responded intuitively to the shift it had made in the structure of the action.

Protecting Patient Choice

rearing the child. As a matter of sanctioning policy, the court's decision might be wise, but the assertion that the doctors did not cause the baby's defects is argumentative at best. It is true that the doctors did not cause the baby's defects in the way that professional malpractice might have caused such injuries. By the court's own logic, however, the protected interest here was choice. The doctors *did cause* a deprivation of choice. The culpable conduct was a failure to inform that prevented the parents from being able to choose to terminate the pregnancy. Thus, a more apt phrasing of the court's concern would be that invasion of the parents' interest in competent care was more culpable than invasion of their interest in choice, thereby justifying a difference in damages.²¹⁴ Regardless of whether one agrees with *Berman's* resolution of the damages problem, the issue is appropriately one of policy about sanctioning, rather than one of causal connection. Defining choice as the protected interest helped to clarify the difference; *Berman's* explicit focus on comparative culpability rather than on the existence of injury was a step in the right direction.

B. *The Limits of Professional Competence: Generalization of the Patterns*

Conflict of interest undermines the doctor's claim to authority, and special values or preferences intensify the patient's right to control. If either factor is present, courts may alter the overall classification of the action or shift sub-elements within standard analyses in order more clearly to identify and protect patient choice. These exceptions ought not to be narrowly delimited. The issues are pervasive and the rationale is more inclusive than courts have yet recognized. Individuals and their preferences are inherently unique. Professional competence can provide only limited resolu-

214. *Berman* might be characterized as specifying an additional set of circumstances in which there may be recovery for infliction of emotional distress. It is probably more accurate, however, to describe the court as limiting, for reasons of sanctioning policy, the recovery it is willing to allow for invasion of its newly defined interest in choice. Other courts might prefer different solutions to the problem of determining what extent and type of recovery is appropriate in these cases. A decision to protect choice does not settle difficult issues of sanctioning policy; it merely clarifies the questions. See Collins, *supra* note 52, at 695-700; *infra* Part IV.

The court's decision in *Berman* that emotional distress damages are the only appropriate remedy for this deprivation of choice finds a precursor in *Vara v. Drago*, 24 A.D.2d 888, 264 N.Y.S.2d 660 (1965). In *Vara*, the defendant failed to tell the plaintiff of his discovery, two months before her due date, that her fetus had died. On appeal, the court affirmed an award of damages for mental anguish *only*. Unless these damages are conceived as the result of outrageous intentional conduct, they were unusual, especially in 1965. RESTATEMENT (SECOND) OF TORTS §§ 46-48, 905 comment c (1977). Freestanding emotional distress damages have only recently been accepted in negligence actions. See, e.g., *Molien v. Kaiser Found. Hosp.*, 27 Cal. 3d 916, 616 P.2d 813, 167 Cal. Rptr. 831 (1980). *Vara* can possibly be explained as a variant on the cases having to do with handling of dead bodies, PROSSER & KEETON, *supra* note 18, at 328-30, but the court makes no reference to those cases. More likely, there was some inchoate sense of an injury akin to what I have labeled here as an interest in patient knowledge and choice.

tion of limited questions. The proposition that regulation of professional competence cannot substitute for vigorous protection of patient choice is, then, a matter of general rather than exceptional applicability.

1. *Medical Uncertainty: The Basis of Electiveness*

Implicit in any assumption that competence can adequately substitute for choice is a medical world in which expertise either points in a single direction or, at least, can best choose such a direction from among competing alternatives. Though the idea is comforting, no such world exists.²¹⁵ A moment's reflection will suggest long lists of things medicine does not fully know or understand, from the cause of the common cold to the cure for cancer. Although doctors are trained to present a face of decisiveness to patients, they are often only sure about their uncertainty.²¹⁶

Medical uncertainty destroys the possibility of a single right answer, leaving many answers to compete. Specializations and schools of thought in medicine have strenuous and unresolved differences. In terms of quality of care, traditional malpractice law can assure that a doctor's behavior is proper as judged by the norms of at least one recognized school of thought.²¹⁷ Strictly as a matter of competence regulation, it is fair that a doctor should not be penalized for a careful, good faith recommendation of a given reputable approach to care. Yet conformity to a particular school of thought does not assure that that viewpoint best fits the circumstances and preferences of the patient. Because there is no certainty about who is right, the patient should receive information about divergent views and be allowed to arrive at her own decision.

Moreover, competence regulation does not guarantee the best possible or the most care; doctors are penalized only if they fall below a minimum threshold of reasonable professional behavior, evidenced legally by what the average doctor in good standing in her profession actually does.²¹⁸ Although doctors' knowledge or advice can be appropriately evaluated by reference to what other competent doctors do, questions of how sure one should be about the fact that no skull fracture is present,²¹⁹ that an abor-

215. J. KATZ, *supra* note 7, at 165-206. Professor Katz, himself a doctor, comprehensively documents both the prevalence of uncertainty and doctors' discomfort in admitting it to their patients.

216. "There is no certainty about the available knowledge, but its uncertainty can be specified." J. KATZ, *supra* note 7, at 183-84 (emphasis in original). Medical training forces doctors to present at least an impression of certainty, even in the face of uncertainty. *Id.* at 184.

217. PROSSER & KEETON, *supra* note 18, § 32, at 186-87.

218. *Id.* Prosser notes that while the "averageness" concept refers to professionals in good standing, even "of these it is not the middle but the minimum common skill which is to be looked to." *Id.* at 187. Furthermore, some states still adhere to the locality rule, a further limitation on the standard of care. *Id.* at 164.

219. *Roark v. Allen*, 633 S.W.2d 804 (Tex. 1982).

Protecting Patient Choice

tion is complete,²²⁰ that immature cells in excised tissue do not signal cancer,²²¹ that glaucoma,²²² heart disease,²²³ or cervical cancer²²⁴ is not developing, that a fetus does not have detectable genetic defect,²²⁵ or that a breast is not unnecessarily amputated²²⁶ are not ultimately questions that can be settled by medical expertise. At bottom, they are questions of allocating scarce resources, personal or societal.²²⁷ Expertise per se provides data and experiential wisdom to inform decisions, but it cannot strike the ultimate balance. Like other questions of utility and value, such issues should be referred to the individual who will enjoy the benefits and suffer the consequences of the choice.²²⁸

Both courts and doctors have been quick to accept uncertainty as a justification for flexing and softening the standards of professional competence, and appropriately so. They have been less quick to recognize uncertainty's implications for patient self-determination.²²⁹ Although medical

220. *Stills v. Gratton*, 55 Cal. App. 3d 698, 127 Cal. Rptr. 652 (1976).

221. *Jamison v. Lindsay*, 108 Cal. App. 3d 223, 166 Cal. Rptr. 443 (1980).

222. *Gates v. Jensen*, 92 Wash. 2d 246, 595 P.2d 919 (1979) (en banc).

223. *Keogan v. Holy Family Hosp.*, 95 Wash. 2d 306, 622 P.2d 1246 (1980) (en banc).

224. *Truman v. Thomas*, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980) (en banc).

225. *Karlsons v. Guerinot*, 57 A.D.2d 73, 394 N.Y.S.2d 933 (App. Div. 1977).

226. *Hanks v. Doctors Ranson, Swan & Burch, Ltd.*, 359 So. 2d 1089 (La. Ct. App.), cert. denied, 360 So. 2d 1178 (La. 1978).

227. Societal judgment might, of course, override individual choice, as in the case of scarce resources (e.g., organ transplants), or because of public financing of health care. *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974) (en banc) (failure to test for glaucoma in patients under 40 is negligent despite conformity to professional standard of care), offers one example of a judicially administered societal intervention into the question of how much care/certainty is enough. The practical effect of *Helling* is to demand a standard response by all doctors to all similarly situated patients, and to brand as culpable any professional who fails to make that response. This issue might be better addressed, however, at the level of individual choice, as suggested here. For further discussion of societal considerations, see *infra* text accompanying notes 326-33.

228. There is a reluctance to think of professions in market terms. For a classic description, see, e.g., *Hughes, Professions*, 92 DAEDALUS 655, 657 (1963) (identifying distinctive traits of a profession, including principle of *credat emptor* rather than *caveat emptor*); *Newmark v. Gimbel's, Inc.*, 54 N.J. 585, 258 A.2d 697 (1969) (distinguishing professionals from commercial actors in terms of which legal rules are appropriate for regulation of conduct). This view has hindered awareness of medical care as a service traded for money, or as necessitating active consumer evaluation in order to maximize utility. Recently a great deal more attention has been given to the need for active consumer decision-making and tighter market controls in health care, mainly as a result of concern about rising medical costs. See, e.g., 42 C.F.R. § 476.2-3 (1984) (Department of Health and Human Services regulations requiring disclosure by professional standards review organizations of costs and performance records of medical care providers); *A Special Symposium: Market-Oriented Approaches to Achieving Health Policy Goals*, 34 VAND. L. REV. 849 (1981).

Several major developments in law reflect and support this trend. See, e.g., *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982) (applying antitrust laws to professions); *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977) (analogous case, Arizona Supreme Court rule prohibiting professional advertising held unconstitutional); *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748 (1976) (state statute prohibiting professional advertising by pharmacists held unconstitutional).

229. The Washington Supreme Court's unusually intense awareness of how uncertainty limits the effectiveness of competence regulation (in *Helling* and *Gates*) probably motivated its expansion of protection for choice in *Gates*. See *supra* note 96.

uncertainty heightens the need for professional *advice*, it also strengthens the case for lay *choice*.

Choosing among alternative courses of action implicates individual characteristics of the patient, such as career, age, and gender, as well as personal attitudes and values, from religious belief to risk aversion. A preference for surgical treatment of a back problem or, alternatively, for long-term rest and traction, may depend on the patient's job or lifestyle. A woman's preference for a radical mastectomy as opposed to conservative surgery or chemotherapy may depend more on her body image, age and career than on medically expert knowledge.²³⁰

The elective quality of plastic surgery and the personal character of procreation are easily perceived. Less recognizable is the fact that the uncertainty and diversity of medical opinion necessarily turn much of medical decision-making into an exercise in electiveness. If cost-benefit comparisons (financial and otherwise) are not made by the patient, there is a significant danger that decisions will reflect the doctor's attitudes and values rather than the patient's.²³¹

2. *Conflict of Values: Close Analogue of Conflict of Interest*

The conflict of loyalties in *Mink v. University of Chicago* was crystallized in a way that made recognition of the affront to patient autonomy relatively easy. Conflicts of interest differ from what might be labeled conflicts of judgment or value mainly in terms of the degree to which such

230. For an illustration, see J. KATZ, *supra* note 7, at 90-93, 182-84. Similarly, a woman's preference for separating the diagnostic biopsy from the final surgery may be controlled by her attitudes toward bodily disfigurement and risk aversion. Cf. *Hanks*, 359 So. 2d 1089 (no liability for nondisclosure of possibility of separating biopsy from amputation; breast removed after erroneous diagnosis).

There are countless other examples suggesting the need for a different allocation of authority between doctors and patients. Is it better to exercise or not to? Experts disagree. See *A Warning About the Exercise Experts*, *San Francisco Chron.*, Sept. 14, 1984, at 24, col. 1. The choice may depend more on how vital exercise is to the patient's mental and emotional well-being or to a family's pattern of activities than on purely medical recommendation. What form of birth control is best? The answer may depend on sexual habits more than on medical conclusions about safety or effectiveness. Are coronary artery bypass operations desirable? That could depend on what changes a person is willing and able to make in exercise and stress patterns. Yaeger, *Bettering the Odds: Cardiologists Focus Efforts on Prevention of Heart Attacks*, *Wall St. J.*, July 2, 1984, at 1, col. 1; see also M. MILLMAN, *THE UNKINDEST CUT: LIFE IN THE BACKROOMS OF MEDICINE* 90-151, 217-49 (1978) (discussing medical management of mistakes and the overselling of coronary bypass in the face of its uncertain value). Is it better to take time to do a fluid culture to determine whether antibiotics will be effective against an infant's constant ear infections or to turn immediately to standard drugs? The choice may depend on the weight one places on unknown risks associated with powerful chemicals. Etcetera.

231. J. KATZ, *supra* note 7, at 173-74, describes a doctor whose recommendations in favor of radical surgery rather than more conservative approaches were influenced more by his attitudes toward his father and his mentor than by scientific evidence. For other examples, see *id.* at 131-41, 175-84; Hilfiker, *Making Medical Mistakes*, *HARPERS*, May 1984, at 59. Hilfiker argues that doctors need to accept and have others accept their errors. This is clearly true. It also, however, underscores the need for sharing difficult decisions with the people whose lives depend on them.

Protecting Patient Choice

crystallization is present. Even the best doctor is influenced by various motives, concerns and goals—many of which may not be as benign from the vantage point of patient interests as the medical research in *Mink*. Concerns about income, prestige, and professional independence affect a doctor's recommendations in indirect ways. Even relatively nonselfish factors such as commitments to particular scientific assumptions or medical techniques, as well as personal or professional values, affect the judgments made by doctors regarding the care of patients.

Moreover, doctors as a group are, like other groups, subject to error, to intellectual or professional fashion, to blindspots and myopia. Group-typical behavior is not necessarily either wrongful or incompetent, but neither will it be carefully evaluated by standards of competence that are set by the actual practice of the group itself. Blindspots associated with group characteristics can bend doctors' preferences in ways that differentiate those preferences from those of their patients. For example, doctors as a group are professionally committed to lifesaving. In the past they have tended to interpret "lifesaving" as meaning the maximum extension of biological life. Recently, with demands for "death with dignity," it has become apparent that large numbers of lay persons have different preferences than those that doctors have chosen to implement.²³² Similarly, for years most doctors have been male. As a result, doctors as a group may well have had different preferences about gender-related medical issues such as birth control, procreation, and breast cancer than the population they treated.²³³

232. Public policy concerning the right to die is being reconsidered in light of changing medical facts and social values. As that process advances, disputes about the relative authority of doctors and patients can be expected to increase. In *Bartling v. Superior Ct.*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984), a patient suffering from five serious diseases asked the hospital to remove his life-sustaining apparatus. The hospital refused and the superior court upheld the hospital. Although the decision was reversed on appeal, reversal came after the patient died. More courts are accepting right to die pleas. See, e.g., *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). But see *Bouvia v. County of Riverside*, No. 159780 (Cal. Super. Ct. Dec. 16, 1983) (order denying preliminary injunction against forced feeding). Despite this trend, many people still find themselves in conflict with individual doctors, hospitals and courts over their rights to control decisions about their treatment where death is likely. An estimated five million Americans have made living wills stating their wish not to be artificially kept alive where there is no hope of recovery. Nelson, *Doctors Debate Right To Stop 'Heroic' Effort To Keep Elderly Alive*, Wall St. J., Sept. 7, 1982, at 1, col. 1, 20, col. 2.

233. See generally G. COREA, *THE HIDDEN MALPRACTICE: HOW AMERICAN MEDICINE TREATS WOMEN AS PATIENTS AND PROFESSIONALS* (1977) (tracing effects of male domination of medical profession on health care received by women); B. EHRENREICH AND D. ENGLISH, *COMPLAINTS AND DISORDERS: THE SEXUAL POLITICS OF SICKNESS* (1973) (tracing history of institutional sexism in health care); Morrow, *Women's Health Care and Informed Consent: Who Should Decide What Is Best For Women—Patients or Doctors*, 9 GOLDEN GATE U.L. REV. 553 (1978-79) (discussing factors that have contributed to current problems in women's health care and capacity for change through use of informed consent); Note, *Coerced Sterilization Under Federally Funded Family Planning Programs*, 11 NEW ENG. L. REV. 589 (1976) (discussing effectiveness of regulations guarding against coercive sterilization); Watchorn, *Midwifery: A History of Statutory Suppres-*

Decisions made in a climate of conflicting values or judgments are every bit as consequential to patients as those made when there are conflicts of interest. And it is, after all, the fact that she will have to live with the consequences of the medical choice upon which the patient's claim to authority preeminently rests. As the above examples suggest, there is good reason to be alert to professional advisors' inchoate divisions of loyalty. Indeed, such divisions should be presumed as a given of human nature; the only meaningful safeguard is assurance of the opportunity for patient rather than professional choice.

Not only have some types of conflict been more readily identifiable, some have also been thought more culpable. Conflict of interest has been traditionally viewed as a more serious problem than conflict of value and judgment. The lesson of *Mink*, however, is that there need be no implication of doctor wrongdoing in the narrow sense of that word to justify aggressive protection of patient choice.

In comparison to the crass self-interest of acting to suppress a lawsuit, the conflict of interest in *Mink*²³⁴ was relatively benign, involving research presumably undertaken for the good of society. The comparatively good intentions of these doctors might once have shielded them from criticism.²³⁵ However, sensitivity concerning patient self-determination has increased. The concept of wrong itself has evolved: Wrongfulness here is the illegitimate usurpation of authority. No matter how benign their goals, or how competent their recommendations, the University doctors' research had the potential to distort their decisionmaking.²³⁶ *Mink* allowed the jury to consider, without reference to the constraints of negligence analysis, whether the doctors' substitution of their judgment for that of their patients was permissible.²³⁷

The problem of unjustified paternalism in medicine transcends the

sion, 9 GOLDEN GATE U.L. REV. 631 (1978-79) (tracing legislation affecting the midwife's opportunities).

234. *Mink v. University of Chicago*, 460 F. Supp. 713 (N.D. Ill. 1978).

235. For extraordinary documentation of relatively casual attitudes toward patient consent where the advancement of science is involved, see J. KATZ, *EXPERIMENTATION WITH HUMAN BEINGS* (1972); Boffey, *Medical Experimentation: Everybody's a Critic*, San Francisco Chron., Dec. 2, 1984, at 19, col. 1.

236. Biased decisionmaking is the reason universities and other research organizations funded by the government are now required to conduct extensive institutional review of all research conducted on human beings. *E.g.*, Dept. of Health and Human Services, Regulations on Protection of Human Subjects, 45 C.F.R. §§ 46.101-46.117 (1984). See Robertson, *The Law of Institutional Review Boards*, 26 UCLA L. REV. 484 (1979). In addition, many private hospitals and treatment centers are establishing their own ethics and decisionmaking review procedures. See Kleiman, *Hospital Philosopher Confronts Life's Basic Issues*, N.Y. Times, Jan. 23, 1984, at B1, col. 5.

237. 460 F. Supp. at 717. In the context of bodily contact, differences of judgment and value are presumed and autonomy protected; it is not necessary to demonstrate a conflict of interest in order to justify the patient's right of control. As I have demonstrated, however, current legal doctrines do not adequately protect against unjustified paternalism where only information is involved. See *supra* Part II.

Protecting Patient Choice

boundaries of traditional conflict of interest.²³⁸ The medical profession holds relatively strong ethical and disciplinary ideals proscribing conflicts of interest,²³⁹ but its norms about deference to patient autonomy in instances of conflict of judgment or value are seriously underdeveloped. Moreover, legal analysis of fiduciary and professional responsibility is only gradually becoming attentive to these subtler problems of allocating authority.²⁴⁰ Because contractual arrangements that govern divisions of authority in most commercial agency relationships are all but absent in professional-client settings,²⁴¹ the need for legal rules that establish the limits of professional authority is especially great.

238. See generally J. CHILDRESS, WHO SHOULD DECIDE? PATERNALISM IN HEALTH CARE (1982) (classifying types of paternalism and analyzing when it is unjustifiable in medical decisionmaking).

239. One of the seven Principles of Medical Ethics adopted by the A.M.A. in 1980 states that "a physician shall . . . strive to expose those physicians deficient in character or competence, or who engage in fraud or deception." JUDICIAL COUNCIL, AM. MEDICAL ASS'N, CURRENT OPINIONS at ix (1984) (Principle II); see also *id.* § 4.04 at 14 (requiring physician to disclose ownership in health care facilities); *id.* § 6.03 at 24 (prohibiting fee-splitting). "The symbol of the profession . . . portrays a group whose members have altruistic motivations and whose professional activities are governed by a code of ethics which . . . condemns misuse of professional skills for selfish purposes." Becker, *The Nature of a Profession*, in 2 THE SIXTY-FIRST YEARBOOK OF THE NATIONAL SOCIETY FOR THE STUDY OF EDUCATION 27, 36 (1962).

Although the A.M.A. Code includes general requirements that the physician shall "respect the rights of patients", *id.* at ix (Principle IV), and shall "deal honestly with patients," *id.* (Principle II), Katz traces the long history of nondisclosure and failure to share decisions with patients. J. KATZ, *supra* note 7, at 1-29. Professor Katz notes the direct conflict between the medical norm of "custody" and the legal norm of personal liberty. *Id.* at 2.

240. The doctrine of informed consent in medicine is part of that effort. J. KATZ, *supra* note 7, at 28, points out that the "recent interest in disclosure and consent," following a "history of silence," could not be expected, as yet, to have altered centuries of contrary medical tradition.

Struggles over professional authority and client control have also emerged within the legal profession. See Bell, *Serving Two Masters: Integration Ideals and Client Interests in School Desegregation Litigation*, 85 YALE L.J. 470 (1976); Burt, *Conflict and Trust Between Attorney and Client*, 69 GEO. L.J. 1015 (1981); Spiegel, *Lawyering and Client Decisionmaking: Informed Consent and the Legal Profession*, 128 U. PA. L. REV. 41 (1979); cf. Jones v. Barnes, 463 U.S. 745 (1983) (failure of attorney to honor client directive regarding nature of arguments made on appeal did not deprive client of effective counsel). The new ABA Model Rules of Professional Conduct make a greater effort to deal with the issue of client choice and professional disclosure than either the comparable medical rules or the earlier legal rules. MODEL RULES OF PROFESSIONAL CONDUCT Rule 1.4 (1982). Explanations of the legal background for the model rules refer to the RESTATEMENT (SECOND) OF AGENCY § 381 (1958) as a basis for broad disclosure obligations. See T. MORGAN & R. ROTUNDA, PROBLEMS AND MATERIALS ON PROFESSIONAL RESPONSIBILITY 175, 177 (2d ed. Supp. 1983).

241. RESTATEMENT (SECOND) OF AGENCY § 376 (1958) anticipates that the extent of an agent's authority will be determined by the terms of the agreement between agent and principal. Although the doctor-patient relationship typically originates from a contract, the terms of the relationship are not usually explicitly bargained for. Instead, the professional model has presumed unquestioning client trust, see Hughes, *supra* note 228, at 657, and what courts are fond of calling "abject dependence." See, e.g., Cobbs v. Grant, 8 Cal. 3d 229, 242, 502 P.2d 1, 9, 104 Cal. Rptr. 505, 513 (1972). These presumptions are obviously in conflict with respect for patient consent and control.

c. Conclusion of Part III

Where conflict of interest disqualifies the doctor or heightened elective-ness intensifies the patient's claim to autonomy, courts have acted to overcome distortions and omissions that have plagued existing legal protection of patient autonomy. The rationale for such exceptions needs to be generalized. Professional competence does not satisfy the goals of patient autonomy. Medical uncertainty forces a high degree of election in decisionmaking, and extra-medical values necessarily shape resulting choices. The conflicts of value and judgment that are inherent in all human decision are both consequential and problematic. Thus, preemption of authority in circumstances where competent adults may be consulted regarding their own fate is unjustifiable. Patient choice ought to be a fully and independently protected legal interest.

IV. A NEW INTEREST IN MEDICAL CHOICE

A. *The Interest is Desirable and Congruent with Other Doctrines*

Serious deficiencies exist in the protection presently accorded to patient autonomy. Both as a matter of omission and as a matter of exception, the present doctrinal schema is inadequate and inconsistent. A new model for the allocation of authority between doctors and patients is needed. A patient should be able to avail herself of a doctor's services without depriving herself of the opportunity to control significant care choices.²⁴² Patients should, of course, be free to delegate authority, but such delegation should not be required or presumed. Giving patients control over medical choices would delimit doctors' authority and their responsibility. At the same time, such control implies that new obligations would be placed on doctors to facilitate and defer to patients' choices. To effectuate such a relationship, the direct creation of an independent interest in medical choice would be preferable to the indirect vindication now derived through protection of other, related interests.

Creating direct legal protection for patient autonomy would be consis-

242. The principle of patient control involves a degree of conflict with professional ideology. Doctors are not supposed to be accountable, insofar as professional decisions are involved, to laypersons. Freidson observes that "the most strategic distinction [between professions and non-professions] lies in legitimate, organized autonomy . . . the right to control its own work . . . [P]rofessions are deliberately granted autonomy, including the exclusive right to determine . . . how the work should be done." E. FREIDSON, *PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE* 71-72 (1972). Although the conflict might in theory be resolved by differentiating between the "how" and the "whether" of work, doctors have not traditionally been attentive to such distinctions. See J. KATZ, *supra* note 7, at 30-47. The concern about professional independence is partly directed against organizational control by laypersons rather than against control by individual patients. Even medicine's organizational independence, however, is threatened by increasingly bureaucratic forms of health care delivery and lay-initiated financial controls on medical decisionmaking.

Protecting Patient Choice

tent with other recent legal developments. The legal duty to facilitate patient choice by disclosing information is likely to be construed as an affirmative duty, and perhaps, therefore, to be resisted under common law traditions. Yet the line dividing an affirmative duty from a prohibitive one is largely semantic. The duty to protect patient choice may also be described as prohibitive: It instructs the doctor-agent not to substitute her judgment for that of the patient. Viewed in this light, an interest in choice is similar to intangible interests in personal sanctuary that are already protected by the law.

Constitutional privacy cases often involve medical or medically-related decisions.²⁴³ These cases, involving birth control,²⁴⁴ abortion,²⁴⁵ form of treatment,²⁴⁶ and refusal of care at death,²⁴⁷ stress the importance of individual autonomy. The government interventions that are constitutionally prohibited in medical privacy cases involve interference with *decisionmaking*, rather than physical intrusion.²⁴⁸ Constitutional development is often broadly rooted in common law principles; in this instance the public law is somewhat in advance of the private.²⁴⁹ The intangible decisionmaking focus of the constitutional privacy interest presages the change in private law proposed here.

As a matter of private law, no explicit extension of a privacy interest to medical contexts has yet been attempted.²⁵⁰ But existing tort privacy ac-

243. Factually, these cases may involve either a doctor allied with a patient against the intrusions of the government, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (antiabortion laws), or a doctor allied with the state in seeking to bar a patient's medical choice, e.g., *Andrews v. Ballard*, 498 F. Supp. 1038 (S.D. Tex. 1980) (patient's right to die). They do not directly address the allocation of authority as between the doctor and the patient. Indeed, there is some evidence that the constitutional privacy right has been vested more in doctors than in patients. Asaro, *Judicial Portrayal of the Physician in Abortion and Sterilization Decisions: The Use and Abuse of Medical Discretion*, 6 HARV. WOMEN'S L.J. 51, 51-52 (1983).

244. *Griswold v. Connecticut*, 381 U.S. 479 (1965).

245. *Roe*, 410 U.S. 113.

246. *Andrews*, 498 F. Supp. 1038.

247. See, e.g., *Bartling v. Superior Ct.*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

248. Some of the constitutional decisions are, like their private law analogues, preoccupied with degree of physical intrusion as the way to calibrate patient autonomy. E.g., *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976) (right of permanently noncognitive patient to be terminated from life support systems). But many involve no physical intrusion, e.g., *Andrews*, 498 F. Supp. 1038 (patient's right to choose form of treatment), and most emphasize patient autonomy as the underlying goal, e.g., *Griswold*, 381 U.S. 479 (right to use birth control). A similar transition from physical to intangible definitions of privacy occurred in Fourth Amendment protection of personal sanctuary. *Katz v. United States*, 389 U.S. 347 (1967) (electronic surveillance through phone taps may violate Fourth Amendment even though there was no physical entrance into area occupied by petitioner).

249. Cf. *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979) (for discussion of case, see *supra* note 160), *aff'd in part, rev'd in part on other grounds*, 634 F.2d 650 (1st Cir. 1980).

250. In discussing possible expansion of the tort interest in privacy, Prosser observed the potential connection between constitutional and tort privacy cases. PROSSER & KEETON, *supra* note 18, § 117, at 866-67. He did not comment specifically on medical applications, however. Cf. RESTATEMENT (SECOND) OF TORTS § 652A comment c (1976) (discussing possible connections between constitu-

tions do protect other interests in intangible personal sanctuary, such as reputation or security, from unwanted publicity.²⁵¹ Among presently recognized privacy actions, invasion of a patient's interest in choice somewhat resembles appropriation.²⁵² The tort of appropriation asserts a kind of property interest in one's likeness and name. An interest in medical choice would assert what amounts to a proprietary interest in information possessed by a doctor concerning one's condition, options and fate. The appropriation at issue in medical cases would be usurpation of the decisional authority that depends upon possession of such information.

The opportunity for maximum feasible control of medical fate would certainly seem to be as important an interest as control of name or likeness, reputation or seclusion. Moreover, although government intrusions on privacy may be justifiable as necessary means to fulfill social goals, a doctor's authority derives only from the patient and should extend no further than the patient decrees. Private usurpation of authority, even with good intentions, is culpable.²⁵³

The interest in freedom from emotional distress also has much in common with the interest in medical choice. Both interests protect aspects of personal sanctuary. The physical context of health care choice provides an analogue to the physical injury or proximity to physical danger that many jurisdictions require for redress of freestanding emotional distress.²⁵⁴ In recent years, courts have become less skeptical about the genuineness of freestanding emotional injury.²⁵⁵ Because objections to recovery for emotional distress paralleled the resistance to stronger protection of patient choice, the increased acceptance of emotional injury claims may ease the way for an interest in medical choice.

Although emotional disturbance is one common consequence of depriva-

tional privacy and tort privacy doctrines).

251. Tort privacy doctrines proscribe invasion of what Professor Fleming calls the "more sophisticated" intangible interests. J. FLEMING, *supra* note 129, at 193.

252. *See id.* at 210-11 (discussing appropriation); PROSSER & KEETON, *supra* note 18, § 117, at 851-54.

253. Some privacy torts require extreme offense or outrage to create a cause of action. RESTATEMENT (SECOND) OF TORTS §§ 652B, 652D, 652E (1976) (intrusion upon seclusion; publicity given to private life; and publicly placing person in a false light). *Cf.* Hirsh, *Current Perspectives on the Tort of Outrage*, 87 CASE & COM., Nov.-Dec. 1982, at 9 (discussing application of action to medical patient's rights). But not all privacy actions require extremely culpable behavior. Thus, appropriation need not involve offensive or outrageous conduct. RESTATEMENT (SECOND) OF TORTS § 652C (1976). Moreover, not all privacy disputes involve unmitigatedly antisocial conduct. News professionals sometimes run afoul of privacy strictures although they, like doctors, are presumptively engaged in a socially legitimate enterprise. Likewise, agents who usurp authority of principals are not excused by their good intentions. RESTATEMENT (SECOND) OF AGENCY § 14 (1958). *See supra* Part III(B)(2).

254. These requirements occur mainly where the action is for negligent infliction, or where the emotional injury is to a bystander. *See, e.g.*, RESTATEMENT (SECOND) OF TORTS §§ 46-48, 312-13 (1976).

255. *See* Molien v. Kaiser Found. Hosp., 27 Cal. 3d 916, 616 P.2d 813, 167 Cal. Rptr. 831 (1980) (recovery of emotional damages for husband of woman negligently informed she had syphilis).

Protecting Patient Choice

tion of choice,²⁵⁶ leaving injuries to choice to be redressed only as a subset of the emotional distress action would be inappropriate. Such an approach would ignore the frequency and centrality of physical consequences arising from invasions of patient choice. More important, just as analysis of patient choice under traditional informed consent doctrine defines that interest as a particular species of damage rather than as an interest in autonomy per se,²⁵⁷ subsuming choice under emotional distress would have the same effect. Injury-specific characterizations distort the interest in choice, subjecting it to inappropriate analytic and remedial restraints.²⁵⁸

Analogies to present doctrine may also be found if the protection of choice is understood as imposing an affirmative duty. Although the common law does not readily create such duties, it will do so if the defendant's relationship with the plaintiff makes the imposition of such duties appropriate.²⁵⁹ The medical relationship is founded upon a contract whose substance is caretaking and whose character is fiduciary.²⁶⁰ There seems little theoretical reason to balk at broadened duties of disclosure to protect patients' interest in an informed choice when other affirmative obligations are already imposed on doctors.²⁶¹

Doctors are universally conceded to be fiduciaries; as such they have special duties to serve their clients' interests. Patients have been redefining their interests in the direction of more active participation in decisionmaking.²⁶² In the wake of such redefinition, the nature of fiduciary obligation must also change to stress more advising and less deciding. Even if the doctor is conceded to have some authority as an agent, agency doctrine

256. *E.g.*, *Berman v. Allan*, 80 N.J. 421, 404 A.2d 8 (1979) (recovery of damages for emotional anguish suffered by parents as result of deprivation of opportunity to choose abortion of Down's Syndrome fetus).

257. *See supra* Part II(B).

258. Some limits on recoverable damages for an invasion of choice might be desirable. *See infra* text accompanying notes 294–314.

259. *See PROSSER & KEETON, supra* note 18, § 56, at 373–82; *RESTATEMENT (SECOND) OF TORTS* §§ 314–314B (1976).

260. There are other such relationships to which a duty to enhance choice might theoretically be extended. Lawyers also have contractual and caretaking responsibilities. *See supra* note 240. Yet the underlying concerns of the medical relationship—bodily condition and fate—are ones in which claims to personal autonomy are uniquely compelling. That context seems an appropriate one in which to explore affirmative duties to protect autonomy.

261. Doctors currently may be held liable in tort for several kinds of inaction. Failure to treat can constitute violation of duties of competent care. Failure to disclose risks of treatment may generate liability under informed consent rules. *Cf. Tresemer v. Barke*, 86 Cal. App. 3d 656, 150 Cal. Rptr. 384 (1978) (by virtue of fiduciary relationship doctor obligated to warn former patient about dangers of IUD of which doctor was made aware after treatment of patient).

262. *See 2 MAKING DECISIONS, supra* note 2, at 221–25 (96% of patients want to be told about diagnosis of terminal illness; 94% want to be told everything about their medical condition; and in deciding between aggressive and supportive therapy in terminal cases, 79% of public thought decision should be made by patient; only 24% of doctors agreed and only 19% said such decisions actually are made that way).

emphasizes the agent's accountability to the principal's control.²⁶³ Both agency and fiduciary principles require disclosure by the agent-fiduciary as an obligation independent of the substantive fairness (here competence) of the transaction, especially where there is any possible division of loyalty.²⁶⁴ Particularly with regard to the professions, the call for increased client control over expert-fiduciaries has intensified.²⁶⁵

Even commercial actors who are neither fiduciaries nor professionals are increasingly subject to affirmative duties to disclose. In ordinary contract settings, each party is presumed to be acting in her own interest; yet disclosure may be demanded to enable a weaker party to make more informed decisions. Nondisclosure may create a claim for damages or a defense to enforcement of a contract.²⁶⁶ The trend toward requiring disclosure is strongest when a party has special knowledge or expertise. As imposed in tort law generally, affirmative duties to disclose potential dangers may help to prevent physical injury. But because such duties to warn are not necessarily coupled with a requirement to remove the risk itself, the emphasis on disclosure to enhance plaintiff's choice-making is analogous to the situation here. If a landlord may be required to disclose known crime risks of a neighborhood,²⁶⁷ or manufacturers the possible hazards of a product,²⁶⁸ imposing affirmative duties upon doctors to inform their patients' choices seems readily justifiable.

Although the duties proposed here are in some ways broader than these analogous examples,²⁶⁹ the differences are appropriate. Unlike most product manufacturers and landlords, doctors have a one-to-one relationship with their patients, facilitating personal consultation and discussion. Furthermore, unlike either landlords or manufacturers, doctors have fiduciary and professional responsibility for their patients. Those constraints were traditionally seen as obviating a need for disclosure and deference;²⁷⁰ they provided a basis for trusting the doctor more than the ordinary contractual

263. RESTATEMENT (SECOND) OF AGENCY § 14 (1958).

264. See *supra* note 168.

265. See *supra* note 240.

266. See, e.g., *Obde v. Schlemeyer*, 56 Wash. 2d 449, 353 P.2d 672 (1960) (basis for claim of damages where seller fails to disclose presence of termites in apartment); *Sorrell v. Young*, 6 Wash. App. 220, 491 P.2d 1312 (1971) (rescission available where seller knew of defect, buyer was unaware, and defect was not apparent); *Slater v. KFC Corp.*, 621 F.2d 932 (8th Cir. 1980) (duty to disclose where superior knowledge is not within the reasonable reach of less experienced party); see also RESTATEMENT (SECOND) OF CONTRACTS § 161(b) (1979).

267. See, e.g., *O'Hara v. Western Seven Trees Corp.*, 75 Cal. App. 3d 798, 142 Cal. Rptr. 487 (1977).

268. E.g., *Davis v. Wyeth Laboratories, Inc.*, 399 F.2d 121 (9th Cir. 1968). For a discussion of a causation standard in relation to product liability warnings, see *supra* note 126.

269. Manufacturers have no duty to tell about alternative products, or landlords about alternative buildings, but only to warn regarding the particular product or building they place on the market.

270. See *Becker*, *supra* note 239, at 27 (discussing code of ethics as guarantee of professionals' trustworthiness and altruism).

Protecting Patient Choice

actor. Increasingly, however, the professional's responsibility is viewed not as a mandate to preempt authority, but as a responsibility to educate, and then defer to, the patient's own decisions. Accordingly, that doctors' affirmative responsibility for disclosure should be greater than that of commercial actors is unsurprising.

B. *How The Interest Would Work*

An interest in medical choice could be administered under either contract or tort doctrine. Either analysis would derive the duty to protect the patient's interest in choice from the doctor-patient relationship—one in order to vindicate reasonable expectations, the other in order to protect the substantive value of autonomy itself.

1. *Contract Analysis*

Because patients have been deemed incapable of individual bargaining about expert services, duties undertaken through a contract for professional care have been given content and specificity through negligence policy rather than through contract analysis. I have argued, however, that although patients may be incapable of supervising the quality and administration of care, they are capable, indeed uniquely so, of balancing ultimate costs and benefits of care decisions. Moreover, they are capable of determining the extent to which they wish to allocate decisionmaking authority to their doctors. Thus, the rationale for adopting a standardized tort analysis does not extend to issues of decisionmaking and allocation of authority; these matters could appropriately be analyzed under contract doctrine. Were such an approach adopted, the entire analytic paradigm would be reversed. Rather than invasion of patient choice being one subtype of injury causation within a professional negligence framework, professionally negligent care would constitute one species of breach of contract.

Explicit agreements concerning the general allocation of authority or about specific care choices will likely be honored under either analytic regime. Traditionally, however, patients have not bargained with their doctors about decisionmaking authority. In the absence of explicit agreement, the problem, contractually, would be to imply a reasonable term. How much delegation of authority should be implied?

Current doctrines show courts to be unwilling to deem decisionmaking authority automatically transferred by the act of hiring a doctor.²⁷¹ Be-

271. See *supra* note 139. General contract law also frowns on unilateral decisionmaking that results from disparate power or adhesion contracting. *E.g.*, *Tunkl v. Regents of Univ. of Cal.*, 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963) (invalidating agreement between hospital and entering

yond the existing rules, both as a matter of expectation and reliance, patients today assume that they will be given the opportunity to make decisions if they wish. Anecdotal and empirical evidence suggest that most patients wish to be informed and to participate more actively in the management of their care.²⁷² Indeed, patient dissatisfaction with health care frequently centers on doctors' failure to provide sufficient information and dialogue.²⁷³ However, even patients who wish to exercise choice remain dependent on doctors for information. Although public knowledge about medicine has greatly increased, patients still rely on doctors for education and counsel, particularly about their individual condition and options.²⁷⁴

By contrast, assuming that payment schemes are adjusted to compensate for time spent, doctors themselves have little, if any, legitimate reliance interest in resisting disclosure or in controlling patients' decisions; they certainly have a less intense interest than do patients. Moreover, doctors are already adapting to patients' growing expectations of involvement, making responsibility to disclose to and consult with patients less foreign than it might once have been.²⁷⁵ Even if doctors' expectations about authority differ, they have reason to know, and under contract principles therefore to be bound by, the intent of patients.²⁷⁶ Particularly in their role as fiduciaries, doctors should be held to defer to the expectations and reliance of their patients.

Thus, although express bargaining should be encouraged, where no explicit term is agreed to, patient control of decisionmaking should be the term implied into the contract. Given the tradition of medical paternalism, patients who wish to opt out of such responsibility could easily do so. Those who seek involvement will likely need greater legal protection.²⁷⁷ A doctor could be expected to bargain explicitly for any other pattern of decisionmaking she wished to require.²⁷⁸

patient exculpating hospital).

272. See 1 MAKING DECISIONS, *supra* note 2, at 17; 2 MAKING DECISIONS, *supra* note 2, at 221-24 (results of empirical survey).

273. See Enright, *supra* note 10, at 76, 90 (discussing evidence that high percentage of malpractice suits are in part caused by failure of doctor to establish good communication with patient).

274. See J. KATZ, *supra* note 7, at 227 (speaking on doctor's crucial role as teacher) and 78 (noting need for doctors to respond to patients' individual needs for information).

275. See *supra* note 14.

276. See RESTATEMENT (SECOND) OF CONTRACTS § 201 (1979).

277. See J. KATZ, *supra* note 7, at 1-29 (tracing the history of paternalism in western medicine). For an especially thoughtful series of articles contrasting medical paternalism, legal imperialism, and other alternatives, see Relman, *The Saikewicz Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233 (1978); Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 AM. J.L. & MED. 337 (1978); and Buchanan, *Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling Saikewicz-type Cases*, 5 AM. J.L. & MED. 97 (1979).

278. The danger that doctors would use their power to insist that patients give them broader decisionmaking authority than the patient might wish would be forestalled by three factors: (1) Contracts would be subject to review under principles governing unconscionability, good faith and adhesion; (2) Doctors may actually be relieved to reduce their responsibility for others' fate; (3) Doctors

Protecting Patient Choice

Once the term governing authority is established, contract analysis would be straightforward, though not simple. A patient explicitly or impliedly contracting for maximum disclosure and choice would be deprived of her expectation if the doctor failed to give material information. To put her where she would have been had the contract been performed, it would be necessary to determine the difference in value between where she would have been had she been given information and choice, and where she is now. Because tort analysis of an interest in choice would also require projection and valuation of what a patient would have chosen, this process would, to a substantial degree, parallel the analysis proposed in the next section.²⁷⁹

2. Tort Analysis

Although existing tort approaches are seriously deficient, the weight of tradition may cause tort analysis of these issues to be continued. Tort analysis could provide adequate protection if patient choice became an independent and fully protected interest in its own right. Analysis of an independent interest in choice would differ from existing analyses in a number of ways.

Duties involving disclosure of knowledge lend themselves to analyses of intentional conduct. Where a defendant has fiduciary and contractual responsibility to a plaintiff, and has primary access to information essential to the plaintiff's recognition and exercise of choice, the defendant must know that failure to disclose that information is substantially certain to cause invasion of the plaintiff's interest. On the other hand, because the doctor typically claims other justifications for nondisclosure and has no specific intent to harm, the simpler and more punitive assumptions frequently applied to intentional torts seem inappropriate to most situations of medical nondisclosure. Privacy torts encompass both negligent and intentional conduct without being confined to one or the other,²⁸⁰ and this approach would also be appropriate for patient choice.

A duty to disclose would be triggered by the possession of information

are increasingly having to compete for health care dollars. Patients wishing more authority in decisionmaking are likely to have the bargaining power to achieve that goal.

279. In *Gates*, for example, where the patient became blind, she probably would not have lost her sight had she opted for further testing. To assess her loss under contract theory, her expectation should be determined by figuring the value of sight, discounted both by the possibility that she might not have undertaken the additional tests and by the projected outcome of having the tests, offset by any value there is in being blind. Calculation of damages based on prediction of probabilistic outcomes has been undertaken in contracts cases, e.g., *Locke v. United States*, 283 F.2d 521 (1960) (projected share of business); *Rombola v. Cosindas*, 351 Mass. 382, 220 N.E.2d 919 (1966) (projected winnings of racehorse). For a discussion of damages under the tort theory, see *infra* text accompanying notes 294-314.

280. See RESTATEMENT (SECOND) OF TORTS §§ 652A-652E (1976).

important and relevant to the patient, rather than by a proposal to touch. This approach would reverse the relationship between information and choice that is created under current doctrine. At present, the requirement of consent determines the necessity of disclosure. Because, however, choice arises out of and depends upon knowledge and reflection, the essential point of access must be knowledge itself.²⁸¹

Where disclosure is triggered by touching, occasions for performance of the duty are rather clearly defined. Although a duty to disclose based upon possession of knowledge per se might seem comparatively unbounded,²⁸² it would not be as unlimited as it might seem. As a function of their existing responsibilities for care, doctors already have the knowledge needed to carry out this proposed new duty.²⁸³ The doctor's duty to know would continue to be regulated in present fashion as a matter of professional competence.²⁸⁴ At issue in relation to an interest in choice would be what the doctor must disclose of what she does know.

Certainly the duty would not be to disclose all that the doctor knows, but only what is materially relevant to the patient at the time of the disclosure. The doctor should affirmatively offer the following information: (1) material clinical observations or test results that describe the condition of the patient at any stage of care; (2) interpretation of this information by the doctor and her advisers, including material judgments and conclusions based on the data; and (3) material possible responses that the patient might elect in light of the information and the possibilities known to the doctor. In each aspect of the duty, "material"²⁸⁵ must be understood to

281. The importance of proper disclosure of information is heightened by the fact that the same information that would allow the patient to control medical choices would also permit her to make other personal choices that depend on her understanding of her medical condition.

282. Even under the earlier rule, courts worried about imposing a duty that would make it necessary to give patients a medical education. *See, e.g., Canterbury v. Spence*, 464 F.2d 772, 782 n.27 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

283. Because doctors are uniquely (both in the sense of "well" and in the sense of "exclusively") situated to provide information vital to patient choice, the duty to avoid the costs of nondisclosure should be placed on them. *See generally* G. CALABRESI, *THE COSTS OF ACCIDENTS* (1969) (presenting theory of cheapest cost avoidance as most appropriate method of allocating cost of accidents).

284. Lack of knowledge, however, would be more exposed under the proposed rule than under the present one. *See infra* note 289.

285. Useful work has already been done to define the concept of materiality for purposes of determining the scope of medical disclosure. The concept of materiality under informed consent doctrine inversely relates probability and seriousness: Even relatively remote possibilities may have to be disclosed if their consequences are very serious. *See, e.g., Canterbury v. Spence*, 464 F.2d at 788.

Waltz and Scheuneman originally proposed the test of materiality and attempted to define it. Waltz & Scheuneman, *supra* note 30, at 638-41. *See also* Halligan, *The Standard of Disclosure by Physicians to Patients: Competing Models of Informed Consent*, 41 LA. L. REV. 9 (1980) (discusses tort of deceit as antecedent upon which courts have relied in developing medical disclosure rules); 2 MAKING DECISIONS, *supra* note 2 (gives empirical indications of what public thinks is material). *But see* Epstein, *supra* note 17, at 124 (arguing that there are "no principled limits" to doctrine's requirements for disclosure).

Traditional informed consent doctrine might offer other acceptable methods of narrowing the dis-

Protecting Patient Choice

extend beyond the doctor's certainties.²⁸⁶ Although some data, judgments and options will be too remote to require mention, disclosure of material *possibilities* in each of the categories is essential. Inappropriate management of uncertainty has been responsible for many of the failures of choice protection analyzed here.²⁸⁷

A concept such as "focus of attention" would help to delimit the duty of disclosure. Of the nondisclosures analyzed here as being vital to choice, many occurred where a doctor made an underlying decision not to act.²⁸⁸ That inaction was not a matter of inadvertance. It was an intentional judgment, the focus of attention and decision, to which liability could have attached had it been incompetent as a matter of professional care. If the relevant knowledge and the decision based upon it were not actually within the doctor's awareness, the issue again becomes whether it should have been—a question of professional competence.²⁸⁹

Under a focus of attention approach, information of the type described should be forthcoming with regard to any presenting symptom, problem or condition that has brought the patient to the doctor for care. Material information should also be forthcoming any time the doctor actually has or acquires information as a result of observations made or initiatives undertaken during care, even if the information is not related to the condition that brought the patient to the doctor.²⁹⁰

The extent of the duty to disclose general information about possibilities that are not the focus of either the doctor's or the patient's concern at the time of the encounter raises the most difficult issues. Anyone might benefit from a cardiogram to screen for heart problems or a tonometry test to identify glaucoma. Explanations of such possible courses of action and reasons why they should or should not be explored would be endless.

closure obligation. Thus, an exception for matters of common knowledge might be employed. In addition, traditional exceptions for mental incapacity, emergency and waiver should apply.

286. J. KATZ, *supra* note 7, at 166-69, 186-89.

287. *E.g.*, Nardone v. Reynolds, 333 So. 2d 25 (Fla. 1976); Hanks v. Doctors Ranson, Swan & Burch, Ltd., 359 So. 2d 1089 (La. Ct. App. 1978); Keogan v. Holy Family Hosp., 95 Wash. 2d 306, 622 P.2d 1246 (1980).

288. *E.g.*, Roark v. Allen, 633 S.W.2d 804 (Tex. 1982) (decision that skull indentations did not require x-ray to determine fracture); Gates v. Jensen, 92 Wash. 2d 246, 595 P.2d 919 (1979) (decision not to test further for glaucoma).

289. Such a rule will create a more precise accountability about knowledge under standards of professional competence. Doctors might find themselves choosing whether to claim they knew but did not disclose (thereby invading the interest in choice), or to admit that they did not know (thereby falling below the threshold for competence).

290. Thus, a patient might come in for an asthma problem, and the doctor might note a skin condition that could be cancerous. Even if the doctor competently concludes it is probably not cancerous, and that no care is necessary, the doctor should disclose the skin condition because it had been a focus of the doctor's attention. If the doctor did not note the condition, the issue would again be one of competence regarding whether she should have. *See also* Ratzan, *Unsolicited Medical Opinion*, 10 J. MED. & PHIL. 147 (1985) (suggesting criteria for and techniques of offering unsolicited medical opinions).

They would threaten what courts have sought to avoid: the obligation to give each patient a medical school education. However, as soon as specific data linking general information to a particular individual is noted, attention is focused and a need to disclose would arise.²⁹¹

Once it is determined that a duty of disclosure applies, breach of that duty ought to be judged not by the standards of expert behavior but by the standards appropriate to protection of patient autonomy. Like the extent of the doctor's knowledge, the accuracy of the doctor's disclosure would still be a question of professional competence, evaluated as it is at present. The occasion for and scope of disclosure, however, would be analyzed in terms of what constitutes reasonable disclosure where one on whom another depends has special access to information relevant to that other's interests, a standard akin to the agent-fiduciary standard. An agent-fiduciary must disclose all information that she knows or should know that the principal would desire to have.²⁹² Given recent documentation that patients want much more medical disclosure and choice than they currently enjoy,²⁹³ such a duty should extend disclosure well beyond the norms of traditional medical practice.

Once duty and breach are established, sanctioning analysis would also differ if choice were the protected interest. The crucial difficulties stem from the uncertainty regarding what would have happened if the patient's interest in choice had not been invaded. Cooper-Stephenson and Saunders²⁹⁴ have argued persuasively that an analysis that balances probabilities to achieve an either/or result is appropriate to determinations regarding events that have occurred. Questions of substantive liability are generally of this genre. Those authors urge, however, that a proportional analysis is fairer where a court must assess intrinsically uncertain events. Such events cannot be analyzed as more probable than not because they are inherently unknowable. Most issues of damage valuation are of this type.²⁹⁵

291. The disclosure required ought to be less extensive with regard to general background information than with regard to its individual application. Such a duty might require the doctor to note briefly the general issue ("Smoking is dangerous to health"), and to provide more extensive information regarding the individual ("Your cough sounds as if you may be having lung problems. We can check it out in the following way . . ."). Also, the obligation to disclose ought not to recur more than once for a single problem of a single patient unless the doctor acquires relevant new data about the patient or the problem.

292. See RESTATEMENT (SECOND) OF AGENCY § 331 (1957).

293. See *supra* note 14.

294. Throughout this section I rely upon K. COOPER-STEPHENSON & I. SAUNDERS, *PERSONAL INJURY DAMAGES IN CANADA* 83-114 (1981). They present both a theory and a review of the cases with reference to appropriate measurement of damages.

295. Although both Canadian and English law have adopted this approach, courts in the United States have been less enthusiastic. *Id.* at 113. Nevertheless, commentators in the United States have endorsed the proportional approach to such determinations. *E.g.*, King, *supra* note 27, at 1396-97; Tom on Torts, *Kentucky Allows Accident Victim's Recovery for Increased Risk of Future Harm*, 27

Protecting Patient Choice

If one adopts Cooper-Stephenson and Saunders' analysis, a balance of probabilities approach would appropriately serve to determine whether the defendant's nondisclosure more probably than not materially deprived the patient of an interest in choice. Two additional uncertainties would then remain to be assessed in valuing any resulting injury. What would the plaintiff, properly informed, have chosen? What, medically speaking, would have been the result if a different course had been selected? Analysis of these issues should employ what Cooper-Stephenson and Saunders call a simple probability test (proportional), because neither involves events that have actually occurred. Each requires the reconstruction of what would have happened had the defendant not interrupted the chain of events by failing to disclose.

Such interruption, the invasion of choice, results in the loss of an uncertain chance of a preferable outcome. That chance can be valued as a matter of assessing damage.²⁹⁶ The familiar maxim that courts should not readily allow uncertainty to prevent vindication of an invaded interest comes into play.²⁹⁷ Damages are adjustable along a monetary continuum. Statistical tools are more readily employed to apportion and value uncertainty for purposes of remedy than to determine substantive liability.²⁹⁸ Moreover, characterizing the issue as one of valuing injury allows the multiple sub-issues involved in these cases to be resolved in an orderly and sequential manner. The court does not have to compress the sub-issues into a single ultimate question as it must where they are treated as a single question of factual cause.²⁹⁹ In order to determine the value of the plaintiff's loss of choice, three questions must be answered.

First, how likely is it that an alternative path would have been chosen? The subjectivity of this first branch of uncertainty makes fact-finding with

AM. TRIAL LAW. A. L. REP. 302, 302 (Sept. 1984). Some courts have also embraced such a perspective, e.g., *Davis v. Graviss*, 672 S.W.2d 928, 931-32 (Ky. 1984). *But see* Rosenberg, *The Causal Connection in Mass Exposure Cases: A "Public Law" Vision of the Tort System*, 97 HARV. L. REV. 851, 874 n.99 (1984) (arguing that in sporadic accident cases proportional rule of recovery is less fair than preponderance of evidence rule).

296. *See* King, *supra* note 130, at 1396-97.

The response of the courts to questions of causation and valuation involving preexisting conditions and claims for future consequences has been largely unsatisfactory. Their failure to distinguish between the functions of causation and valuation, or to identify and value rationally the true interests lost, has created a serious gap in the remedial structure. Courts have had difficulty perceiving that a chance of avoiding some adverse result or of achieving some favorable result is a compensable interest in its own right.

Id. at 1354.

297. RESTATEMENT (SECOND) OF TORTS § 912, at 479 (1979).

298. K. COOPER-STEPHENSON & I. SAUNDERS, *supra* note 294, at 83-114.

299. *See* J. FLEMING, *supra* note 132, at 108 (noting problems created by placing "a wide spectrum of inquiries" within "monistic" doctrine of proximate cause). For a discussion of problems arising from courts' tendencies to treat what should be issues of valuation as questions of causation, see King, *supra* note 130, at 1354.

regard to it the most difficult.³⁰⁰ Although no perfect way of determining an answer exists, as determinations in other circumstances show,³⁰¹ the court could derive some probabilistic estimate of alternative courses. The projected decision of this individual, rather than "a reasonable person," should provide the standard; any other standard fails to protect the very autonomy that lies at the heart of the interest.³⁰²

Subjective states are susceptible of objective proof; they are demonstrable through evidence of conduct or words observable by others.³⁰³ Because the issue here involves a hypothetical rather than an actual event, however, objective evidence will not directly or definitively demonstrate what the individual's choice would have been. Objective evidence, however, could elucidate why this individual might or probably would have chosen a given path.³⁰⁴

300. The word "subjective" sometimes refers to inner, i.e., mental or emotional, states and sometimes to particularization regarding a given individual. See Eisenberg, *The Responsive Model of Contract Law*, 36 STAN. L. REV. 1107 (1984) (discussing these as two main spectra within contract theory). The reconstruction of patient choice actually involves both kinds of subjectivity. In the informed consent caselaw, both types of "subjective" standards have been almost totally rejected as being too unreliable. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 790 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

301. For instance, where a plaintiff claims damage through reliance on a promise, the court will have to reconstruct what that individual would have done in the absence of the promise, under circumstances in which hindsight and self-interest will taint the evidence. See, e.g., *Feinberg v. Pfeiffer Co.*, 322 S.W.2d 163 (Mo. Ct. App. 1959) (in determining whether plaintiff relied on promised retirement stipend, one issue was whether plaintiff would have quit work if promise had not been made). Like medical choice, reliance involves both reconstruction of what an individual would have chosen to do, and what the outcome of that choice would have been. See Eisenberg, *Donative Promises*, 47 U. CHI. L. REV. 1, 18 (1979); see also *infra* note 309; cf. *supra* note 279 (discussing contract cases calculating damages based on prediction of probabilistic outcomes).

302. The approach proposed here parallels Professor Eisenberg's recommendation that most contract law principles should be individualized, and that they may be either objective or subjective, depending upon the circumstances. Eisenberg, *supra* note 300, at 1111. Patient choice cases present more problems both of fairness and of administrability than does the average contract case, but in light of what is at stake, those problems should be manageable. Eisenberg's justification for individualization—that "a major goal of contract law is to facilitate the realization of individual objectives," *id.* at 1111—applies with much greater force here. Bodily fate is a more intense and personal interest than are "highly differentiated goods," and no "cover" at all is possible.

303. See, e.g., *Lucy v. Zehmer*, 196 Va. 493, 84 S.E.2d 516 (1954) (court used objective words and acts of sellers to determine whether they were joking when they agreed to sale of property); RESTATEMENT (SECOND) OF CONTRACTS § 18 comments a and c, § 19 (1981) (explaining objective standards for evaluating assent to contract); cf., e.g., *Lange v. Hoyt*, 114 Conn. 590, 159 A. 575 (1932) (Christian Scientists not required to have child undergo surgery to mitigate damages).

304. If, for example, she made her living as a graphic artist or a photographer, she could persuasively claim that she would have gone to more than average lengths to protect her sight. A few courts have allowed consideration of such individual factors under the "in the circumstances" aspect of the reasonable causation standard in informed consent. See, e.g., *Steele v. St. Paul Fire & Marine Ins. Co.*, 371 So. 2d 843 (La. App.), cert. denied, 374 So. 2d 658 (La. 1979) (implicitly reflecting special attention courts give to individual choice in procreation cases). Objective information about individuals' hypothetical preferences regarding future medical care has become increasingly available. Several states have adopted provisions allowing individuals to make binding advance statements about care in circumstances of terminal illness. See, e.g., Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7186-7195 (West Supp. 1985). Legal provisions have been adopted that effectuate clearly stated individual preferences regarding organ donation. See, e.g., Uniform Anatomical Gift Act, CAL. HEALTH

Protecting Patient Choice

Moreover, a requirement to reconstruct the choice of a given individual does not preclude the introduction of non-individualized objective information. Thus, the court would find useful testimony about choices that other people actually make when confronted with similar risks and odds.³⁰⁵ However, the role of such information should be delimited as bearing only on the credibility of the claim. The individual nature of the ultimate question should be clearly preserved.

The potentially self-serving nature of the plaintiff's testimony should be less worrisome if the court requires and uses objective evidence to determine only a proportional chance that a different path would have been taken. If jury evaluation still seems likely to reflect an excess of sympathy or lack of adequate evaluation of credibility, the court could apply some intermediate protective device. For example, a court could employ a presumption that this individual would have decided as a reasonable person would have, but could then allow the individual to rebut the presumption by showing persuasive objective evidence of individual reasons for deviation.³⁰⁶

Second, the jury would have to determine what would have happened if a different choice had been put into effect.³⁰⁷ Expert testimony would probably be essential here, but again, such testimony should be restricted to assessment of factual medical data. Statistical predictions about outcome odds in a given case would not prove what would actually have happened in the case at bar. But courts routinely use such general data to determine an individual's damages.³⁰⁸

Finally, the value of where the plaintiff stands under the actual chain of events would need to be compared with where she would have stood as a result of the alternative course of events, discounted by the appropriate probability assessments. Comparison of values could begin with reasonable averages, but should also factor in objectively demonstrable individual

& SAFETY CODE §§ 7150-7157 (West 1970).

305. Such data would be of two kinds: (1) statistics showing what people actually have chosen when faced with comparable decisions; and (2) statistics regarding prospective preferences as established by public opinion polls. *See, e.g.*, 2 MAKING DECISIONS, *supra* note 2, at 136, 244 (percent of public desiring to be informed of condition, including diagnosis of cancer).

306. *Cf. Cunningham v. Charles Pfizer & Co.*, 532 P.2d 1377 (Okla. 1975) (presumption plaintiff would have heeded warning on product rebuttable by evidence of what reasonable person would have done).

307. In *Gates v. Jensen*, the answer would have been relatively easy. Further testing would have had a high probability of discovering the glaucoma. 92 Wash. 2d 246, 250, 595 P.2d 919, 922 (1979). In some cases, however, answers would present more difficulties. For example, if a woman alleges she would have opted for a lumpectomy rather than a radical mastectomy, the jury would have to judge the increased probability of having a recurrence of cancer had she followed the alternative course.

308. Thus, courts awarding damages for wrongful death do not know how long an actual individual would have lived, or how much she would have earned. But they use general actuarial probabilities (which take account of as many individual factors as possible) to render those uncertain projections adequately certain. *See* RESTATEMENT (SECOND) OF TORTS § 92 comments c, d, and e (1976).

variables that affect medical preferences, such as age or occupation, or even personal attitudes or circumstances where those could be established by evidence more probative than the plaintiff's simple assertion.

Applying these proposed techniques would be difficult, but the incentive to resolve the complicated problems associated with the vindication of choice derives from the depth of the concern about patient autonomy. As elsewhere, running some risks with inaccurate damages is preferable to not following the logic of doctrine at all.³⁰⁹ Moreover, the methods of calculation suggested here should reduce concern about uncertainty and about recoveries being unduly influenced by hindsight.

Issues regarding types of compensable harm would remain. The intangibility of the interest should not obscure the substantial and often physical nature of the consequences flowing from its invasion. As I have demonstrated, the redefinition of interest suggested here would significantly alter the analysis of duty, breach, causation and value in regard to traditional physical injury. Thus, even if courts were to restrict redress for invasions of choice to physical consequences, realignment of the protected interest would significantly increase legal protection of patient choice.

Identification of an intangible interest in choice could also allow recovery for less traditional categories of harm. Courts could evaluate consequences of a substantial but not necessarily "physical" or "injurious" (as socially judged) harm, for example, the birth of an unwanted child or the undesired prolongation of death. Yet, as a matter of sanctioning policy, courts need not deem compensable all consequences of invasions of choice. For example, although emotional distress damages would constitute a particularly likely result of invasions of this interest,³¹⁰ courts could restrict such recoveries.³¹¹ However, categorical limits on emotional distress damages in medical contexts seem, if anything, to be eroding.³¹²

Under certain conditions, an invasion of choice might not produce any substantial consequences, physical or otherwise. Thus, for instance, if the doctor had not told Ms. Gates of the test indicating possible glaucoma, but she did not, in fact, develop the disease, the doctor would technically have

309. For other illustrations of legal redress in conditions of substantial uncertainty, see *Davis v. Graviss*, 672 S.W.2d 928 (Ky. 1984) (projection of uncertain future injury); *Feinberg v. Pfeiffer Co.*, 322 S.W.2d 163 (Mo. Ct. App. 1959) (reliance on promise); *Locke v. United States*, 283 F.2d 521 (1960) (value of bargained-for chance); *Rombola v. Cosindas*, 351 Mass. 382, 220 N.E.2d 919 (1966) (uncertain expectation); RESTATEMENT (SECOND) OF TORTS §§ 910, 924 (1979) (uncertain prospective consequences of present injury).

310. See, e.g., *Capron*, *supra* note 52, at 639-45.

311. See, e.g., *Berman v. Allan*, 80 N.J. 421, 404 A.2d 8 (1979). Most courts dealing with wrongful birth actions have allowed emotional distress damages. See, e.g., *Jacobs v. Theimer*, 519 S.W.2d 846 (Tex. 1975); *Naccash v. Burger*, 223 Va. 406, 290 S.E.2d 825, 830-31 (1982).

312. See, e.g., *Molien v. Kaiser Found. Hosp.*, 27 Cal. 3d 916, 616 P.2d 813, 167 Cal. Rptr. 831 (1980); *Sullivan v. O'Connor*, 363 Mass. 579, 587-88, 296 N.E.2d 183, 188-89 (1973); *Hirsh*, *supra* note 253, at 9-10.

Protecting Patient Choice

violated the interest in information and choice but the consequences here would be mainly intangible and symbolic. Two possible methods of treating such cases emerge. The court could award nominal damages, or it could award general damages, as is done in privacy actions.³¹³ The latter approach would better redress the purely dignitary element of the new interest. However, because so many demonstrably consequential invasions of patient choice have been ignored under the existing doctrinal scheme, even adoption of the former approach would allow dramatically strengthened protection of patient autonomy. An interest is not delegitimated because in a particular instance its invasion produced little demonstrable harm. Finally, unless the doctor harbored specific or malicious intent to deprive a patient of choice, punitive damages would be inappropriate.³¹⁴

3. *Contract or Tort?*

Several possible grounds for choosing between the two analyses might be suggested. First, the indexing of cases under one or the other doctrinal category may influence the selection of norms and concepts to be used in the analysis. Contract analysis is traditionally rooted in respect for individual choice and might more effectively protect that concern. By contrast, the standard professional negligence action has so dominated tort analysis of medical relationships that it might be difficult for an interest in choice to achieve sufficient independence within the tort domain.

Second, tort has traditionally provided the locus of redress for physical injury. However, both fields have expanded their compass, with contract now recognizing physical and emotional injuries³¹⁵ and tort redressing even negligent injuries to economic,³¹⁶ emotional,³¹⁷ and privacy³¹⁸ interests, as well as to more traditional interests in physical well-being and property. There seems little reason to distinguish on this somewhat outmoded basis.

Finally, a tort approach makes a stronger statement about public policy regarding patient autonomy, while contract, deferring to the parties' election, remains more neutral. Under the proposals I make here, however, the outcomes under the two analyses would, in fact, converge. Under my tort analysis, the interest would emanate from public policy but would be subject to individual choice (waiver) by the patient, or with greater diffi-

313. See W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 117, at 815 (4th ed. 1971); *RESTATEMENT (SECOND) OF TORTS* § 904 (1976). These could be based on some standard amount that was more than nominal, or on a jury appraisal of the facts and circumstances.

314. See *RESTATEMENT (SECOND) OF TORTS* § 908 (1976).

315. See, e.g., *Sullivan v. O'Connor*, 363 Mass. 579, 296 N.E.2d 183 (1973).

316. See PROSSER & KEETON, *supra* note 18, § 95A, at 679-81.

317. *RESTATEMENT (SECOND) OF TORTS* §§ 46-48, 313 (1976).

318. *Id.* at § 652.

culty, by the doctor if she required waiver as a condition of contracting to provide services. Under the contract analysis, I have proposed that, based both on empirical data about patient expectations and on public policy values, courts should read into the contract, as an implied term, patient control of decisions unless the parties explicitly agree to the contrary. Again, then, the contract would include a term requiring patient control as the background rule, alterable only by the affirmative and mutual decision of the parties.

Under contract analysis there remains some danger that, in implying a term, courts would turn to custom of the trade and supply a term based on traditionally paternalistic medical custom. But the needs and expectations of doctors should not exclusively define what is customary. Moreover, the expectations of both doctors and patients are changing. Public policy points, as it does in other consumer contexts,³¹⁹ toward special judicial concern for protection of consumers' (patients') reasonable expectations.

C. *Policy Effects*

1. *Are Patients Capable of Choice?*

The interest proposed here would place a great deal of responsibility on patients. Some may fear that many individuals will be unable to discharge the responsibilities that autonomy would impose.³²⁰ Rationality is inevitably limited; motives and wishes are frequently not conscious. Although these are powerful arguments for seeking personal support and expert advice, the same limits apply to the rationality and motives of doctors, relatives or friends. The burden of consequences provides the compelling reason to place final authority with the affected individual rather than with others who advise or care for that individual.

2. *Effects on Health Care Outcomes*

If patients had more knowledge and control, experts would have less. Would poorer health be the result?³²¹ Medical decisions involve both uncertainty and conflicts of judgment and value. Neither experts nor society can judge what is best for an individual better than the individual herself. The quality of patient choice will, of course, depend on the quality of

319. See, e.g., RESTATEMENT (SECOND) OF CONTRACTS § 211 (1981) (protection against contravention of consumer expectations in standardized agreements).

320. See J. KATZ, *supra* note 7, at 26-27. See generally R. BURT, *supra* note 5 (discussing complex motives affecting medical choice in a number of specific instances).

321. This is perhaps the core objection to proposals to strengthen patient choice. See J. KATZ, *supra* note 7, at 27.

Protecting Patient Choice

information provided by the doctor. But assuming adequate performance of that obligation, patient-made decisions should generally yield outcomes that are preferable as evaluated by the ultimate consumer, the patient.

Moreover, there is evidence that patients who are well-informed progress better than do those who are treated more paternalistically.³²² Such patients implement treatment plans more fully³²³ and can aid the doctor's diagnostic process.³²⁴ More debatable, but not to be overlooked, is evidence that the mobilization of patients' psychic resources is critically important in the struggle for health.³²⁵

3. *Effects on the Distribution of Health Care*

Wealth already buys greater access to health care services.³²⁶ Any system that increased patient autonomy might exacerbate that effect.³²⁷ If choices were more thoroughly subjected to cost-benefit analysis by individ-

322. See Fiore, *Fighting Cancer—One Patient's Perspective*, 300 NEW ENG. J. MED. 284 (1979); Mumford, Schlesinger, Glass, Patrick & Curedon, *A New Look at Evidence About Reduced Cost of Medical Utilization Following Mental Health Treatment*, 141 AM. J. PSYCHIATRY 1145 (1984). There is also evidence that information can reduce emotional problems which accompany physical illness. See Comment, *When the Truth Can Hurt: Patient-Mediated Informed Consent in Cancer Therapy*, 9 U.C.L.A.-ALASKA L. REV. 143, 151 & n.33, 152 & n.34 (1980).

323. Noncompliance is a serious problem in health care. See J. KATZ, *supra* note 7, at xiv and sources cited in Introduction n.2; Press, *The Predisposition to File Claims: The Patient's Perspective*, 12 LAW, MED. & HEALTH CARE 53, 54 (April 1984) (patients' noncompliance reported by some studies as high as 50-60%). Noncompliance likely indicates patients who have "voted with their feet" when they do not feel in control of their treatment. The very term "noncompliance" suggests orders given by the doctor to a passive patient.

324. See J. KATZ & A. CAPRON, *supra* note 30, at 89-90. Doctors not providing necessary instruction regarding self-care may be liable for negligent care. See, e.g., *Crosby v. Grandview Nursing Home*, 290 A.2d 375 (Me. 1972); see also LeBlang & King, *supra* note 189, at 24-26.

325. See N. COUSINS, *ANATOMY OF AN ILLNESS AS PERCEIVED BY THE PATIENT: REFLECTIONS ON HEALING AND REGENERATION* 11, 14-23 (1979); K. PELLETIER, *MIND AS HEALER, MIND AS SLAYER* 10-12 (1977); O. SIMONTON, S. MATHEWS-SIMONTON, J. CREIGHTON, *GETTING WELL AGAIN* 4-12 (1978).

326. Many people have no health insurance coverage. See Bayer, *Justice and Health Care in an Era of Cost Containment*, 9 SOC. RESP.: JOURNALISM, L. MED. 37, 43-47 (1983). For a discussion of the severe problem of access to health care, see 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *SECURING ACCESS TO HEALTH CARE* 90-113 (1983) [hereinafter all volumes cited as *SECURING ACCESS*]; Starr, *Medical Care and the Pursuit of Equality in America*, in 2 *SECURING ACCESS*, *supra* at 1-22. For a discussion of the difficulty of access to high cost procedures like organ transplant or renal dialysis, see J. AREEN, P. KING, S. GOLDBERG & A. CAPRON, *supra* note 32, at 852-861; Knox, *Heart Transplants: To Pay or Not to Pay*, 209 SCIENCE 570 (1980) (reviewing Department of Health and Human Services criteria for Medicare/Medicaid reimbursement for new technologies), and for relatively low cost procedures such as abortion, see, e.g., *Harris v. McRae*, 448 U.S. 297, 329-37 (1980) (Brennan, J., dissenting); *id.* at 337-48 (Marshall, J., dissenting).

327. See the discussion of equity concerns under a market controlled system in Havighurst, *Competition in Health Services: Overview, Issues and Answers*, 34 VAND. L. REV. 1117, 1142-43 (1981). Individual decisionmaking may be less influential because third-party payors play such a central role in access to health care. CONGRESSIONAL BUDGET OFFICE, *CONTAINING MEDICAL CARE COSTS THROUGH MARKET FORCES* 1-2 (1982). But see Rushefsky, *A Critique of Market Reform in Health Care: The "Consumer-Choice Health Plan,"* 5 J. HEALTH POL., POL'Y & L. 720, 726-37 (1981) (suggesting significance of third party reimbursement may have been overestimated).

ual consumers, rather than being made mostly by supposedly wealth-neutral professionals, would comparatively poorer patients end up with even less equitable access to health care than they now have?

Doctor-directed decisionmaking deprives the poor as well as the rich of autonomy and self-determination. Whatever professional ideology would have us believe, professionally competent choice is not in fact immune to economic incentives.³²⁸ The tendency to preempt the choices of poor patients may be significantly greater than it is where wealthy patients are involved.³²⁹ Thus, poor patients may have an even greater stake in strengthened protection for autonomy than do the affluent. The difficulty, however, is that self-determination is a hollow concept to anyone who lacks the resources to implement choice.

The problem of social justice in access to health care is essentially moral and political. Professional expertise cannot and should not provide society with answers about how scarce resources should be distributed any more than it should provide answers about individual utilities regarding medical choice. If there are not enough kidneys to go around, it is disingenuous to pretend that medical expertise can do more than to *advise* regarding some factors that are likely to be relevant in deciding who ought to get one. Expertise can inform those who must make decisions regarding comparative medical risks and benefits. But it should not decide who should receive a transplant any more than it can decide who wants higher levels of certainty. Admittedly, it is politically easier to respond to demands for a "right" to health care by citing the impersonal commands of "medical indication"³³⁰ than it is to articulate and endorse the social, political and economic criteria by which society will determine distribution of health care.³³¹ Yet offering professional expertise as the source of an-

328. Some hospitals and doctors refuse to provide services without advance deposits or proof of insurance. 1 *SECURING ACCESS*, *supra* note 326, at 100-101.

329. See 2 *MAKING DECISIONS*, *supra* note 2, at 20 (doctors tell less to patients they perceive as being less able to understand, a factor highly correlated with socioeconomic status); Note, *Coerced Sterilization Under Federally Funded Family Planning Programs*, 11 *NEW ENG. L. REV.* 589, 595 (1976) (describing coercive practices of medical providers in urging sterilization of welfare mothers).

330. See, e.g., *Cowan v. Meyers*, 3 Civ. 22987 (Cal. Ct. App. filed June 10, 1983) (challenging such restrictions on state-paid health care services). One major effort to introduce the criterion of medical necessity was the Professional Standards Review Organization (PSRO) legislation designed to use peer review to cut costs for Medicare and Medicaid on the basis of whether services were necessary. 42 U.S.C. § 1320(C)(3) (1982). See Blumstein, *The Role of PSROs in Hospital Cost Containment*, in *HOSPITAL COST CONTAINMENT: SELECTED NOTES FOR FUTURE POLICY* 461 (M. Zubkoff, I. Raskin & R. Hanft eds. 1978) (assessing contribution PSROs can make to hospital cost containment). Private insurers also limit their coverage of discretionary services by contract in order to reduce costs. Havighurst, *supra* note 327, at 1127.

331. See G. CALABRESI & P. BOBBITT, *TRAGIC CHOICES* 186-91 (1978); Baily, "Rationing" and American Health Policy, 9 *J. HEALTH POL., POL'Y & L.* 489 (1984) (discussing reluctance of President's Commission to use or explore concept of "rationing" as opposed to "allocation"); Havighurst, *Health Care Cost-Containment Regulation: Prospects and an Alternative*, 3 *AM. J.L. & MED.* 309, 313-15 (1977) (regarding difficulty of political confrontation with problems of cost con-

Protecting Patient Choice

swers to questions of social justice is at best incomplete and at worst deceitful.

Furthermore, if professional expertise is allowed to regulate the distribution of health care resources, its adequacy as a surrogate for individual choice is further undermined. If doctors allocate care, their loyalty to the best interests of their patients is necessarily diminished, just as it is by other conflicts of interest. A doctor who accepted as optimal a given level of certainty about the presence of glaucoma or about the completeness of an abortion might claim to be acting not only as a rational expert, but also as an implementer of social policy.³³² That doctor could not, however, simultaneously claim to be acting on behalf of a patient who places an unusually high value on her eyesight or on her lifestyle as a nonparent.

The strands of professional competence need to be disentangled from those of social justice, just as they need to be separated more thoroughly from those of individual choice. The question of what limits should be placed upon individual choice by considerations of social justice is beyond the focus of this Article.³³³ I have argued only that, in regulating medical decisionmaking, doctrine should maximize individual autonomy rather than decisionmaking by professional experts.

4. *Effects on Consumption and Cost of Health Care*

Increasing demand for medical services is a major cause of rising costs of health care.³³⁴ Increased cost is a problem for individuals, for organizations that finance health care benefits, and for the economy as a whole.³³⁵ Given greater knowledge and control, individuals may increase some kinds of health care consumption. At a minimum, more doctor time would be required to inform and consult with patients regarding their options. Patients who are made aware that additional tests are available to determine, for example, the health of a fetus, the risk of glaucoma, or the possibility of skull fracture might opt for such additional tests.

However, a central premise of much of the current literature on medical cost control is that greater patient choice would yield a significant reduction in health care consumption.³³⁶ Indeed, unless consumers have meaningful control over the implementation of medical recommendations,

tainment and cost benefit analysis).

332. For example, by keeping costs down.

333. For a discussion of issues of social justice in health care, see, e.g., 1 *SECURING ACCESS*, *supra* note 326, at 18-47; Veatch, *What Is a "Just" Health Care Delivery?*, in *ETHICS AND HEALTH POLICY* 127, 131-42 (R. Veatch and R. Branson eds. 1976).

334. CONGRESSIONAL BUDGET OFFICE, *supra* note 327, at 1.

335. 1 *SECURING ACCESS*, *supra* note 326, at 184-85.

336. Blumstein & Sloan, *supra* note 154, at 860-61, 894-95; Marmor, Boyer & Greenberg, *Medical Care and Procompetitive Reform*, 34 *VAND. L. REV.* 1003, 1011-16 (1981).

many cost-control incentives will be ineffective.³³⁷ If fully informed, patients might decline many types of recommended surgery or drugs as being unnecessary or undesirable. For example, there has been much debate about termination of care by patients demanding a right to die, or greater control over the surroundings and conditions under which death or birth will occur.³³⁸ In particular, a deepened knowledge about the value of self-care and prevention, along with a healthier respect for the limits and uncertainties of medicine, would minimize the unrealistic search for absolute protection against danger and mortality.³³⁹

5. *Effects on Liability Burdens of Doctors*

Recognition of an independent interest in patient information and choice would impose a new or at least a more extensive responsibility, and hence a broadened liability, on doctors. Commentators have expressed concern that liability burdens on doctors are already too great. Yet given what has been said both about patient expectations and about cost control, this new responsibility does not seem inappropriate. Moreover, choice protection would actually reduce doctors' liability in ways that would offset this expansion.

Empirical evidence suggests that even when undesirable medical outcomes occur, the greater the degree to which the patient participates and is informed, the less likely she is to file a malpractice claim.³⁴⁰ Furthermore, greater protection of patient choice would relieve doctors of some of the responsibility for *decision* risks because more decisions would be made by patients.³⁴¹ Sharing authority with patients could, therefore, be both a psychic and a legal relief.

Greater clarity in identifying and protecting an interest in choice might

337. Increasing the patient's direct financial responsibility for chosen medical services would also decrease demand. Thus under a regime of increased individual choice, demand could be curtailed by requiring patients who seek levels of care that exceed standards of competent practice to pay a higher share of the cost of such care. Such a scheme might also, however, require a reciprocal program of rebate to those who choose less care than professional norms would recommend.

338. See, e.g., *Bartling v. Superior Ct.*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984) (competent adult wished to refuse medical care and be allowed to die); Watchorn, *supra* note 233 (discussing midwifery as desirable and less expensive alternative to hospital birth).

339. Nor would increased protection of choice necessarily promote the practice of defensive medicine. Choice protection does not change standards for what the doctor should know or recommend; it affects only what the doctor should disclose about what she knows. In any case, malpractice suits may be a more limited factor in stimulating defensive medical practice than has been thought. See Epstein, *supra* note 17, at 107 n.43.

340. Press, *supra* note 323, at 54 (relationship factors more important than harm *per se* in filing malpractice suits); Enright, *supra* note 10, at 90.

341. Press observes that the myth of medical perfection creates a situation in which "the question of who is in charge is easily converted into a question about who is responsible." Press, *supra* note 323, at 59. *But see* Adams & Zuckerman, *supra* note 35, at 484-85 (informed consent is significantly associated with higher annual rate of malpractice claims after 1976).

also reduce unpredictability and irrationality in current malpractice recoveries. Because they receive ambiguous signals from the legal system, doctors have found it difficult to discern meaningful guidelines for conduct.³⁴² Moreover, growing public anger regarding medical paternalism may sometimes cause juries and even judges to render decisions that are anomalous under established principles, because they feel that patient choice is being inadequately protected by present doctrines. A clear and decisive mandate to disclose information for purposes of patient choice might actually improve predictability and reduce litigation.

Some have suggested that, in dealing with medical accidents generally, no-fault systems are preferable to fault-based analysis under traditional tort approaches.³⁴³ No-fault schemes assume the central issue to be compensation for an irreducible quantum of medical accidents. Such a rationale has force in the context of malpractice but is unpersuasive where the interest is patient autonomy. There is nothing inevitable about the allocation of decisionmaking authority between patients and doctors.³⁴⁴ Incentives aimed at furthering traditional tort goals of conduct guidance and deterrence are especially appropriate here. Indeed, the whole point of changed standards would be to avoid the very harms occasioned by invasion of choice by altering perceptions both of what is culpable and of what is appropriate with regard to decisionmaking roles.³⁴⁵

6. *Effects on the Doctor-Patient Relationship*

Realignment of authority in the doctor-patient relationship raises fears about the quality of that relationship.³⁴⁶ The spectre of doctor turned puppet is not attractive. Nor are these simply self-serving fears of doctors wishing to retain their uncontrolled authority. There are dangers in rendering either party to a caretaking relationship choiceless.³⁴⁷

342. 2 MAKING DECISIONS, *supra* note 2, at 25 (only 32% of physicians surveyed agree that the legal requirements of obtaining informed consent are clear and explicit).

343. See sources collected in Meisel, *Expansion*, *supra* note 6, at 143-51; Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 YALE L.J. 1141 (1975). Although Epstein argues that consensual principles are generally preferable to strict liability in resolving medical disputes, he undermines his own theory in the context of informed consent by adopting paternalistic medical custom rather than patient expectation as the appropriate measure of disclosure wherever there is no explicit agreement to the contrary. Epstein, *supra* note 17, at 102-07, 120-28.

344. Professor Meisel comments on the conflicting functions of medical accident compensation and informed consent, noting that "[i]t would be ironic if the informed-consent doctrine, which spawned strict liability for medical accidents, were to contain the seeds of its own destruction . . ." Meisel, *Expansion*, *supra* note 6, at 151.

345. If the resistance to fault analysis stems from concern about excessive judgments against individual defendants, other forms of control, such as the proportional recovery system proposed here, would be preferable solutions.

346. Fears about the doctor-patient relationship being disrupted by greater patient involvement are mentioned in J. KATZ, *supra* note 7, at 27; Miller, *supra* note 35, at 2100.

347. See generally R. BURT, *supra* note 5 (discussing dynamics of doctor-patient relationship and

A broadened obligation to disclose would not make the doctor an impersonal purveyor of technical information. She would remain professionally and personally responsible for recommending and implementing decisions. Nor could she hide behind disclosure of unassimilated information. Rather, she would retain the role of responsible advisor. Accountability for the advising function would have to be carefully monitored, lest the doctor abandon it under the guise of deferring to patient choice.

Patients could not compel a doctor to do something to which the doctor objects as a matter of personal or professional ethics or competence.³⁴⁸ Given the varied views of doctors, however, patients should usually be able to find someone who has no personal objection to implementing the choice the patient wishes to make.³⁴⁹

CONCLUSION

Medical decisionmaking involves the interwoven, overlapping and often competing claims of personal autonomy and professional competence. The challenge of regulating medical decisionmaking is to allocate the proper weight to each of these values. The task is both difficult and important, for the conflict may be between professionally defined "correct" choices in matters ultimately involving life and death, and no less a value than self-determination.

A new model for the allocation of authority between doctors and patients is needed. Existing legal protection for medical patients' autonomy is more limited than has been recognized and more deficient than should be tolerated. Present doctrines falsely equate the protection of autonomy

need for both parties to retain power and responsibility).

348. See, e.g., *Doe v. Mundy*, 378 F. Supp. 731, 736 (E.D. Wis. 1974) (medical personnel not required to perform abortions against personal convictions), *aff'd*, 514 F.2d 1179 (7th Cir. 1975). A right to refuse to perform such services is protected by federal legislation in Title II of The National Research Service Award Act of 1974, Pub. L. No. 93-348, § 214, 88 Stat. 342, 353 (codified at 42 U.S.C. § 300a(b)(2), (c) (1982)). See Ruddick, *Doctors' Rights and Work*, 4 J. MED. & PHIL. 192 (1979) (advocating doctors' "bill of rights").

349. See 2 MAKING DECISIONS, *supra* note 2, at 23 (36% of patients reported that they have changed doctors because they disagreed with the doctor; 20% report that a doctor has told them to find another doctor if they did not agree with that doctor's advice). A more complete identification of doctor and patient preferences and the development of market-oriented shopping for a doctor whose views are compatible with one's own would be desirable. If no qualified doctor would implement the patient's choice, a difficult conflict occurs. See *Bouvia v. Riverside County*, No. 159780 (Cal. Super. Ct. Dec. 16, 1983). A doctor's autonomy, like a patient's, deserves respect. Common law traditions about omission and commission suggest that it may be worse to force a doctor to act against her values than to deprive the patient of the opportunity to effectuate a desired course of action. The logic of the market also suggests that if no one wishes to provide a service, the patient must go without. Yet the tradition of medical paternalism is so strong that deference to such principles would invite the same weakened protection of patient choice that now exists. Furthermore, access to medical care is widely considered to be one of the most fundamental of necessities. Therefore, in this scenario the presumption of control should be with the patient, and the doctor should carry the burden of showing that there is an unacceptable personal compromise.

Protecting Patient Choice

with control over bodily contact. These doctrines also submerge analysis of the interest in autonomy within the related but divergent framework of redress for professional incompetence. Although courts sometimes provide greater vindication for patient choice where there is a conflict of interest on the part of the doctor or heightened electiveness on the part of the patient, these exceptions are unpredictable and inadequately generalized. Protection of patient autonomy remains derivative rather than direct, episodic rather than systematic. As a result, significant harms to patients' interest in choice go unredressed.

The subtlety of power-sharing in an ideal relationship between doctor and patient must be acknowledged.³⁵⁰ Even patients who are clearly competent to make decisions will suffer confusion and ambivalence. They will need guidance and support of professionals and loved ones. Moreover, professionals are to a significant degree motivated by caring for others; we need them to continue to be. Respect for patients' autonomy should not cause doctors either to abandon compassion or to shed their responsibility for advising and caring for patients. But medical decisions depend upon moral values, economic considerations and risk preferences, as well as on medical expertise. Because health care decisions affect the patient more directly than anyone else, the patient's choices, educated but not pre-empted by the doctor's expertise, should be controlling.

The law is not the only relevant tool for achieving such a relationship between doctor and patient. But ultimately the law is about line-drawing, and some basic division of authority is essential both for purposes of norm-setting and of dispute resolution. The fact that practice, time and complexity will embroider nuance and qualification upon the basic structure does not alter the need for such a framework. Patient autonomy should be recognized and protected as a distinct legal interest.

350. For a thoughtful discussion of the difficulties and limitations of sharp role delineation both for doctors and patients, see R. BURT, *supra* note 5.